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CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Mrs. Priyanka Verma. on 30/3/23.

After reviewing the medical history and on clinical examination it has been found that he/she is

	Tick
• Medically Fit	
• Fit with restrictions/recommendations Though following restrictions have been revealed, in my opinion, these are not impediments to the job. 1. Anemia 2. Grade II fatty liver 3. However, the employee should follow the advice/medication that has been communicated to him/her. Review after 3 months	✓
• Currently Unfit. Review after _____ recommended	
• Unfit	

Dr. Saurabh Agarwal
Medical Officer
Apollo Clinic,

Dr. Saurabh Agarwal
MBBS, MD, FIDM (UK), FAGE
Reg. No. 68395
Clinic Hazratganj

This certificate is not meant for medico-legal purposes

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Patient Name- Mrs. Priyanka Verma.		**Date-**	30/3/23.
Age- 32		**Sex-**	F
B P – Systolic 122	**Diastolic** 75mmHg	**R.B.S.-**	
Pulse- 98 b/min		**SPO2-**	94%.
Temp- 95.1°F		**Height-**	
Weight- 74 Kgs.		**BMI-**	
Consultant- Dr. Saurabh Agarwal		**Fat-**	

- Grade II fatty liver
- Anemia

H/O Allergy

℞
① Tab Heptagon 1-0-1 X 1 month
② Tab Evion 600 IU 1-0-0 X 1 month
③ Tab Ferricip XT 0-1-0 X 1 month (after lunch)

Advice: Avoid oily spicy food
Diet modification
Exercise 30 min/day
Eat green leafy vegetable
Eat Iron rich fruits

Inv: USG Abdomen after 3 months

Dr. Saurabh Agarwal
MBBS, MD, FIDM (UK), FAGE
Reg. No. 68395
Apollo Clinic Hazratganj

Valid for 7 Days

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Address : TECHNO HERITAGE, Jehangirabad Palace,
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TO BOOK AN APPOINTMENT
7897 123 777

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Patient Name	: **MRS. PRIYANKA VERMA**	Reported	: ***30.mar.2023***
Age/ Gender	: **32 Y/F**	Status	:
UHID/ MR No	: **FHAZ.0000004060**	Client Name	:
Ref Doctor	:	Patient Location	: **LUCKNOW**

X-RAY CHEST PA

- Trachea is central in position.
- Bilateral lung fields are normally aerated.
- Both hilar shadows are normal.
- Both C.P angles are clear.
- Cardiac shadow is within normal limits.
- Bony cage appears normal.

OPINION: **NORMAL STUDY.**

Please correlate clinically

Dr. PRIYANK CHAUDHARY
(RADIOLOGIST)

Discrepancies due to technical or typing error should be reported for correction seven days. No compensation ability stands

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NAME	: MRS. PRIYANKA VERMA	RT NO	: 4060
DATE	: 30.MAR.2023	AGE	: 32 Y
REFERRED BY	: PAN INDIA	SEX	: F

ULTRASOUND OF WHOLE ABDOMEN

- **LIVER**: is normal in size (13.4 cms) with normal shape & **increased echogenicity**. Biliary radicals are not dilated. No obvious focal lesion. Portal & hepatic veins are normal in caliber.
- **GALL BLADDER**: is partially distended. Wall thickness is normal. No pericholecystic fluid collection noted. CBD is not dilated.
- **PANCREAS**: is normal in size and contour. Parenchyma shows normal echotexture. No pancreatic duct dilatation is seen. No peri-pancreatic fluid collection seen.
- **SPLEEN**: is normal in size (9.9 cms), shape & position. Parenchyma shows normal echotexture. Splenic veins are not dilated.
- **B/L KIDNEYS**:
- Both kidneys are normal in size, site, shape, position. Cortical echoes are normal. Cortico-medullary differentiation is maintained. Pelvicalyceal system are not dilated. No obvious calculus / mass / cyst seen.
- **URINARY BLADDER**: is well distended with normal contour. Wall appears regular. No evidence of any calculus /mass lesion is seen.
- **UTERUS**: It is anteverted with normal size measuring 77x48x37 mm. Myometrial & endometrial echoes are normal. Endometrial stripe measures 6.7 mm is normal. No obvious fluid collection seen with in endometrial canal. No focal mass lesion seen. Cervix appears normal.
- **RIGHT OVARY**: is normal in size, shape and echotexture.
- **LEFT OVARY**: is normal in size, shape and echotexture.
- No fluid in POD.

