भारत सरकार

GOVERNMENT OF INDIA

விஜயசாந்தி பெருமாள் சுப்பரமணியம்

Vijaya Santhi Perumal Subramaniam

பிறந்த நாள்/ DOB: 15/10/1992

/ FEMALE

7003 9907 6488

எனது ஆதார், எனது அடையாளம்

MEDICAL EXAMINATION FORM

Confidential without Prejudice Report. To Be Filled In Strictly By the Physician/Diagnostic Center

PART I: GENERAL DETAILS

NAME OF THE PATIENT Vijaya Sarthi P.S

DOB 15/10/92 Age 31 Sex Female Phone number 9585515678

PART II: MEDICAL EXAMINATION REPORT (Strictly to be filled by Medical Examiner)

(Kindly tick wherever applicable)

A. PERSONAL HISTORY:

1. Previous history if any:

Disease	Yes/ No	Medicine & Surgery Details	Disease	Yes/ No	Medicine & Surgery Details
Diabetes Mellitus	NO		Cancer	NO	
Hypertension	NO		Tumor/Benign	NO	
IHD	NO		Genital urinary disorder	NO	
Stroke	NO		Rheumatic joint diseases or symptoms	NO	
Surgeries	NO		Asthma	NO	
Tuberculosis	NO		Pulmonary Disease	NO	
Congenital Disease	NO		Anemia	NO	
Arrhythmia	NO		Bleeding disease or Disorder.	NO	
Aids (HIV)	NO		Mental Stress	NO	

2. Habits:

Diet	NO	Alcohol	NO	Tobacco/Smoking	NO	Medicine	NO

3. Major complaints/Relevant past history if any: Ulcer (Gastric)

4. Previous Illness (Hospitalization Investigation, consultation)

5. Family history: Diabetes - ~~Brother~~ Parents

Pressure - Father

Heart

B. MEDICAL EXAMINERS FINDING AND ASSESSMENT [illegible]
are asked not to give any information to the person, assured, about the results

1. Anthropometry:

Height	156 cm	Weight	kg 59.15	BMI	

2. Vital Parameters:

(i)

Respiratory Rate	21	Pulse Rate	66 bpm

(ii) Blood Pressure (Three consecutive Readings):

Systolic	130	130	120
Diastolic	80	80	76
Further readings at 10 minute interval if the first reading exceeds 140/90	mmhg	mmhg	mmhg

3. Skin

Is there is any evidence of:

Chronic Ulcer:	☐	YES	☑	NO	Eczema	☐	YES	☑	NO
Swelling	☐	YES	☑	NO	Varicose Veins	☐	YES	☑	NO
Skin Discoloration	☐	YES	☑	NO	Psoriasis	☐	YES	☑	NO

Any Other skin problem and specific location describe NO

EXAMINATION FINDINGS DETAILS

4. Cardiovascular System: S1S2(A)

5. Genito-Urinary System: NA

6. Respiratory System: AEBE clear

7. Gastro-Entrology System:

(a) Oropharyngeal: NA

(b) Abdomen:

Soft
Non tender

Evidence of Hernia, Hydrocele, Fissure, Fistula & piles,

If yes, please describe

8. Nervous System: Conscious Oriented

9. Eye Check-up (N)

10. ENT (N)

12. For Female Clients Only:

1. Is there any disease of breast? –
2. (I) Is there any evidence of pregnancy? –

   (II) If Pregnant, are any complications to be expected? –
3. Do you suspect any disease of uterus, cervix of ovaries? –
4. Any menstrual complaints? Regular menses

C. SUMMARY of the examination findings:

Positive Findings if any: (Please Specify)

_____

_____

Advice:

_____

Conclusion on the fitness of the client:

_____

D. DOCTOR'S DECLARATION:

I confirm that I have examined this CLIENT and the findings stated above are true and correct to the best of my knowledge.

