

# CONSULTATION SUMMARY

**Patient MRN** : 17540000333676  
**Patient Name** : Priyesh Pandey  
**Gender/Age/Dob** : Male , 35 Years , 04/11/87  
**Patient Phone No** : 7828231035  
**Patient Address** : 340,Panchwati Nagar,Kapa,  
Raipur,Raipur,Chhattisgarh,  
India,-492004

**Consultation Date** : 27/05/2023 01:57 PM  
**Consultant** : Dr. Mukesh Kumar Sharma  
(GENERAL MEDICINE)  
**Consultation Type** : OP , NEW VISIT



## CLINICAL DIAGNOSIS

- DYSLIPIDEMIA  
PREDIABTES

## CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

- CAME FOR HEALTH :  
CHECK UP
- NO COMPLAIN :
- H/O: ACUTE :  
PANCREATITIS

## PAST MEDICAL HISTORY

- No significant past medical history

## VITALS

Blood Pressure: 128/84 mmHg      Heart Rate: 103 bpm      Temperature: 97.4 F  
Respiratory Rate: 26 /min  
SPO2 : 97 % , Room air  
Weight: 94 kg  
Fall Score: Low      Pain Score: 0

## ALLERGY

- No known allergies

## MEDICATION ORDER

### DRUG NAME

- 1) FENOFIBRATE-TABLET-145MG-STANLIP



X - r - 10

### PATIENT INSTRUCTION

**Patient Instruction:** Once Daily ( 0 - 0 - 0 - 1 )  
Tablet Orally After Food For 30 Days , **Qty:** 30 ,  
**Start Date:** May 27, 2023 , **End Date:** Jun 25,  
2023

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DRUG NAME	PATIENT INSTRUCTION
2) SAROGLITAZAR-TABLET-4MG-LIPAGLYN <i>Handwritten: 1-0-0-1</i>	<b>Patient Instruction:</b> Once Daily ( 0 - 0 - 0 - 1 ) Tablet Orally After Food For 30 Days , <b>Qty:</b> 30 , <b>Start Date:</b> May 27, 2023 , <b>End Date:</b> Jun 25, 2023
3) MONTELUKAST+LEVOCETIRIZINE-TABLET-10MG+5MG-MONTEMAC L <i>Handwritten: 1-0-0-1</i>	<b>Patient Instruction:</b> Once Daily ( 0 - 0 - 0 - 1 ) Tablet Orally At Bed Time For 10 Days , <b>Qty:</b> 10 . <b>Start Date:</b> May 27, 2023 , <b>End Date:</b> Jun 05, 2023
4) BENFOTIAMIN+VB12+ALA+FOLICACID+INOSITOL-TABLET--BALAVIN FORTE <i>Handwritten: 1-0-0-0</i>	<b>Patient Instruction:</b> Once Daily ( 1 - 0 - 0 - 0 ) Tablet Orally After Food For 30 Days , <b>Qty:</b> 30 , <b>Start Date:</b> May 27, 2023 , <b>End Date:</b> Jun 25, 2023

**PROCEDURE HISTORY**

- No known surgical history

**NOTES**

- DIABETIC DIET  
RBS CHARTING AS ADVISED  
REGULAR EXERCISE

**SOCIAL HISTORY**

- No significant social history

**FAMILY HISTORY**

- No significant family history

**FOLLOW UP DETAILS**

- Physical Consultation after 1 Month

**CONSULTANT DETAILS**

Dr. Mukesh Kumar Sharma , CONSULTANT , GENERAL MEDICINE  
Registration No : 5549/2014

One free consultation with the same doctor within next 6 days.

