

### MEDICAL SUMMARY

NAME:	Mrs. Hethavath Sanjay	UHID:	5196
AGE:	27 YRS	DATE OF HEALTHCHECK:	26/2/2023
GENDER:	Female		

HEIGHT:	170 cm	MARITAL STATUS:	M
WEIGHT:	59.6 kg	NO OF CHILDREN:	1
BMI:	20.6		

C/O: Headache - 2 times

K/C/O: PRESENT MEDICATION: - No

P/M/H: - No

P/S/H: Appendicitis

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING: - No

FAMILY HISTORY FATHER: - HTN

ALCOHOL: - No

MOTHER: -

TOBACCO/PAN: - No

O/E:

LYMPHADENOPATHY: - No

BP: 110/80 PULSE: - 96/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING: - No

TEMPERATURE: - SCARS: -

OEDEMA: -

S/E:  
RS:



P/A: - No

CVS: - Normal

Extremities & Spine: - Normal

ENT: -

CNS: - Normal, no neurological signs

Skin: - Normal

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :	[Handwritten line across all cells]			
NEAR :	[Handwritten line across all cells]			
COLOUR VISION:	[Handwritten line across all cells]			

• ANDHERI • COLABA • NASHIK • VASHI

## OPHTHALMIC EVALUATION

UHID No.: 5196 Date: 25/2/22  
 Name: Mrs Sandhya Age: 27 Gender:  Male /  Female

Without Correction :

Distance: Right Eye 8/6 Left Eye 6/6  
 Near : Right Eye 5/6 Left Eye 5/6

With Correction :

Distance: Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_  
 Near : Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near										

Colour Vision : Normal (BC)

Anterior Segment Examination : \_\_\_\_\_

Pupils : / NO (BC)

Fundus : \_\_\_\_\_

Intraocular Pressure : 14 mmHg (BC)

Diagnosis : \_\_\_\_\_

Advice : bc

Re-Check on \_\_\_\_\_ (This Prescription needs verification every year)

**DR. RUCHIRA SHARMA**  
 M. S. (OPHTH)  
 CONSULTING OPHTHALMOLOGIST  
 & MICRO SURGEON  
 REG. No.: 3262 / 09 / 02

Dr. R  
 (Consultant Ophthalmologist)

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

## DENTAL CHECKUP

Name: Mrs. Sandhya	MR NO:
Age/Gender : 27/F	Date: 25/2

Medical history:  Diabetes  Hypertension  \_\_\_\_\_

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains				
Mobility				
Caries ( Cavities )				
a) Class 1 (Occlusal)				
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

NA

**TREATMENT ADVISED:**

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis:  Scaling & polishing  
 Orthodontic Advice for Braces:  Yes /  No  
 Prosthetic Advice to Replace Missing Teeth:  Denture  Bridge  Implant  
 Oral Habits:  Tobacco  Cigarette  Others since \_\_\_ years  
 Advice to quit any form of tobacco as it can cause cancer.  
 Other Findings: NA

**DR. SNEHA NITIN GADHIYA**  
 BDS (BACHELOR OF DENTAL SURGERY)  
 REG NO: 39708



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Name: ms kethanath J. Age: 27 Sex: F UHID No.: \_\_\_\_\_ Date: 25/10/13

27 yrs, ms 5 yrs, P, U  
+ pap smear

men + mp - 15 days back

oin + P, U

PS+ :- nil.

ce - tar

atenole

cey / MAD

HA - S.H

SECRET

PS - pap smear taken



Dr. \_\_\_\_\_



**Apollo Clinic**  
**VASHI**

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

Name : Mrs. Kethavath Sandya Rani Gender : Female Age : 27 Years  
 UHID : FVAH 5196. Bill No : Lab No : V-2059-23  
 Ref. by : SELF Sample Col.Dt : 25/02/2023 10:10  
 Barcode No : 6755 Reported On : 25/02/2023 18:32


TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

CBC (Complete Blood Count)-WB (EDTA)

Haemoglobin(Colorimetric method)	<b>10.5</b>	g/dl	11.5 - 15
RBC Count (Impedance)	4.44	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	<b>33.5</b>	%	35 - 55
MCV:(Calculated parameter)	<b>75.4</b>	fl	78 - 98
MCH:(Calculated parameter)	<b>23.7</b>	pg	26 - 34
MCHC:(Calculated parameter)	31.4	gm/dl	30 - 36
RDW-CV:	15.5	%	10 - 16
Total Leucocyte count(Impedance)	5530	/cumm.	4000 - 10500
Neutrophils:	50	%	40 - 75
Lymphocytes:	<b>44</b>	%	20 - 40
Eosinophils:	02	%	0 - 6
Monocytes:	04	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.5	Lakhs/c.mm	1.5 - 4.5
MPV	10.9	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)			
RBCs:	Hypochromasia(+), Microcytosis(+)		
WBCs:	Lymphocytosis		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter.		