IMPRESSION:

➢ ***GRADE II FATTY LIVER.***

ADV: Please correlate clinically

Note:- discrepancies due to technical or typing errors should be reported for correction for seven days. No compensation liability stands.

Typed by
Poonam Tiwari

Dr. Priyank K.S. Chaudhary
MBBS, DMRD, DNB(Radiodiagnosis)

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Patient Name- Mrs. Priyanka Verma.		**Date-**	30/3/23
Age- 32		**Sex-**	f.
B P – Systolic	**Diastolic**	**R.B.S.-**	
Pulse-		**SPO2-**	
Temp-		**Height-**	
Weight-		**BMI-**	
Consultant- Dr. Sanhita Sinha.		**Fat-**	

H/O allergy, dry cough.

	R	L
Ear		
EAC	N	mild wax (+)
TM	retracted (mild)	retracted (mild)
TFT		
Rinne	AC > BC	AC > BC
Weber	to (L)	
ABC	SAE	SAE

Nose - (L) MT.
PNS - Non tender.
oral cavity - dental deposits (+), tartar seen.
oropharynx - WNL.
Neck - No palpable nodes.

adv.
- Fluticone F1 N/S 1puff at night in each nostril x 2 weeks then sos.
- Steam inhalation

Valid for 7 Days

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Report Doc No.: **4779** | Patient No.: **3710-3700**
Name : **Mrs. Priyanka Verma / 32 Year / Female** | Collected On : **30-03-2023**
Refered By : **ARCOFEMI HEALTHCARE LIMITED** | Report On: **30-03-2023 05:50 PM**

ARCOFEMI MEDIWHEEL FEMALE HEALTH PACKAGE

CBC (Complete Blood Count)

Hemoglobin Method :*(Cyanmethemoglobin)*	**10.4 gm%**	Normal 12-15 gm%
Hematocrit (PCV) Method :*(Calculated parameter)*	**32.2 %**	Normal 36-45 %
RBC Count Method :*(Electrical Impedence)*	4.73 million/cmm	Normal 3.7-5 million/cmm
MCV Method :*(Calculated parameter)*	**68.1 fl**	Normal 83-101 fl
MCH Method :*(Calculated parameter)*	**22.0 pg**	Normal 27-32 pg
MCHC Method :*(Calculated parameter)*	32.3 g/dl	Normal 31-37 g/dl
RDW-CV Method :*(Electrical Impedence)*	**17.2 %**	Normal 11.6-14 %
TLC (Total Leucocyte Count) Method :*(Electrical Impedence)*	9100 cells/cu.mm	Normal 4000-10000 cells/cu.mm
DLC (Differential Leucocyte Count) Method :*(Electrical Impedence)*		
Neutrophil	57 %	40-80
Lymphocyte	34 %	20-40
Eosinophil	04 %	1-6
Monocyte	05 %	2-10
Basophil	00 %	0-1
ABSOLUTE LEUCOCYTE COUNT Method :*(Electrical Impedence)*		
NEUTROPHILS	5187 cells/cu.mm	2000-7000
LYMPHOCYTES	**3094 cells/cu.mm**	1000-3000
EOSINOPHILS	364 cells/cu.mm	20-500
MONOCYTES	455 cells/cu.mm	200-1000
Platelet Count Method :*(Electrical Impedence)*	212 thousand/mm3	Normal 150-450 thousand/mm3

GBP (Peripheral Blood smear)

RBC : Show mild anisopoikilocytosis and are predominantly microcytic hypochromic with few Normocytic normochromic cells seen.

WBC : Total leucocyte count is within normal limit with normal distribution of cells

Platelets : Platelets are adequate in number.

No hemoparasite or immature cells seen .