Printed By: Dr. Mukesh Kumar Sharma | Printed On: 27.05.2023 15:55



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**Patient Address** : 340,Panchwati Nagar,Kapa,  
Raipur,Raipur,Chhattisgarh,  
India,-492004

**Consultation Date** : 27/05/2023 09:42 AM  
**Consultant** : Dr. Sonal Vyas  
(OPHTHALMOLOGY)  
**Consultation Type** : OP , NEW VISIT



### CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

- FOR ROUTINE CHECK UP:

### CLINICAL DATA

- VISION  
RE 6/6 , N6  
LE 6/6 , N6

COLOR VISION - BE NORMAL

### ADVICE

- REGULAR CHECK UP

### PAST MEDICAL HISTORY

- No significant past medical history

### PROCEDURE HISTORY

- No known surgical history

### ALLERGY

- No known allergies

### FAMILY HISTORY

- No significant family history

### SOCIAL HISTORY

- No significant social history

### CONSULTANT DETAILS

Dr. Sonal Vyas VISITING CONSULTANT , OPTHALMOLOGY



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Raipur,Raipur,Chhattisgarh,  
India,-492004

**Consultation Date** : 27/05/2023 01:10 PM  
**Consultant** : Dr. Aditi Sharma (E.N.T)  
**Consultation Type** : OP , NEW VISIT



## CHIEF COMPLAINTS & HISTORY OF PRESENT ILLNESS

- FOR ROUTINE ENT EXAMINATION :
- NO COMPLAIN :

## SYSTEMIC EXAMINATION

- 70 degree examination of throat : NAD
- Neck : LARYNGEAL CRIPITUS PRESENT .NO PALPABLE LYMPHADENOPATHY.
- Oral Cavity : NAD
- Ear : WHITISH FLAKES BOTH EAC ,TM INTACT NORMAL

## PAST MEDICAL HISTORY

- No significant past medical history

## INVESTIGATION ORDER

OTHERS : PURE TONE AUDIOMETRY (PTA)

## PROCEDURE HISTORY

- No known surgical history

## ALLERGY

- No known allergies

*Plomate crew*

## FAMILY HISTORY

- No significant family history

*ur*

## SOCIAL HISTORY

- No significant social history

*in*



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## ECHOCARDIOGRAPHY REPORT

Patient ID : 17540000333676 Report Date : 27/05/2023  
Patient Name: : Mr. Priyesh Pandey  
Age / Gender : 35 Years/ male

### MEASUREMENT

AO : 28 ( 20 - 35 )mm LVID(d) : 47 ( 36 - 52 )mm IVS: 09 ( 06 - 11 )mm  
LA : 31 ( 19 - 40 )mm LVID s : 28 ( 23 - 39 )mm PW: 09 ( 06 - 11 )mm  
EF : 60%

### VALVES

Mitral Valve : Normal  
Aortic valve : Normal  
Tricuspid Valve : Normal  
Pulmonary Valve : Normal

### CHAMBERS

Left Atrium : Normal  
Right Atrium : Normal  
Left Ventricle : Normal  
Right Ventricle : Normal

### SEPTAE

IVS : Intact  
IAS : Intact

### GREAT ARTERIES

Aorta : Normal  
Pulmonary Artery : Normal



Patient ID : 17540000333676 Report Date : 27/05/2023  
Patient Name: : Mr. Priyesh Pandey  
Age / Gender : 35 Years/ male

**WALL MOTION ABNORMALITIES**

No RWMA at rest

**FINAL DIAGNOSIS**

- No RWMA at rest
- Normal LV systolic function. LVEF-60%.
- Normal cardiac chambers dimension
- IVC normal & collapsing >50% with respiratory variation.
- No I/C clot, vegetation or pericardial effusion

*S. Gouniyal*

Dr. S.Gouniyal  
MD, DM  
Senior interventional Cardiologist

*Prashant Madharia*

DR. PRASHANT MADHARIA  
MD, PGDCC  
Consultant Non- Invasive Cardiology

Dr. JINESH JAIN  
MD, DM  
Consultant, interventional Cardiology









**DEPARTMENT OF LABORATORY MEDICINE**

Final Report

Patient Name : Priyesh Pandey MRN : 17540000333676 Gender/Age : MALE , 35y (04/11/1987)  
 Collected On : 27/05/2023 09:52 AM Received On : 27/05/2023 10:32 AM Reported On : 27/05/2023 02:03 PM  
 Barcode : 7R2305270010 Specimen : Urine Consultant : Dr. Mukesh Kumar Sharma(GENERAL MEDICINE)  
 Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 7828231035

