OPD ASSESSMENT FORM

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Name Mrs. Rukhsharna Rafik Age.Sex 51/F MR.No.

Doctor Dr Krunal Gajjar Date 14/10/22

Ht : 156 cm Wt. : 89.2 kg Temp : N Pulse : 82 BPM BP : 138/69 mmHg

SPO2 : 99 % Post of walk SPO2 :

Chief Complaints :

C/O Dyspepsia., constipation.

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

P/A } NAD
CVS }

Past History :

K/C/O Hypothyroidism.

Provisional Diagnosis :

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

Investigation advised :

℞

→ Tab. Dapaone-M (10/500) 1-0-0 × (02) months
BBF.

→ Lactifiber SF Powder (1) Jar.
2 sloop ē Water Hs. month

→ Cap. Sompraz-D (40) 1-0-0 × (15) days.

Dr. Krunal Gajjar
M.B.B.S., MD (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No: G-20422
SUNSHINE GLOBAL HOSPITAL
SURAT

Follow Up : **Date :** **Signature**

In case of emergency Please report to Emergency Department of Hospital OR
Call : 75748 49465, 0261-4111000

DOC. No. SGHS/FMT/OPD002 | DOI 14/06/2014 | Rev. No. 0.1

NABH

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OPD ASSESSMENT FORM

Name Mrs. Rigsona Rafik. Age.Sex 51/F MR.No. 514450(

Doctor Dr Hardik shroff. Date 14/10/23.

Ht : ______ Wt. : ______ Temp : ______ Pulse : ______ BP : ______

SPO2 : ______ Post of walk SPO2 : ______

Chief Complaints :
C/o Frontal headache
H/o Headache Burning
occasionally

Drug / Food Allergy : No sys. illness

Prior Medication Reviewed : Yes ☐ No ☐

On examination : BE Ant seg NAD

Past History :

Vn 6/12P
6/9-6P

St R -7.0/-1.25 x 80 6/9-6P
LE -5.0/-1.5 x 160 6/6
N/6 +2.25

Fundi Central

Provisional Diagnosis :

BE Compound Myopia

Nutritional Assessment :

☐ Obese
☐ Well nourished
☐ Mild- moderate nourished
☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

℞

Change of gl

BE - Refract change

Investigation advised :

Dr. Hardik Shroff
DOMS, DNB (Ophthalmology)
Regd. No. G-28902
SUNSHINE GLOBAL HOSPITAL
Piploa, SURAT

Follow Up : SOS Date : ______

Signature

In case of emergency Please report to Emergency Department of Hospital OR
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SIH-1506

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ECHO CARDIOGRAPHIC REPORT

Patient's Name : Mrs. Rubsana Rafik Sayed Date : 14/10/2023 12:05

Sex : F Age : 51 Ref. by Dr. : Medicheck Done by Dr. Surendra Singh

LV Size : (N)

LVEF : 68 % (VISUAL)

DIASTOLIC DYSFUNCTION : NO

LVH : NO

RWMA : ANTERIOR WALL

ANTERIOR SEPTUM

IVS

LV APEX

POSTERIOR WALL

LATERAL WALL

INFERIOR WALL

NO RWMA

MITRAL VALVE : (N)

AORTIC VALVE (N)

PULMONARY VALVE : (N)

TRICUSPID VALVE (N)

PAH :

PASP :

RA : (N)

LA :

RV :

IVC : (N)

IAS : Intact

IVS :

IVS (s)	cm	LV(s)	cm	PW (s)	cm	LVEF =	68	%
IVS (d)	cm	LV (d)	cm	PW (d)	cm	FS =		%

CONCLUSION :

NO regional WMA

f

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PAT. NAME : Ruqsana Sayad	**Date** : 14/10/2023
REF. DOCTOR : Hosp. Dr.	**AGE** : 51 Yrs / F
INV. : USG Abdomen & Pelvis	**MR NO.** : S144506

Findings:

Liver is enlarge in size (16.9 cm), shape and shows normal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is not visualized, post cholecystectomy status.
CBD and Portal Vein appears normal is size and calibre.