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Page 5 of 1  
  
 Dr. Milind Patwardhan  
 M.D(Path)  
 Chief Pathologist

End of Report  
 Results are to be correlated clinically

Name : Mrs. Kethavath Sandya Rani      Gender : Female      Age : 27 Years  
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TEST      RESULTS      BIOLOGICAL REFERENCE INTERVAL

**ESR(Westergren Method)**

**Erythrocyte Sedimentation Rate:-**      35      mm/1st hr      0 - 20

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M.D(Path)  
Chief Pathologist

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TEST

RESULTS

**Blood Grouping (ABO & Rh)-WB(EDTA) Serum**

ABO Group:

**:B:**

Rh Type:

**Positive**

Method :

Tube Agglutination (forward and reverse)

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

**HbA1c(Glycosylated Haemoglobin )WB-EDTA**

(HbA1C) Glycosylated Haemoglobin : 5.2 %  
 Normal <5.7 %  
 Pre Diabetic 5.7 - 6.5 %  
 Diabetic >6.5 %  
 Target for Diabetes on therapy < 7.0 %  
 Re-evaluation of therapy > 8.0 %

Mean Blood Glucose : 102.54 mg/dL

Corelation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298


Method High Performance Liquid Chromatography (HPLC).

**INTERPRETATION**

- \* The HbA1c levels corelate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
- \* This Methodology is better then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints and uremia does not INTERFERE with the results in this methodology.
- \* It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts.& every 3 - 4 months in well controlled daibetics .
- \* Mean blood glucose (MBG) in first 30 days ( 0-30 )before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

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Indira Health And Lifestyle Private Limited.  
**NABL Accredited Laboratory**  
The Emerald, 1st Floor, Plot No. 195, Sector-12,  
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Tel.: (022) - 2788 1322 / 23 / 24 ☎ 8291490000  
Email: apolloclinicvashi@gmail.com

**Apollo Clinic**  
**VASHI**


Name : Mrs. Kethavath Sandya Rani      Gender : Female      Age : 27 Years  
UHID : FVAH 5196.      Bill No :      Lab No : V-2059-23  
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
<b>PLASMA GLUCOSE</b>			
Fasting Plasma Glucose :	87	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : $\geq$ 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	76	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : $\geq$ 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
<b>Lipid Profile- Serum</b>			
S. Cholesterol(Oxidase)	137	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	73	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	14.6	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	43.4	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	79	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	<u>3.2</u>		3.5 - 5
Ratio of LDL/HDL	<u>1.8</u>		2.5 - 3.5

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Page 8 of **Dr. Milind Patwardhan**  
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Chief Pathologist

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL


**LFT(Liver Function Tests)-Serum**

S.Total Protein (Biuret method)	8.08	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.25	g/dL	3.5 - 5.2
S.Globulin (Calculated)	<b>3.83</b>	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.11		0.9 - 2
S.Total Bilirubin (DPD):	0.36	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.14	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.22	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P): 16		U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P): 11		U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic): 70		U/L	35 - 105
S.GGT(IFCC Kinetic): 12		U/L	07 - 32

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	<b>BIOCHEMISTRY</b>	
S.Urea(Urease Method)	22.0      mg/dl	10.0 - 45.0
BUN (Calculated)	10.26      mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.69      mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	14.87	9:1 - 23:1
S.Uric Acid(Uricase Method)	4.3      mg/dl	2.4 - 5.7

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
<b>Thyroid (T3,T4,TSH)- Serum</b>			
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.96	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	93.15	nmol/L	66 - 181 nmol/L
TSH (Thyroid-stimulating hormone) (ECLIA)	3.34	□IU/mL	Euthyroid : 0.35 - 5.50 □IU/mL Hyperthyroid : < 0.35 □IU/mL Hypothyroid : > 5.50 □IU/mL

Grey zone values observed in physiological/therapeutic effect.

**Note:**

**T3 :**

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

**T4 :**

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

**TSH :**

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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**Dr. Milind Patwardhan**  
M.D(Path)

Page 10 of 11 **Chief Pathologist**

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

**PHYSICAL EXAMINATION**

QUANTITY	60	mL
COLOUR	Pale Yellow	
APPEARANCE	Slightly Hazy	Clear
SEDIMENT	Absent	Absent

**CHEMICAL EXAMINATION(Strip Method)**


REACTION(PH)	6.0	4.6 - 8.0
SPECIFIC GRAVITY	1.010	1.005 - 1.030
URINE ALBUMIN	Absent	Absent
URINE SUGAR(Qualitative)	Absent	Absent
KETONES	Absent	Absent
BILE SALTS	Absent	Absent
BILE PIGMENTS	Absent	Absent
UROBILINOGEN	Normal(<1 mg/dl)	Normal
OCCULT BLOOD	Absent	Absent
Nitrites	Absent	Absent