DR. ANAND PRAKASH GAUR
MBBS, DGO
(Consultant Gynaecologist)
MMC Reg. No.
2005/02/0955

1. Name of the Medical Examiner: _____

Signature of the Medical Examiner: _____

Stamp of the Medical Examiner

Registration Number _____

Date of medicals conducted: _____

Place: _____

2. Name of the Client: _____

Signature of the Client: _____

NOTE: NAME AND SIGNATURE OF MEDICAL EXAMINER AND THE CLIENT IS MANDATORY ON THIS FORM

HEALTH

Ophthalmology Case Paper

Reg. No: Date: 19/12/2024

Patient Name: Mr./Mrs. Vijaya Shanthi

Age: 31 Sex: F Address:

Mobile No: 9585535678

Systemic Illness	NAD
Allergies	No allergies

	Right Eye	Left Eye
Color Vision	N	N
Distance	$\frac{6}{6}$ N	$\frac{6}{6}$ N
Near	6N	6N

DR. ANAND PRAKASH GAUR
MBBS, [illegible] CEBDM
(Consultant Physician)
Sign. and Stamp
MMC Reg. No.
2005/02/0965

Shanthi, Vijaya

20.02.2024 7:28:50

Location:
Room:
Order Number:
Indication:
Medication 1:
Medication 2:
Medication 3:

57 bpm
-- / -- mmHg

Female

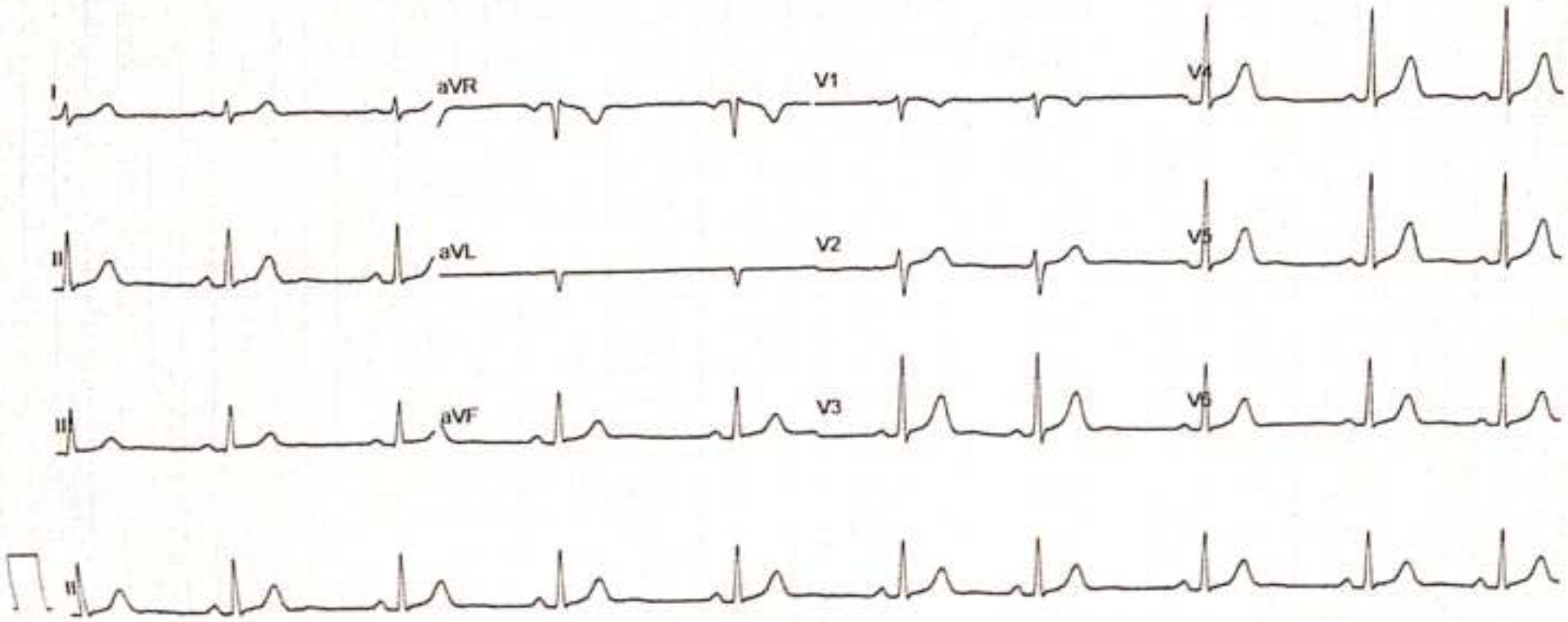
32 Years

QRS	84 ms
QT / QTcBaz	398 / 387 ms
PR	154 ms
P	90 ms
RR / PP	1056 / 1052 ms
P / QRS / T	61 / 80 / 66 degrees