Checked By

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Report Doc No.: **4779**
Name : **Mrs. Priyanka Verma / 32 Year / Female**
Refered By : **ARCOFEMI HEALTHCARE LIMITED**

Patient No.: **3710-3700**
Collected On : **30-03-2023**
Report On: **30-03-2023 05:50 PM**

ESR (Wintrobs)		**28 mm/h**	Normal 0-20 mm/h
Blood Grouping/ABO RH Typing			
Blood Group	:	**"AB"**	
Rh Factor	:	**POSITIVE**	
Blood Sugar (Fasting) Method :*(GOD-POD)*		81 mg/dl	Normal 70-110 mg/dl
Blood Sugar (PP) Method :*(GOD-POD)*		110 mg/dl	Normal 80-160 mg/dl

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Report Doc No.: **4779**
Name : **Mrs. Priyanka Verma / 32 Year / Female**
Refered By : **ARCOFEMI HEALTHCARE LIMITED**

Patient No.: **3710-3700**
Collected On : **30-03-2023**
Report On: **30-03-2023 05:50 PM**

Kidney Function Test (KFT)

Serum Urea Method :*(UREASE)*	21 mg/dl	Normal 10-50 mg/dl
Serum Creatinine Method :*(Creatinine amidohydrolase)*	0.7 mg/dl	Normal 0.6-1.4 mg/dl
Serum Sodium Method :*(Direct ISE)*	139 mmol/L	Normal 135-146 mmol/L
Serum Potassium Method :*(Direct ISE)*	3.8 mmol/L	Normal 3.5-5.1 mmol/L

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Refered By : **ARCOFEMI HEALTHCARE LIMITED**

Patient No.: **3710-3700**
Collected On : **30-03-2023**
Report On: **30-03-2023 05:50 PM**

Liver Function Test (LFT)

Serum Bilirubin - Total Method :*(Diazo sulfanilic)*	0.7 mg/dl	Normal 0.2-1.2 mg/dl
Serum Bilirubin - Direct Method :*(Diazo sulfanilic)*	**0.4 mg/dl**	Normal 0-0.3 mg/dl
Serum Bilirubin-Indirect Method :*(Calculated parameter)*	0.3 mg/dl	Normal 0.3-1 mg/dl
Serum SGOT/AST Method :*(UV with P-5-P)*	22 U/L	Normal 10-46 U/L
Serum SGPT/ALT Method :*(UV with P-5-P)*	27 U/L	Normal 10-49 U/L
Serum Alkaline Phosphatase (SALP) Method :*(p-nitrophenyl phosphate)*	**110 U/L**	Normal 35-104 U/L
Serum Gamma-Glutamyltransferase (GGT) Method :*(IFCC)*	12 U/L	Normal 0-38 U/L

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Refered By : **ARCOFEMI HEALTHCARE LIMITED**

Patient No.: **3710-3700**
Collected On : **30-03-2023**
Report On: **30-03-2023 05:50 PM**

Lipid Profile

Serum Cholesterol -Total Method :*(CHE/CHO/POD)*	111 mg/dl	Normal < 200
Serum Triglyceride Method :*(Enzymatic)*	82 mg/dl	Normal < 150
Serum Cholesterol VLDL Method :*(Calculated parameter)*	17 mg/dl	Normal < 30
Serum Choleterol HDL Method :*(Polymer-Detergent)*	**33 mg/dl**	Normal > 40
Serum Cholesterol LDL Method :*(Calculated parameter)*	61 mg/dl	Normal < 100
Total Cholesterol/HDL Ratio Method :*(Calculated parameter)*	3.36	Normal 0-4.5
LDL/HDL Ratio Method :*(Calculated parameter)*	1.88	Normal 0-3

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Patient No.: **3710-3700**
Collected On : **30-03-2023**
Report On: **30-03-2023 05:50 PM**

HbA1c

TEST NAME	RESULT	UNIT	BIO. REF. RANGE	METHOD
HBA1C, GLYCATE HEAMOGLOBIN, *WHOLE BLOOD EDTA*	5.3	%		TURBIDIMETRIC

Comment:

Reference range as per American Diabetes Association (ADA):

REFERENCE GROUP	HBA1C IN %
NON DIABETIC ADULTS> 18 YEARS	<5.7
AT RISK (PREDIABETES)	5.7-6.4
DIAGNOSING DIABETES	≥6.5
DIABETICS	
EXCELENT CONTROL	6-7
FAIR TO GOOD CONTROL	7-8
UNSATISFACTORY CONTROL	8-10
POOR CONTROL	>10

Note: Dietary preparation or fasting is not required.