Pancreas appears normal in size and shows normal echopattern to the extent assessed.
Spleen appears normal in size, shape and homogenous echopattern.

Both kidneys appear normal in size, shape and echopattern. The corticomedullary differentiation is well maintained. No e/o any calculus or hydronephrosis is seen.

Aorta and para-aortic regions appears normal. No e/o any lymphadenopathy.
Urinary bladder appears well distended and normal.
Uterus appears normal size, shape and echopattern. No e/o any focal or diffuse lesion noted.
Endometrial thickness is normal.
Both ovaries appear normal in size, shape and echopattern.
No e/o free fluid in abdomen / pelvis.

IMPRESSION:

- **Hepatomegaly.**

Dr. Sneha Dumaswala
MBBS, DNB-Radiodiagnosis
Consultant Radiologist
G-21796

Transcribed By: Asha

Date & Time of report: 14/10/2023 – 11:03 AM

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PAT. NAME : Ruqsana Sayad	**Date** : 14/10/2023
REF. DOCTOR : Hosp. Dr.	**AGE** : 51 Yrs / F
INV. : Radiograph of Chest PA	**MR NO.** : S144506

Clinical Details: HC

Observation:

- Both the lung fields appears normal.
- Both costophrenic angles appear clear.
- Both the hila appears normal.
- Trachea appears in midline.
- Cardiac size and other mediastinal shadows appears normal.
- Both domes of diaphragm appear normal.
- Bony thorax appears normal.

Dr. Sneha Dumaswala
MBBS, DNB-Radiodiagnosis
Consultant Radiologist
G-21796

Transcribed By: Asha

Date & Time of report: 14/10/2023 – 11:00 AM

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Name Mrs. Rutgsaney Rafik Age.Sex 51/F MR.No. S144506

Doctor Dr Shailaja Desai Date 14/10/23

Ht : _____ Wt. : _____ Temp : _____ Pulse : _____ BP : _____

SPO2 : _____ Post of walk SPO2 : _____

Chief Complaints :

- Routine Dental check up

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

- +stain

Past History :

Provisional Diagnosis :

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

Rx

1) Scaling

Investigation advised :

U.P. Desai
Dr. Shailaja Desai
B.D.S. (Dental Surgeon)
A-9793
Dental Surgeon
Sunshine Global Hospital, Surat

Follow Up : **Date :** _____ **Signature**

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Call : 75748 49465, 0261-4111000

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MR No.	: **S144506**	**Collection Date**	: 14/10/2023 9:40AM
Patient Name	: **Mrs. Ruqsana Rafik Salyed**	**Age**	: 51 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 14/10/2023 11:24AM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	**11.2**	gm/dl	12.0 - 15.0
PCV	38.0	%	36 - 46
RBC COUNT	4.73	mill/cmm	4.0 - 5.0
MCV	80.3	fl	76 - 96
MCH	**23.7**	pg	26 - 32
MCHC	**29.5**	%	32 - 36
RDW	**15.8**	%	11 - 15
PLATELET COUNT	4.09	lacs/cmm	1.5 - 4.5
WBC COUNT	7090	/cmm	4000 - 11000
ESR	**20**	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	52	%	40 - 70
LYMPHOCYTES	35	%	20 - 40
EOSINOPHILS	06	%	1 - 6
MONOCYTES	07	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Normochromic Normocytic, Anisocytosis(+)		
WBC MORPHOLOGY	Within Normal Range		
PLATELET ON SMEAR	Adequate		
HEMOPARASITES	Not Seen		

SYSMEX XN-550

******* End Report *******

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MR No.	: **S144506**	**Collection Date**	: 14/10/2023 9:40AM
Patient Name	: **Mrs. Ruqsana Rafik Salyed**	**Age**	: 51 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 14/10/2023 11:18AM

HAEMATOLOGY

Parameter	Result		Normal Range
BLOOD GROUP & RH FACTOR			
BLOOD GROUP	"A"		
RH FACTOR	POSITIVE		

BIOCHEMISTRY

FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	**128**	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

CLINICAL CHEMISTRY

THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	**0.843**	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	8.17	ug/dl	5.1 - 14.0
TSH (CLIA)	1.42	uIU/ml	0.2 - 4.5

Note:-
Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechnism involving concentrations of FT3 (free T3) and FT4 (freeT4). Additionally the hypothalamic tripeptide. thyrotropin releasing hormone (TSH) directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy also stimulate the thyroid gland to synthesize and secrete T3 and T4.
Quantification of TSH significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism. TSH levels are significantly elevated whiled in secondary and tertiary hypothyroidism . TSH levels are low.