Sinus bradycardia with sinus arrhythmia
Otherwise normal ECG

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

DR. ANAND PRAKASH GAUR
MBBS, CC[illegible]DCFSDM
(Consultant Physician)
MMC Reg. No.
2005/02/0965



[illegible] 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 60 Hz 4x2.5x3_25_R1 Unconfirmed 1/1

Patient Consent Form: Omitting Tests from Health Check Package

Patient Information:

Full Name: Vijaya Santhi P S

Date of Birth: 15-10-72

Address: No6, 1st block, Chintamani CHS, Mhada colony, Gudabolo

Reference: ekincare

Contact Number: 9585536678

Email Address: vishanthisubramaniam@gmail.com

I, Vijaya Santhi, hereby give my consent to (Hospital Name) Credence hospital to omit certain tests from the health check package that I have selected. I understand that this decision may have implications for the completeness of the health assessment and the information provided to me.

Name of Health Check Package: [Health Check Package Name] Pap Smear

Date of Scheduled Health Check: [Scheduled Health Check Date] 19/2/2024

Omitted Tests: [List of Tests to be Omitted] \

I have been given the opportunity to ask questions and have received satisfactory answers regarding the tests being omitted from the health check package. I understand that I have the right to request a complete health assessment and include all recommended tests. However, I voluntarily choose to omit the specified tests and accept any potential consequences that may arise as a result of this decision.

I acknowledge that [Your Organization] and its healthcare professionals have explained the purpose, benefits, risks, and alternatives of the omitted tests to me. I understand that the decision to omit tests has been made based on my specific circumstances and preferences.

By signing this consent form, I confirm that I have read and understood the contents of this form, and I willingly provide my consent to omit the specified tests from the selected health check package.

Patient Signature: P.S Vijaya Santhi

Date: 19/2/24.

Note: A copy of this signed consent form should be provided to the patient and retained in their medical records.

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN & DIAGNOSTIC CENTER

Name: Miss. Vijaya Santhi **Age/Sex: 32Y/Female**

Date: 19/02/2024

2 D Echocardiography & color Doppler Study

FINDINGS:

- No left ventricle regional wall motion abnormality.
- No left ventricle diastolic dysfunction.
- No left ventricle wall hypertrophy. No LV dilation.
- Normal left ventricle systolic function. LVEF apprx-60%.
- No mitral regurgitation.
- No aortic regurgitation.
- No TR. No pulmonary hypertension.
- Cardiac valves are structurally normal.
- Normal size of cardiac chambers.
- Intact IAS & IVS.
- No LV clot/vegetation/pericardial effusion.
- Normal RV systolic function. No hepatic congestion.

Conclusion:

Normal 2D echo & color Doppler Study.

DR. KUMAR RAJEEV
M.D.(Med),DNB(Cardiology)

Name: Miss. Vijaya Santhi **Age/Sex: 32Y/Female**

Date: 19/02/2024

2D Measurements:

LA	35 mm
AORTIC ROOT	28 mm
EF SLOPE	90 mm/sec
LVIDD	40 mm
LVIDS	29 mm
IVS(D)	09 mm
PW(D)	09 mm
RVID	28 mm
LVEF	60%

Doppler study:

AV max -	1.1 m/sec	E vel	0.9 m/sec
PV max -	0.9 m/sec	A vel	0.7 m/sec
PASP		E/A	1.3

PATIENT'S NAME	MISS. VIJAYA SANTHI	AGE :- 32y/F
REFERRED BY	CREDENCE CARE HOSPITAL.	DATE :- 19/02/2024

USG BREAST

Bilateral breast parenchyma show normal echotexture.