1. A1C test should be performed at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control).
2. Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. When mean annual HbA1c is <1.1 times ULN (upper limit of normal), renal and retinal complications are rare, but complications occur in >70% of cases when HbA1c is >1.7 times ULN.
3. Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present. Fructosamine may be used as an alternate measurement of glycemic control.

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Patient No.: **3710-3700**
Collected On : **30-03-2023**
Report On: **30-03-2023 05:50 PM**

T3 T4 TSH

Serum T3 Method :*(Chemiluminescence Immunoassay)*	1.25 ng/ml	Normal 0.7-2 ng/ml
Serum T4 Method :*(Chemiluminescence Immunoassay)*	8.22 µg/dl	Normal 6.1-12.2 µg/dl
Serum Thyroid Stimulating Hormone (TSH) Method :*(Chemiluminescence Immunoassay)*	4.25 uIU/ml	Normal 0.3-5.6 uIU/ml

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Refered By : **ARCOFEMI HEALTHCARE LIMITED**

Patient No.: **3710-3700**
Collected On : **30-03-2023**
Report On: **30-03-2023 05:50 PM**

Urine R/M

DEPARTMENT OF CLINICAL PATHOLOGY			
URINE EXAMINATION REPORT			
TEST NAME	**VALUE**	**UNIT**	**NORMAL VALUE**
PSYSICAL EXAMINATION:-			
Urine Color	Pale Yellow		Pale yellow
Reaction	Acidic		Acidic/Alkaline
Appearance	Clear		Clear
Specific Gravity	1.020		1.010-1.025
CHEMICAL EXAMINATION:-			
Albumin	Absent		Trace/Nil
Glucose	Absent		Absent
Ketone	**Trace**		Absent
Blood	Absent		Absent
Bilirubin	Absent		Absent
Urobilinogen	Absent		Absent
Nitrite	Absent		Absent
MICROSCOPIC EXMINATION:-			
Pus Cells(WBC)	1-2	Cells/hpf	
Red Blood Cells (RBC)	Nil	Cells/hpf	
Epithelial Cell	5-6	Cells/hpf	
Casts	Nil	Nil	
Bacteria	Nil		
Crystals	Nil	Nil	

End of Report

Checked By

Dr. Divya Mehdiratta
MBBS, MD (Pathologist)

Mrs. Priyanka Verma
Age - 32Y/F

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C/o - none

Vn < 6/9P / 6/18

VNCPH < 6/6 / 6/6

Nvn < N6 / N6

Cvn < 35/38 / 35/38

Subjective Improvement.

R → -1.0 DS — 6/6
L → -1.25 DS — 6/6

Nvn < N6 / N6

~~*~~ Constant Use

* Blue cut glass

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Priyanka Verma 32/F

C/C - regular dental checkup

O/E - stains ++

calculus ++.

papillary gingival attachment (labial).

Adv - (1) oral prophylaxis (moderate).

Dr. ROHIT MADAN
MDS (Periodontist & Oral Implantologist)
Consultant Dentist
DCI Reg. No. 002259
Apollo Clinic, Hazratganj

30.3.23.

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Patient Name- Mrs. Priyanka Verma.		Date-	30/3/23
Age- 32		Sex-	F.
B P – Systolic	Diastolic	R.B.S.-	
Pulse-		SPO2-	
Temp-		Height-	
Weight-		BMI-	
Consultant- Dr. Meena Pandey.		Fat-	

C/O wants issue.

married.
ML – 3y.
O/H P0+0
M/H – Regular
· Flow 3 days.
· 2-3 pad
· Dys- (–)ve
No/h chronic illness
Bronchial Asthma.