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MR No.	: **S144506**	**Collection Date**	: 14/10/2023 9:40AM
Patient Name	: **Mrs. Ruqsana Rafik Saiyed**	**Age**	: 51 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 14/10/2023 11:18AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	7.1	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**157.07**	mg/dl	

The test is done on Cobas Integra 400plus-Turbidimetric Inhibition ImmunoAssay

Note:- Criteria for the diagnosis of diabetes HbA1c >/=6.5*

1. HbA1c is important test for the assessment of long term blood glucose control (also called glycemic control).
2. HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of long term glycemic control than blood glucose determination.
3. HbA1C is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefor remains unaffected by short term fluctuations in blood glucose levels.
4. Long term complications of diabetes such as retinopathy,nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.
5. Genetic Variants (Hb-S trait,Hb-C trait) elevated fetal haemoglobin & chemically modified derivatives of haemoglobin (eg carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1C measurement.

SERUM URIC ACID			
SERUM URIC ACID (Uricase)	**6.7**	mg/dl	2.4 - 5.7

******* End Report *******

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MR No.	: **S144506**	**Collection Date**	: 14/10/2023 9:40AM
Patient Name	: **Mrs. Ruqsana Rafik Saiyed**	**Age**	: 51 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 14/10/2023 11:19AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	**248**	mg/dl	50 - 200
HDL CHOLESTEROL Direct	**73**	mg/dl	40 - 60
LDL CHOLESTEROL Direct	**169**	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	124	mg/dl	50 - 150
LDL Calc	24.8	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	3.4		0 - 5
LDL / HDL RATIO	2.32		0 - 3

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment.
- Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Details on test interpretation available from the lab.

TEST	NEAR OPTIMAL (Moderate Risk)	BORDER LINE (Risk)	HIGH (Risk)	VERY HIGH
CHOLESTROL	160-199	200-239	240-279	280
HDL	50-59	40-49	< 40	
LDL	100-129	130-159	160-190	>190
TRIGLYCERIDES	150-169	170-199	240-499	>500
CHO/HDL RATIO	3.3-4.4	4.4-11.0	>11.0	
LDL/HDL RATIO	0.5-3.0	3.0-6.0	>6.0	

******* End Report *******

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MR No.	: **S144506**	**Collection Date**	: 14/10/2023 9:40AM
Patient Name	: **Mrs. Ruqsana Rafik Saiyed**	**Age**	: 51 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 14/10/2023 11:22AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	89	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.3	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.1	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.2	mg/dl	0.0 - 0.8
SGPT (IFCC)	08	U/L	5 - 41
SGOT (IFCC)	14	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	6.9	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.0	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.9	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	**1.38**	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	0.6	mg/dl	0.5 - 1.2
BUN [BLOOD UREA NITROGEN]			
BUN	12.7	mg/dl	8 - 23
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	**4.6**	mg/L	
URINE CREATININE (JAFFE)	**119.5**	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	3.84	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

******* End Report *******

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MR No.	: **S144506**	**Collection Date**	: 14/10/2023 9:40AM
Patient Name	: **Mrs. Ruqsana Rafik Salyed**	**Age**	: 51 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 14/10/2023 11:24AM

CLINICAL PATHOLOGY

Parameter	Result	Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION		
TYPE OF SPECIMEN - URINE	Random	
PHYSICAL EXAMINATION		
QUANTITY	30	ml
COLOUR	Pale Yellow	
APPEARANCE	Sl.Turbid	
REACTION (pH)	6.0	
SPECIFIC GRAVITY	1.010	
CHEMICAL EXAMINATION		
PROTEIN	Absent	
GLUCOSE	Absent	
KETONE	Absent	
BILE SALT	Absent	
BILE PIGMENT	Absent	
OCCULT BLOOD	Absent	
NITRITE	Absent	
MICROSCOPIC EXAMINATION		
PUS CELLS	1-2	/hpf
EPITHELIAL CELLS	3-4	/hpf
RBC	Absent	/hpf
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