Mammary zone shows normal glandular tissue.

Retromammary tissue appears normal.

No axillary lymphnodes are seen bilaterally.

No evidence of any other lesion noted.

IMPRESSION: NO ABNORMALITY DETECTED.

DR SAGAR GARGE

PATIENT'S NAME	MISS. VIJAYA SANTHI	AGE :- 32 y/F
REFERRED BY	CREDENCE CARE HOSPITAL	DATE : 19/02/2024

USG WHOLE ABDOMEN & PELVIS

LIVER is normal in size , normal in shape and echotexture. No evidence of any focal lesion seen. The portal vein appears normal & shows normal hepato-petal flow. No evidence of intra-hepatic biliary duct dilatation.

GALL BLADDER not-visualised, consistent with post-operative status. .

Visualised parts of head & body of PANCREAS appear normal. PD is not dilated.

SPLEEN is normal in size and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis

URINARY BLADDER is partially filled with urine wall is mild thickened irregular.

UTERUS is normal in size.

Visualised bowel loops appear normal. There is no free fluid seen in abdomen and pelvis.

IMPRESSION :

- **No Significant abnormality is detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

DR SAGAR GARGE
(consultant Radiologist)

JUMBO DIAGNOSTIC CENTER
THE DIAGNOSTIC SPECIALISTS

Patient Name : MRS. VIJAYA SUBHRAMANIAM
Age / Gender : 32 Years / Female
Referral Doctor: HEALTH CHRCK UP
Collection Date : 19/02/2024 10:41 AM
Pt.Type / ID : OPD/ 512
Reporting Date : 19/02/2024 05:41 PM

Complete Blood Count (CBC)

Test Description	Value(s)	Unit	Reference Range
Hemoglobin	**11.5**	gms/dl	12 - 15
RBC Count	3.83	mil./cmm	3.8 - 5.8
Haematocrit (HCT)	**33.6**	%	37 - 47
	RBC Indices		
MCV	87.73	fL	80 - 100
MCH	30.03	pg	27 - 34
MCHC	34.23	gm/dl	32 - 36
RDW-CV	12.0	%	11 - 16
Total WBC Count	7100	/uL	4000 - 10000
	DIFFERENTIAL COUNT		
Neutrophil	61	%	40 - 70
Lymphocytes	35	%	20 - 40
Eosinophil	02	%	1 - 6
Monocytes	02	%	2 - 8
Basophils	00	%	0 - 1
	Platelet Indices		
Platelet Count	223000	/cmm.	150000 - 450000
RBC Morphology	Normocytic Normochromic		
WBC Morphology	Within Normal Limits		
Platelet	Adequate on smear		

Done on fully Automated cell counter-ERBA H360

Checked By

Authenticity Check

Dr. Harshal Thorat
MD (Path)
Reg No. 2014/10/4438

Jumbolabhub@gmail.com

Patient Name : MRS. VIJAYA SUBHRAMANIAM
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Pt.Type / ID : OPD/ 512

Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
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ESR (ERYTHROCYTE SEDIMENTATION RATE)

Test Description	Value(s)	Unit	Reference Range
Erythrocyte Sedimentation Rate (Wintrobe method)	08	mm/hr	< 20

Interpretation: It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

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BLOOD GROUP (BG)

Test Description	Value(s)	Unit	Reference Range
Sample Type : WHOLE BLOOD EDTA			
Blood Group :	B Rh Positive		

METHOD : Monoclonal blood grouping (Agglutination test) by slide method

KIT : Span diagnostics.

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BLOOD GLUCOSE LEVEL (FASTING & POST PRANDIAL)

Test Description	Value(s)	Unit	Reference Range
Glucose Fasting (Plasma)	90.0	mg/dl	70 - 110
Glucose PP (Plasma)	102.0	mg/dl	90 - 150

Interpretation : Fasting Blood Sugar more than 126 mg/dl on more than one occasion can indicate Diabetes Mellitus.