P/V-
P/S – NAD
P/A – NAD.

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Age- 32		**Sex-**	F
B P – Systolic 122	**Diastolic** 75mmHg	**R.B.S.-**	
Pulse- 98 B/min		**SPO2-**	94%.
Temp- 95.1°F		**Height-**	
Weight- 74 Kgs.		**BMI-**	
Consultant-		**Fat-**	

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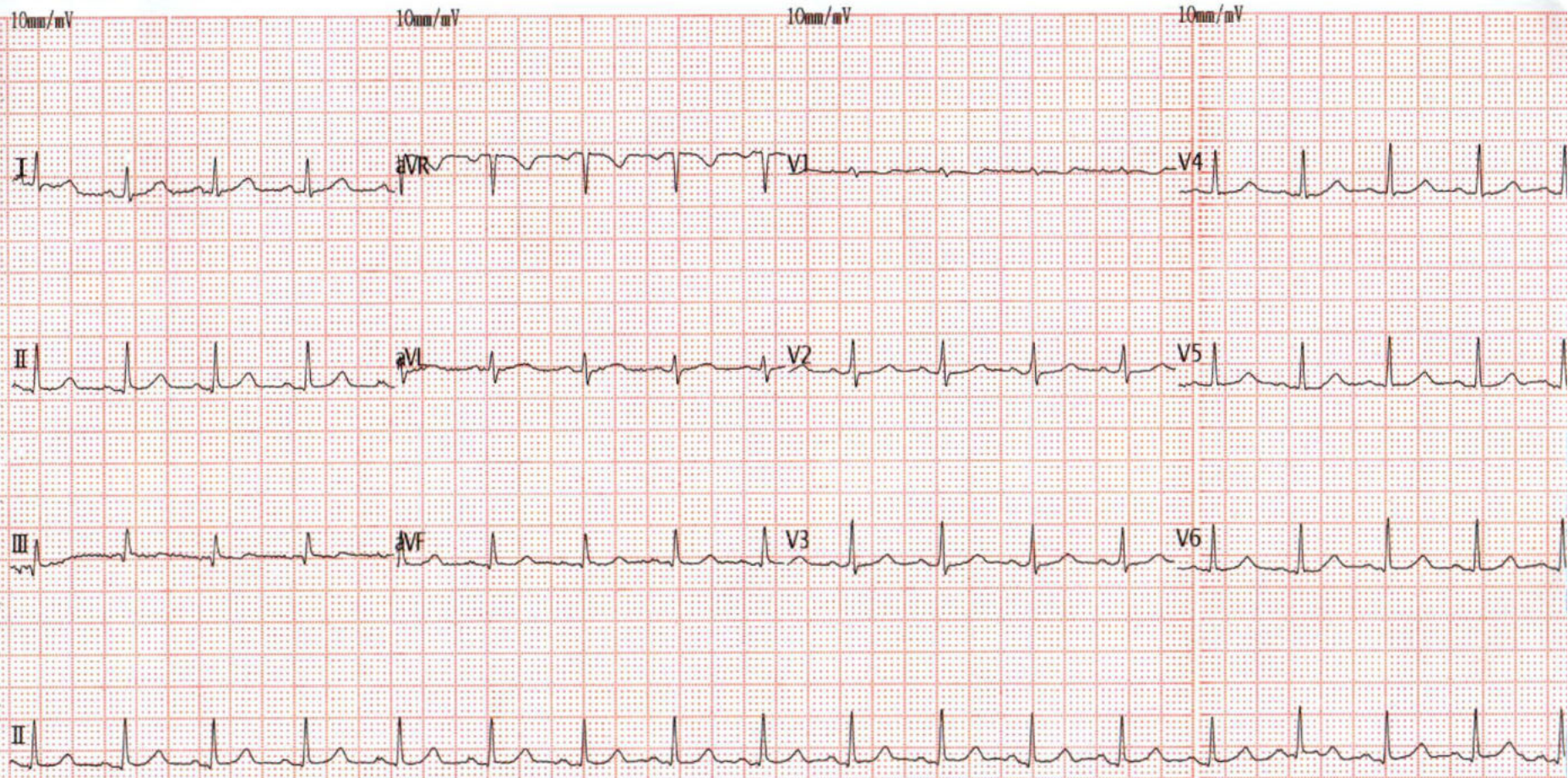