**CLINICAL PATHOLOGY**

Test	Result	Unit	Biological Reference Interval
<b>URINE ROUTINE &amp; MICROSCOPY</b>			
<b>PHYSICAL EXAMINATION</b>			
Volume	45	ml	-
Colour	Pale Yellow	-	-
Appearance	Clear	-	-
<b>CHEMICAL EXAMINATION</b>			
pH(Reaction)	5.0	-	4.5-7.5
Sp. Gravity (Automated)	1.025	-	1.002-1.03
Protein	Negative	-	Negative
Urine Glucose	Negative	-	Negative
Ketone Bodies	Negative	-	Negative
Bile Salts	Negative	-	Negative
Bile Pigment (Bilirubin)	Negative	-	Negative
Urobilinogen	Negative	-	Negative
Urine Leucocyte Esterase	Negative	-	Negative
Blood Urine	Negative	-	Negative
Nitrite	Negative	-	Negative

**MICROSCOPIC EXAMINATION**



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**Appointments**  
**1800-309-0309**  
**Emergencies**  
**8821-818181**



Patient Name : Priyesh Pandey MRN : 17540000333676 Gender/Age : MALE , 35y (04/11/1987)

Pus Cells (Microscopy)	1-2	/hpf	2-3
RBC (Microscopy)	Not Seen	/hpf	0-0
Epithelial Cells (Microscopy)	2-3	/hpf	2-3.
Crystals	Not Seen	-	-
Casts	Not Seen	-	-
Bacteria	Not Seen	-	-
Yeast Cells	Not Seen	-	-
Mucus	Not Seen	-	-
<b>Urine For Sugar (Fasting)</b>	<b>Negative</b>	-	-



Dr. Smriti Rathore  
 M.B.BS, MD Pathology  
 Consultant

**BIOCHEMISTRY**

Test	Result	Unit	Biological Reference Interval
<b>Fasting Blood Sugar (FBS)</b> (Hexokinase)	<b>116 H</b>	mg/dL	70.0-99.0
<b>Post Prandial Blood Sugar (PPBS)</b>	<b>119 L</b>	mg/dL	120.0-140.0
<b>HbA1c</b>			
HbA1c (HPLC NGSP Certified)	<b>6.2 H</b>	%	Both: Normal: 4.0-5.6 Both: Pre Diabetes: 5.7-6.4 Both: Diabetes: => 6.5 ADA Recommendation 2017
Estimated Average Glucose	131.24	-	-

**Interpretation:**

HbA1c above 6.5% can be used to diagnose diabetes provided the patient has symptoms. If the patient does not have symptoms with HbA1c > 6.5%, repeat measurement on further sample. If the repeat test result is < 6.5%, consider as diabetes high risk and repeat

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Patient Name : Priyesh Pandey MRN : 17540000333676 Gender/Age : MALE , 35y (04/11/1987)

measurement after 6 months.

2. HbA1C measurement is not appropriate in diagnosing diabetes in children, suspicion of type 1 diabetes, symptoms of diabetes for less than 2 months, pregnancy, hemoglobinopathies, medications that may result sudden increase in glucose, anemia, renal failure, HIV infection, malignancies, severe chronic hepatic, and renal disease.

3. Any sample with >15% should be suspected of having a haemoglobin variant.

**LIPID PROFILE (CHOL,TRIG,HDL,LDL,VLDL)**

Cholesterol Total (Cholesterol Oxidase/peroxidase)	125	mg/dL	0.0-200.0
Triglycerides (LPL/GK)	<b>299 H</b>	mg/dL	0.0-150.0
HDL Cholesterol (HDLC) (Dextran Sulphate/ PEG Cholesterol Esterase)	<b>35 L</b>	mg/dL	40.0-60.0
Non-HDL Cholesterol	90.0	-	-
LDL Cholesterol (Cholesterol Oxidase Esterase Peroxidase)	30	mg/dL	0.0-100.0
VLDL Cholesterol (Calculated)	<b>60 H</b>	mg/dL	0.0-40.0
Cholesterol /HDL Ratio (Calculated)	3.6	-	0.0-5.0