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LIPID PROFILE

Test Description	Value(s)	Unit	Reference Range
Total Cholesterol	141.0	mg/dl	Low < 125 Desirable : < 200 Borderline High : 201 - 240 High : > 240
Triglycerides	133.0	mg/dl	Low < 25 Normal : < 150 Borderline High : 151 - 199 High : > 200
HDL Cholesterol	42.0	mg/dl	< 35 Low >80 High
Non HDL Cholesterol	**99.00**	mg/dl	Desirable : < 130 Boderline high : 130 - 159 High : > 160
LDL Cholesterol	**72.40**	mg/dl	Low < 85 Optimal : <100 Near/Above Optimal : 101 - 129 Borderline High : 130 - 159 High : >160
VLDL Cholesterol	26.60	mg/dl	Below 40
TOTAL CHOL/HDL Ratio	3.36	-	Desirable/Low Risk : 3.3 - 4.4 Borderline/Middle Risk : 4.5 - 7.1 Elevated/High Risk : 7.2 - 11.0
LDL/HDL Ratio	1.72	-	Desirable/Low Risk : 0.5 - 3.0 Borderline/Middle Risk : 3.1 - 6.0 Elevated/High Risk : >6.1
Appearance of Serum	Clear		

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Pt.Type / ID : OPD/ 512

Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
Reporting Date : 19/02/2024 05:41 PM

LIVER FUNCTION TEST (LFT)

Test Description	Value(s)	Unit	Reference Range
Bilirubin Total	0.73	mg/dL	0.3 - 1.5
Bilirubin Direct	0.23	mg/dL	0.0 - 0.5
Bilirubin Indirect	0.5	mg/dL	0.2 - 0.9
SGOT (AST)	25.0	U/L	0 - 45
SGPT (ALT)	38.0	U/L	0 - 45
Alkaline Phosphatase	180.0	U/L	80 - 306
Protein Total	6.9	g/dL	6 - 8
Albumin	3.7	g/dL	3.2 - 5.0
Globulin	3.0	g/dL	2.5 - 3.3
A/G Ratio	1.23	-	1.0 - 2.1

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Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
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GAMMA GT

Test Description	Value(s)	Unit	Reference Range
Gamma Glutaryl Trans Peptidase	27.0	U/L	5 - 40

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Pt.Type / ID : OPD/ 512

Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
Reporting Date : 19/02/2024 05:41 PM

BLOOD UREA NITROGEN

Test Description	Value(s)	Unit	Reference Range
BUN* Serum,Calculated	9.0	mg/dL	7 - 18.0

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Collection Date : 19/02/2024 10:41 AM
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CREATININE

Test Description	Value(s)	Unit	Reference Range
CREATININE Jaffe IDMS	0.7	mg/dl	0.6 - 1.4

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Pt.Type / ID : OPD/ 512

Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
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URIC ACID

Test Description	Value(s)	Unit	Reference Range
Uric Acid	5.50	mg/dl	2.6 - 6.0

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Pt.Type / ID : OPD/ 512

Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
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GLYCOSYLATED HAEMOGLOBIN (GHB / HBA1c)

Test Description	Value(s)	Unit	Reference Range
HbA1c H.P.L.C	**5.4**	%	Below 6.0% - Normal Value 6.0% - 7.0% - Good Control 7.0% - 8.0% - Fair Control 8.0% - 10% - Unsatisfactory Control Above 10% - Poor Control

Interpretation: Glycosylated Haemoglobin is acurate and true index of the " Mean Blood Glucose Level in the body for the previous 2-3 months.HbA1c is an indicator of glycemic control. HbA1c represent average glycemia over the past six to eight weeks. Glycation ofhemoglobin occurs the entire 120 days life span of the red blood cell, but with in this 120 days. Recent glycemia has the largestinfluence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in themouth before sampling, 25% in the month before that, and the remaining 25% in months 2-4.