******* End Report *******

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MR No.	: **S144506**		
Patient Name	: **Mrs. Ruqsana Rafik Salyed**	**Collection Date**	: 14/10/2023 9:40AM
Ref By	: Dr. Hospital A Doctor	**Age**	: 51 Y **Sex** : Female
		Report Date	: 14/10/2023 12:53 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
POST PRANDIAL BLOOD GLUCOSE [PPBS]			
POST PRANDIAL BLOOD GLUCOSE (Hexokinase)	139	mg/dl	100 - 140
POST PRANDIAL URINE GLUCOSE	SNR		
POST PRANDIAL URINE KETONE	SNR		

******* End Report *******

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

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DOC. No.	SGHS/FMT/IPD009	DOI	14/06/2014	Rev. No.	0.0

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GYNAECOLOGICAL CONSULTATION

MR. NO. 9144506

Name: Mrs. Rugsany Rafik Sayed   Date: 14/10/23

Age: 51   Ht.: 156 cm   Wt.: 892   B.P.: 138/69 mmHg

Clinical Evaluation / History / Presenting Complain:

Routine

Fill. A.Y.

Gynecological History :

	Yes	No
1. Have you ever noticed any bleeding between menstrual periods ? માસિક ના સમય સિવાય વચ્ચે અનીયમીત બ્લીડીંગ થાય છે ?	☐	☐
2. Are / were your periods Irregular ? પીરીયડ્સ ઈરેગ્યુલર છે ?	☐	☐
3 Are you pregnant now ? અત્યારે તમે પ્રેગનન્ટ છો ?	☐	☐
4 Have you had your change of life (Menopause)? મેનોપોઝ ની કોઈ લક્ષણ ની તકલીફ છે ?	☐	☐
5 Are / were you taking birth control pills? તમે ગર્ભનિરોધક ગોળીઓ છે ?	☐	☐
6. Do you have a lump in your beast ? સ્તનમાં દુ:ખાવો / સોજો / ગાંઠ છે ?	☐	☐
7. Did anyone in your family suffer from beast cancer ? કુટુંબમાં કોઈને બ્રેસ્ટ કેન્સર છે ?	☐	☐
8. Did anyone in you family suffer from any other cancer ? કુટુંબમાં કોઈને કોઈ પણ પ્રકારનું કેન્સર હતું ?	☐	☐

– Bamita
– Chhaya

Obstetric History :

1. Menstrual History : Menarche at .... Yrs

Menses:
- a. Scanty / Average / Excess
- b. No of Days: 3-5 / 5-7 / More than 7 days
- c. Interval .... days, Reg / Irregular
- d. Pain : Before / During / After / Painless

Last menstrual Period (LMP): 3rd Sept

2. Obstetric History :

Gravida .... Pare .... Abortion .... Live ....

Married life with cohabitation...

Children M: 2W F: Last Delivery: Yrs back

Any bad Obstetric event / history   Yes / No

If yes Describe:

(APM)

History of Contraception & Family Planning:

Examination

a. Breast Examination - Right Nm Left Nm

b. Per abdomen examination Soft dm

c. Local examination Vulva : Nm Vagina Nm

d. Per Speculum Examination

Secl

e. Per vaginal examination :

Cervi : Uterus : AV/RV : Normal / Bulky

Adnexa :

PAP's Smear Taken Yes / No

Clinical Impression:

Recommendation:

A. Additional Inv. / Referral Suggested

B. Therapeutic Advice

C Tab

Followup Date

DR. BHAVNA DESAI
MD,DGO
REG. NO.-10538
SUNSHINE GLOBAL HOSPITAL
SURAT.