**LIVER FUNCTION TEST(LFT)**

Bilirubin Total (Caffeine Benzoate)	0.4	mg/dL	0.2-1.3
Conjugated Bilirubin (Direct) (Caffeine Benzoate)	0.3	mg/dL	0.0-0.4
Unconjugated Bilirubin (Indirect) (Calculated)	0.2	-	0.2-0.8
Total Protein (Biuret Method )	8.0	gm/dL	6.3-8.3
Serum Albumin (Bromocresol Purple Dye Binding)	4.7	gm/dL	3.5-5.0
Serum Globulin (Calculated)	3.3	-	2.3-3.5
Albumin To Globulin (A/G)Ratio	1.4	-	1.0-2.1
SGOT (AST) (UV With Pyridoxal-5-phosphate)	36	IU/L	17.0-59.0
SGPT (ALT) (UV With Pyridoxal-5-phosphate)	53	U/L	21.0-72.0
Alkaline Phosphatase (ALP)	68	IU/L	38.0-126.0



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Patient Name : Priyesh Pandey MRN : 17540000333676 Gender/Age : MALE , 35y (04/11/1987)

Gamma Glutamyl Transferase (GGT) (GCNA) 30 U/L 15.0-73.0

**RENAL PACKAGE - 2 (RFT FASTING)**

Fasting Blood Sugar (FBS) (Hexokinase) **116 H** mg/dL 70.0-99.0

Blood Urea Nitrogen (BUN) (Urease) 11 mg/dL 9.0-20.0

**SERUM CREATININE**

Serum Creatinine (Jaffe's Kinetic IDMS) 0.9 mg/dL Male :0.66-1.25  
Female :0.52-1.04

eGFR (Calculated) 96 mL/min/1.73m<sup>2</sup> Both: <60 indicative of renal impairment  
Both: Note:eGFR is inaccurate for Hemodynamically unstable patients eGFR is not applicable for less than 18

Serum Sodium (Indirect IMT) 146 mmol/L 137.0-150.0

Serum Potassium (Indirect IMT) 4.4 mmol/L 3.5-5.1

Serum Chloride **107 H** mmol/L 95.0-106.0

Serum Calcium (Cresol Complex) 10.0 mg/dL 8.4-10.2

Serum Magnesium (Methyl Thymol Blue Dye Binding) 2.1 mg/dL 1.6-2.3

Serum Uric Acid (Uricase) 7.2 mg/dL 3.5-8.5

Serum Phosphorus (Phosphomolybdate Reduction) 3.4 mg/dL 2.5-4.5



Dr. Smriti Rathore  
M.B.BS, MD Pathology  
Consultant



**HAEMATOLOGY**

Test	Result	Unit	Biological Reference Interval
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Patient Name : Priyesh Pandey MRN : 17540000333676 Gender/Age : MALE, 35y (04/11/1987)

<b>Erythrocyte Sedimentation Rate (ESR)</b>	<b>15 H</b>	mm/hr	<b>0.0-10.0</b>
(Westergren Method)			
<b>COMPLETE BLOOD COUNT (CBC)</b>			
Haemoglobin (Hb%) (Photometric Measurement)	14.1	g/dL	14.0-16.0
Red Blood Cell Count (Electrical Impedance)	5.13	millions/ $\mu$ L	4.5-6.5
PCV (Packed Cell Volume) / Hematocrit (Calculated)	42.3	%	40.0-54.0
MCV (Mean Corpuscular Volume) (Derived From RBC Histogram)	82	fL	76.0-96.0
MCH (Mean Corpuscular Haemoglobin) (Calculated)	27.5	pg	27.0-32.0
MCHC (Mean Corpuscular Haemoglobin Concentration) (Calculated)	33.3	%	30.0-36.0
Red Cell Distribution Width (RDW) (Derived)	13.3	%	11.6-14.0
Platelet Count (Electrical Impedance Plus Microscopy)	250	Thousand / $\mu$ L	150.0-450.0
Mean Platelet Volume (MPV)	8.9	fL	7.0-11.7
Total Leucocyte Count(WBC) (Electrical Impedance)	6.2	Thous/cumm	4.0-10.0
<b>DIFFERENTIAL COUNT (DC)</b>			
Neutrophils (VCS Technology Plus Microscopy)	60	%	40.0-75.0
Lymphocytes (VCS Technology Plus Microscopy)	32	%	20.0-45.0
Monocytes (VCS Technology Plus Microscopy)	06	%	2.0-10.0
Eosinophils (VCS Technology Plus Microscopy)	02	%	0.0-6.0
Basophils	00	%	0.0-1.0
Absolute Neutrophil Count	3.72	-	-
Absolute Lymphocyte Count	1.98	-	-