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Collection Date : 19/02/2024 10:41 AM
Pt.Type / ID : OPD/ 512
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THYROID FUNCTION TEST (TFT)

Test Description	Value(s)	Unit	Reference Range
TOTAL TRIIODOTHYRONINE (T3) Competitive Chemi Luminescent Immuno Assay	120.0	ng/dl	60 - 181
TOTAL THYROXINE (T4) Competitive Chemi Luminescent Immuno Assay	5.66	µg/dL	4.5 - 12.6
THYROID STIMULATING HORMONE (TSH) SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY	2.34	uIU/mL	0.3 - 5.5

SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY

Reference range for < 18 years

TEST	1 - 3 D	4 - 30 D	31 - 60 D	61 D - 12 M	1 - 5 Y	6 - 10 Y	11 - 14 Y	15 - 18 Y
TSH	0.1-9.2	0.2-8.5	0.2-7.8	0.30-5.9	0.4-4.8	0.5-4.7	0.5-4.6	0.6-4.5
T3	41.7-272.1	48.2-272.1	54.7-272.1	76.8-272.1	89.2-246.7	87.2-218.1	86.6-199.8	85.3-188.8
T4	4.9-15.8	5-15.3	5.2-14.8	5.7-13.3	5.7-11.7	5.4-10.7	5.2-10	5.1-9.6
FT3	1.5-5.3	1.6-5.2	1.6-5.1	1.8-4.8	2-4.5	2.1-4.4	2.3-4.4	2.3-4.3
FT4	0.84-2.08	0.85-1.98	0.85-1.89	0.89-1.62	0.89-1.48	0.85-1.46	0.84-1.45	0.84-1.45

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Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
Reporting Date : 19/02/2024 05:41 PM

URINE ROUTINE REPORT

Test Description	Value(s)	Unit	Reference Range
	Physical Examination		
Quantity	20	ml	-
Colour	Pale Yellow		Pale yellow/Yellow
Appearance	Slightly Hazy		Clear
Specific Gravity	1.010		1.005-1.030
pH	Acidic		Acidic
Deposit	Absent		Absent
	Chemical Examination		
Protein	Absent		Absent
Sugar	Absent		Absent
Ketones	Absent		Absent
Bile Salt	Absent		Absent
Bile Pigment	Absent		Absent
Urobilinogen	Normal		Normal
	Microscopic Examination (/hpf)		
Pus Cell	1-2		Upto 5
Epithelial Cells	1-2		Upto 5
Red Blood Cells	Absent		Absent
Casts	Absent		Absent
Crystals	Absent		Absent
Bacteria	Absent		Absent

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Pt.Type / ID : OPD/ 512

Age / Gender : 32 Years / Female
Collection Date : 19/02/2024 10:41 AM
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STOOL ANALYSIS REPORT

Test Description	Value(s)	Unit	Reference Range
	Physical Examination		
Colour	Yellow		Brown
Mucus	Absent		Absent
Frank Blood	Absent		Absent
Consistency	Semi solid		Semi solid
Parasite	Absent		Absent
Reaction	Acidic		Acidic
Occult Blood	Negative		Negative
	Microscopic Examination (/hpf)		
Ova of Parasites	Absent		Absent
RBC	Absent		Absent
Pus cells	1-2		Absent
Macrophages	Absent		Absent
Fat Globules	Absent		Absent
Veg. Matter	Absent		Absent
Vegetative Forms	Absent		Absent
Cysts	Absent		Absent
Epithelial cells	Occasional		Absent

END OF REPORT

Checked By

Authenticity Check

Dr. Harshal Thorat
MD (Path)
Reg No. 2014/10/4438

Jumbolabhub@gmail.com

JUMBO DIAGNOSTIC CENTER
THE DIAGNOSTIC SPECIALISTS

Patient Name	: VIJAYA SUBHRAMANIAM	Patient ID:4781
Age /Gender : 32 yrs/FEMALE		Date : 20/02/2024

X-RAY CHEST PA

Plain P.A. Radiograph of chest shows :-
The hilar shadows are normal in size, position and density.
Both Cardiophrenic and Costophrenic angles are clear.
The Cardiac silhoutte is within normal limits.
Aortic shadow is normal.
Restofthevisualizedmediastinumshadowsarenormal.
Both domes of diaphragms arenormal.
The visualised bony thorax is normal.
CONCLUSION :
NO SIGNIFICANT ABNORMALITY DETECTED

DR. NikunjKothia
MBBS, DMRD Reg-2009093218

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