**MICROSCOPIC EXAMINATION**

PUS CELLS	2 - 3 / hpf	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	<b>10 - 12 / hpf</b>	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Absent	Absent

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Page 11 of 11 Chief Pathologist

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### CYTOPATHOLOGY REPORT

Specimen No: AP-328-23

Specimen Adequacy: ADEQUATE

#### **CELLS**

ENDOCERVICAL: Absent

ENDOMETRIAL: Absent

SQUAMOUS: **SUPERFICIAL(++) AND INTERMEDIATE(++) SQUAMOUS CELLS**

HISTIOCYTES: Absent

RBCs: Absent

POLYMORPHS: **Present(+)**

LYMPHOCYTES: Absent

#### **FLORA**

TRICHOMONAS VAGINALIS: Absent

MONILIA: Absent

BACTERIA: Absent

DODERLEIN BACILLI: Absent

LEPTOTHRIX: Absent

#### **CELLULAR CHANGES**

METAPLASIA: Absent

DYSPLASIA: Absent

MALIGNANT CELL: Absent

ATROPHIC CHANGES: Absent

IMPRESSION: **NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY**

Anushka Chavan  
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Dr. Milind Patwardhan  
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Chief Pathologist

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Sandhya, Keshavath  
5196

27 Years

Female

25.02.2023 12:03:36  
Apollo Clinic  
1st Flr, The Emerald, Sector-12,  
Vashi, Mumbai-400703.