Vent. Rate(BPM) : 105

PR Int.(ms) :	119		
P/QRS/T Int.(ms) :	90	88	155
QT/QTc Int.(ms) :	328	437	
P/QRS/T Axis(Deg.) :	17	58	40
RV1/SV5 Amp.(mV) :	0.06	0.00	
RV5/SV1 Amp.(mV) :	0.71	0.05	

V2 33 Technician :

<ECG Analysis Result>:

802 Sinus Tachycardia
132 Low Voltage(Chest Leads)
401 Short P-R Interval
*** Borderline Abnormal ECG ***

Note : Unconfirmed Report Need to Review

ST LEVEL(mV)

I	II	III	aVR	aVL	aVF
+0.02	+0.02	+0.00	-0.02	+0.01	+0.01
V1	V2	V3	V4	V5	V6
+0.00	+0.00	+0.00	+0.00	+0.00	+0.00

25mm/s AC50 FMC ADS 2023-03-30 14:44:24 <MRS PRIYANKA > 000000004060 F 32Y / cm/Kg / mmHg

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PATIENT NAME :MRS PRIYANKA VERMA	AGE / SEX: 32 YRS/F
UHID :4060	DATE : 30 , MAR, 2023

2-D ECHO& M-MODE EXAMINATION
VALVES

1.MITRAL VALVES STUDY:

a)**Motion:** Normal b) **Thickness:** Normal c)**Calcium**- none

2. AORTIC VALVE STUDY

a) **Aortic root** 2.5cm. b)**Aortic Opening** 2.0cm. c)**Closure:**Central

d)**Calcium-** none e)**Eccentricity Index** 1 f) **Vegetation**- none

g) **Valve Structure** : Trileaflet

3.PULMONARY VALVE STUDY Normal

a)**EF** Slope Normal b)**A Wave** +
c)**Thickness** Normal d)**Others** –

4.TRICUSPID VALVE Normal.

6. AORTIC MITRAL CONTINUITY: maintained

Left Atrium	3.6x3.4cm.	Clot	: none	Others:
Right Atrium	Normal	Clot	:none	I.A.S.: intact
IVC	11mm with normal respiratory variation			

(Cont ……..2)

VENTRICLES

RIGHT VENTRICLE: Normal

Ejection fraction: 66%

LEFT VENTRICLE :

Fractional Shortening 36%

IVS (D) 1.1cm.(S) 1.2 cm.

LV mass:134g

LVID(D) 3.76cm.(S) 2.40 cm.

PW (D) 1.0cm (S) 1.4 cm

RWMA: None
IVS: Intact

TOMOGRAPHIC VIEWS

PARASTERNAL LONG AXIS VIEW:
Normal

Good LV contractility

SHORT AXIS VIEWS:

Aortic Valve Level

AOV- Normal
MV-Normal
PV-Normal
TV-Normal

Mitral Valve Level

Papillary Muscle Level:

APICAL 4 CHAMBER VIEW No clot / vegetation

OTHER SPECIAL VIEWS:

(Cont.....3)

PERICARDIUM
Normal

DOPPLER STUDIES

	Velocity (m/ sec)	Flow Pattern	Regurgitation	Gradient mmHg
MITRAL	E=0.73;A=0.64 E/A=1.1;E/e`=6	Normal	Nil	-
AORTIC	0.9	Normal	Nil	3.6
TRICUSPID	1.9	Normal	Trace	14
PULMONARY	0.9	Normal	Nil	3.6

PASP=14+RAP

CONCLUSIONS:

- No RWMA
- LVEF = 66%
- Trace TR
- IAS/IVS intact
- No MR/AR
- No clot / vegetation.
- No pericardial effusion.
- No Diastolic Dysfunction

DR. A.K SINGH
MD,DM(Cardiology)