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Patient Name : Priyesh Pandey MRN : 17540000333676 Gender/Age : MALE , 35y (04/11/1987)

Absolute Monocyte Count 0.37 - -  
 Absolute Eosinophil Count 0.12 - -

**BLOOD GROUP & RH TYPING**

Blood Group "A" - -  
 RH Typing Positive - -



Dr. Smriti Rathore  
 M.B.BS, MD Pathology  
 Consultant

**IMMUNOLOGY**

Test	Result	Unit	Biological Reference Interval
<b>THYROID PROFILE (T3, T4, TSH)</b>			
Tri Iodo Thyronine (T3) (Chemiluminescence)	1.28	ng/mL	0.97-1.69
Thyroxine (T4) (Chemiluminescence)	8.75	ug/dl	5.53-11.0
TSH (Thyroid Stimulating Hormone) (Chemiluminescence)	4.075	mIU/mL	0.465-4.68



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**CLINICAL PATHOLOGY**

Test Result Unit

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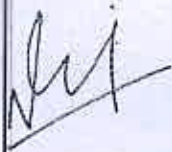


Patient Name : Priyesh Pandey MRN : 17540000333676 Gender/Age : MALE , 35y (04/11/1987)

**Urine For Sugar (Post Prandial)**

Negative

--End of Report--



Dr. Neeraj Naik  
M.B.B.S., D.C.P Consultant Pathologist  
Consultant

**Note**

- ♦ Abnormal results are highlighted.
- ♦ Results relate to the sample only.
- ♦ Kindly correlate clinically.



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NAME: MR. PRIYESH PANDEY

AGE: 35YRS/M MRN :333676

REF. BY: DR. M.SHARMA

DATE: 27.05.2023

**SONOGRAPHY OF ABDOMEN AND PELVIS**

The Real time, B mode, gray scale sonography was performed.

**LIVER** : The liver is enlarged in size 18.5cm & reveals increased echotexture grade-I/II.

**PORTAL VEIN** : The portal vein is normal in calibre.

**GALL BLADDER** : The gall bladder is minimally distended.

Visualized proximal CBD is normal in calibre.

**SPLEEN** : The spleen is normal in size and shape. No evidence of focal lesion is noted.

**PANCREAS** :The pancreas is poorly visualized.

**B/L KIDNEYS** :

The right kidney measures - 9.4 x 4.5cm and left kidney measures - 11.1 x 4.7cm in size. Both kidneys reveal normal cortical echotexture and have smooth margins. Cortico-medullary differentiation is maintained. No calculus or hydronephrosis is seen.

**URINARY BLADDER** : The urinary bladder is well distended.

**PROSTATE**: The prostate is normal in size 17cc.

No free fluid is seen in the peritoneal cavity.

Excessive intrabowel gases are noted.

**IMPRESSION** :

**Hepatomegaly with grade-I/II fatty liver.**

ADVISED: Clinical correlation & appropriate further evaluation.



*Ranjana*

**DR RANJANA KEDIA**  
MBBS, CBET  
CONSULTANT SONOLOGIST





<b>Patient Name</b>	Priyesh Pandey	<b>Requested By</b>	Dr. Mukesh Kumar Sharma
<b>MRN</b>	17540000333676	<b>Procedure Date Time</b>	2023-05-27 13:44:08
<b>Age/Sex</b>	35Y 6M/Male	<b>Hospital</b>	NH-RAIPUR

**CHEST RADIOGRAPH (PA VIEW)**

**CLINICAL DETAILS:**For health checkup.

**FINDINGS:**

- The lung fields and bronchovascular markings appear normal.
- The cardiac size is within normal limits.
- Mediastinum and great vessels are within normal limits.
- Trachea is normal and is central. The hilar shadows are unremarkable.
- The costo-phrenic angles are clear. No evidence of pleural effusion or pneumothorax.
- The visualized bones and soft tissue structures appear normal.
- Both the diaphragmatic domes appear normal.

**IMPRESSION:**

- Normal chest radiograph.



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