Gynaecologist's Signature

DOB:
yr. FEMALE

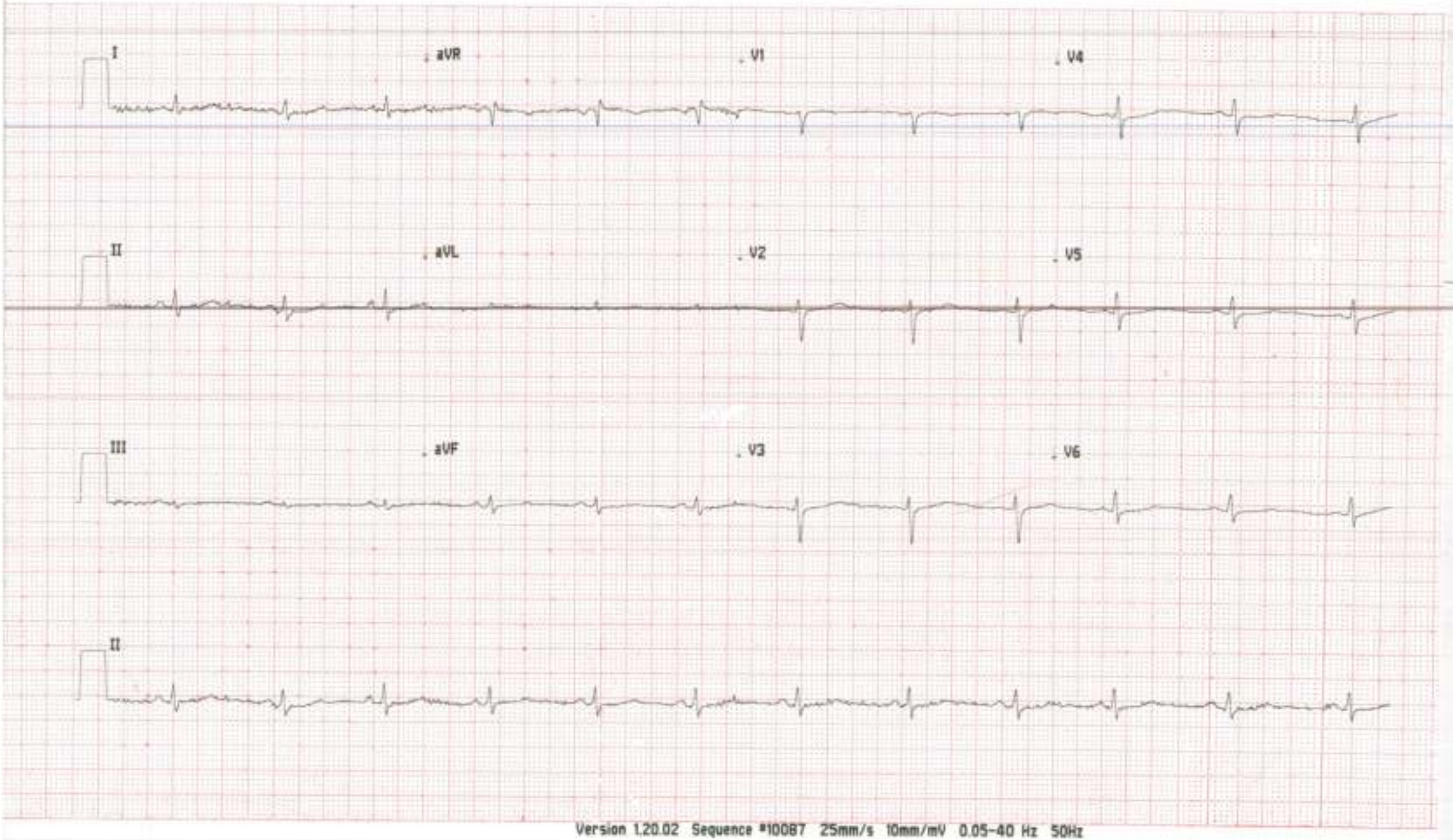
Vent rate:	71 BPM
PR int:	121 ms
QRS dur:	81 ms
QT/QTc:	363/386 ms
P-R-T axes:	57 17 31

SINUS RHYTHM
NORMAL ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS

Reviewed by ----------

1403. R:49sm q

SIF RAFIK



Version 1.20.02 Sequence #10087 25mm/s 10mm/mV 0.05-40 Hz 50Hz