**NORMAL ECG**

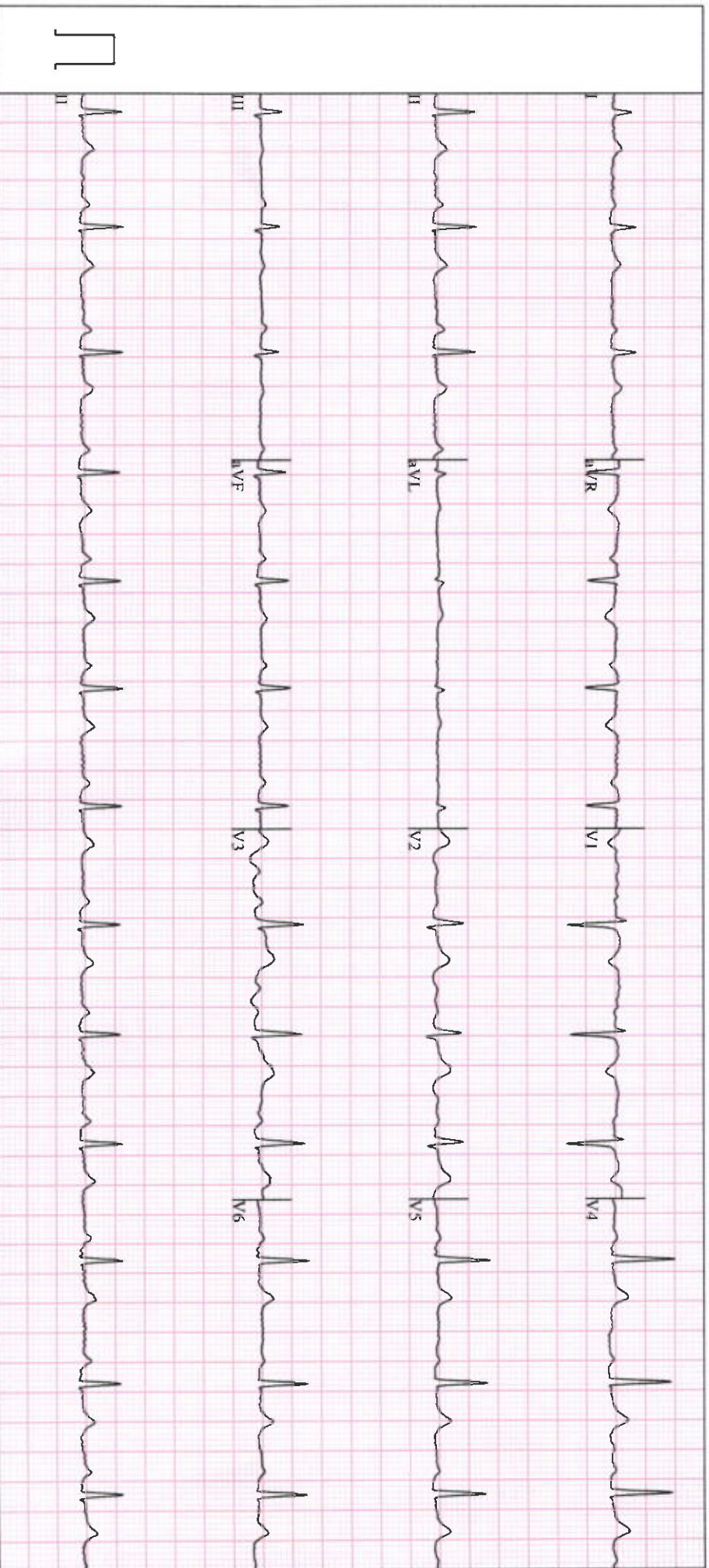
77 bpm  
-- / -- mmHg

*nr*  
*Re*

**DR. RISHI A. BHARGAVA**  
MD, DM (Cardiology)  
CONSULTANT CARDIOLOGIST  
Reg. No.: 2019/020494

QRS : 66 ms  
QT / QTcBaz : 372 / 420 ms  
PR : 170 ms  
P : 96 ms  
RR / PP : 780 / 779 ms  
P / QRS / T : 62 / 57 / 52 degrees

Normal sinus rhythm  
Normal ECG





Apollo Clinic  
The Emerald, Plot No-195/B, Sector-12,  
Neel Siddhi Towers, Vashi-400703

Station  
Telephone:

## EXERCISE STRESS TEST REPORT

Patient Name: KETHAVATH, SANDHYARANI  
Patient ID: 5196  
Height:  
Weight:

DOB: 24.07.1996  
Age: 26yrs  
Gender: Female  
Race: Asian

Study Date: 25.02.2023  
Test Type: Treadmill Stress Test  
Protocol: BRUCE

Referring Physician: --  
Attending Physician: DR. RISHI BHARGAVA  
Technician: Anu Salve

Medications:  
--

Medical History:  
NIL

Reason for Exercise Test:  
Screening for CAD

### Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:06	0.00	0.00	93	120/80	
	STANDING	00:04	0.00	0.00	93	120/80	
	HYPERV.	00:11	0.00	0.00	92	120/80	
	WARM-UP	00:18	0.90	0.00	96		
EXERCISE	STAGE 1	02:08	1.70	10.00	133	120/80	
	STAGE 2	02:07	2.50	12.00	153	166/92	
	STAGE 3	01:24	3.40	14.00	166	166/92	
RECOVERY		01:37	0.00	0.00	114	140/82	

The patient exercised according to the BRUCE for 5:36 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 90 bpm rose to a maximal heart rate of 166 bpm. This value represents 85 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 166/92 mmHg. The exercise test was stopped due to Target heart rate achieved.

### Interpretation

Summary: Resting ECG: normal.  
Functional Capacity: normal.  
HR Response to Exercise: appropriate.  
BP Response to Exercise: normal resting BP - appropriate response.  
Chest Pain: none.  
Arrhythmias: none.  
ST Changes: none.  
Overall impression: Normal stress test.

### Conclusions

TMT IS NEGATIVE FOR INDUCIBLE MYOCARDIAL ISCHAEMIA AT THE WORKLOAD ACHIEVED.

Physician-DR. RISHI BHARGAVA

**Dr. RISHI A. BHARGAVA**  
MD, DM (Cardiology)  
CONSULTANT CARDIOLOGIST  
Reg. No.: 2019/02/0494

PATIENT'S NAME	KETHAVATH RANI	AGE :- 27 y/F
UHID NO	5196	25 Feb 2023

**X-RAY CHEST PA VIEW**

**OBSERVATION:**

Bilateral lung fields are clear.  
Both hila are normal.  
Bilateral cardiophrenic and costophrenic angles are normal.  
The trachea is central.  
Aorta appears normal.  
The mediastinal and cardiac silhouette are normal.  
Soft tissues of the chest wall are normal.  
Bony thorax is normal.

**IMPRESSION:**

- No significant abnormality seen.



**DR. DISHA MINOCHA  
DMRE (RADIOLOGIST)**

<b>PATIENT'S NAME</b>	<b>SANDHYA RANI K</b>	<b>AGE :- 27Y/F</b>
<b>UHID</b>	<b>5196</b>	<b>25 Feb 2023</b>

**USG WHOLE ABDOMEN (TAS)**

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

**Gall Bladder** appears well distended with normal wall thickness. There is no calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of **PANCREAS** appear normal.

**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 or calculi or mass seen.

**RIGHT KIDNEY** measures 9.5 x 4.4 cm. **LEFT KIDNEY** measures 10.4 x 4.9 cm.

**URINARY BLADDER** is well distended; no e/o wall thickening or mass or calculi seen.

**UTERUS** is anteverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures 7.6 mm.

Both ovaries are normal in size, shape and position.

Visualised **BOWEL LOOPS** appear normal. There is no free fluid seen.

**IMPRESSION** –

- **No significant abnormality detected.**

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



**DR. NITESH PATEL**  
**DMRE (RADIOLOGIST)**