CHARUSAT HOSPITAL

ચારૂસેટ હોસ્પિટલ, ચાંગા

વર્લ્ડ ક્લાસ મલ્ટી સ્પેશિયાલિટી હોસ્પિટલ

Body Profile

તારીખ / Date	23/03/2024
રજીસ્ટ્રેશન નંબર / Registration Number	CH-2024-005468
દર્દીનું નામ / Patient's Name	Vishal Samual Khristi
સંપર્ક નંબર / Contact Number	

હેલ્પ લાઈન

એપોઈન્ટમેન્ટ માટે સંપર્ક

+91-2697-265502/504

+91-9537[illegible]27873

૨૪ કલાક ઈમરજન્સી સંપર્ક

+91-2697-265500

+91-75748 38111

નોંધ : ફરી બતાવવા આવો ત્યારે આ ફાઈલ અચુક સાથે લાવવી.

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Patient Name :	VISHAL SEMUAL KHRISTI	**Sample No. :**	SAMPLE-0108152
Patient ID :	CH-2024-0054568	**Visit No. :**	OPD/2024/03/0001266
Age/Sex :	37y/Male	**Call. Date :**	23-Mar-2024 09:13
Referred By :	KRUNAL VYAS	**S. Coll. Date :**	23-Mar-2024 14:28
Ward :	-	**Report Date :**	23-Mar-2024 14:43

2BS

Investigation	Result	Normal Value
st Prandial Blood Sugar (2Hrs) :	117.5 mg/dl [NORMAL]	100 - 140

NAITIK BHATIA
NSULTANT PATHOLOGIST
B.B.S,D.C.P)

DR. KETAN KAPADIA
CONSULTANT PATHOLOGIST
(M.B.B.S,M.D)

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DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR	INVESTIGATION
23-03-2024	VISHALBHAI S KHRISTI	37	M	BODY PROFILE	UM-TOTAL ABDOMEN USG

USG ABDOMEN report.

Liver: show evidence of normal size,parenchymel echotexture & no evidence of focal cystic mass lesion seen.Normal hepatic vasculature seen with no evidence of intrahepatic biliary dilatation seen.
Solitory mass of app 1.4 cm size,hyperechogenic echotexture,well defined seen in right lobe liver-possibility of benign nature,? Haemangioma.
Gall bladder: is physiologically contractedwith no evidence of calculus or sludge.Thickness of gall bladder wall is normal with no evidence of pericholecystic fluid collection.
CBD,portal vein & spleenic vein size are normal.

Spleen: size & parenchymel echotexture is normal with no focal mass lesion seen.

Pancreas: show evidence of normal size & parenchymel echotexture with no evidence of focal mass lesion.

Aorta: show normal caliber & no evidence of paraaortic mass lesion seen.

Right kidney: show evidence of normal size,position,corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.
No evidence of focal solid or cystic mass lesion seen.

Left kidney: show evidence of normal size,position,corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.
No evidence of focal solid or cystic mass lesion seen.

Bladder: walls are normal & no evidence of stone or mass seen.

Prostate: show evidence of normal size & parenchymel echotexture.
No evidence of ascitis or abnormal bowel loops seen.

Size cm app

Right Kidney	Left Kidney
8.75X3.96	8.91X4.74

COMMENTS:
Solitory mass of app 1.4 cm size,hyperechogenic echotexture,well defined seen in right lobe liver-possibility of benign nature,? Haemangioma.

No other obvious abnormality detected.

Thanks for reference
DR KIRTI C THAKKAR
M.B.B.S,D.M.R.D

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Patient Name :	VISHAL SEMUAL KHRISTI	Sample No. :	SAMPLE-0108134
Patient ID :	CH-2024-0054568	Visit No. :	OPD/2024/03/0001266
Age/Sex :	37y/Male	Coll. Date :	23-Mar-2024 09:13
Referred By :	KRUNAL VYAS	S. Coll. Date :	23-Mar-2024 11:46
Ward :	-	Report Date :	23-Mar-2024 12:26

moglobin (HB) estigation	Result	Normal Value
	14.9 gm/dl [NORMAL]	[M : 14-18, F : 12-16]

noglobin C stigation	Result	Normal Value
	5.32 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
C Count :	7220 /c.mm [NORMAL]	4000 - 10000

C :

elet count stigation	Result	Normal Value
elets	1.91 Lakh/cmm [NORMAL]	1.5 - 4.5

count - Differential tigation	Result	Normal Value
	45 % [NORMAL]	40 - 70
norphs	41 % [HIGH]	20 - 40
hocytes	07 % [HIGH]	1 - 6
ophils	07 % [NORMAL]	2 - 10
cytes	00 % [NORMAL]	0 - 1
hils		

D UREA

gation	Result	Normal Value
Urea	27.2 mg/dl [NORMAL]	15 - 40

tinine

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rd :	-	Report Date :	23-Mar-2024 12:26

Investigation	Result	Normal Value
erum Creatinine	0.92 mg/dl [NORMAL]	Male : 0.9 to 1.5 mg/dl Female : 0.8 to 1.2 mg/dl
UN		
vestigation	13 [NORMAL]	8.0 to 23.0 (mg/dl)
UN :		
RIC ACID		
vestigation	4.73 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0
erum Uric Acid		
SR		
vestigation	06 mm [HIGH]	[M : 3 - 5, F : 4 - 7]
SR - After One Hour		
ood Group		
estigation	AB	
O :	Positive	
:		
STING BLOOD GLUCOSE		
estigation	90.4 mg/dl [NORMAL]	70 - 110
sting Blood Sugar :		
sting Urine Sugar :	Absent	
A1C		

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b A 1c	6.2 %	> 8 : Action Suggested 7-8 : Good Control < 7 : Goal 6-7 : Near Normal Glycemia < 6 : Non-diabetic Level

mments

Hb A1C also know asGlycosylated Haemoglobin is the most important test for the assessment of longterm Blood glucose control (also called glycemic control).
Hb A1C reflects mean glucose concentration over past 69-8 week and provides a much better indicationn of longterm glycemic contril than blood glucose determination.
This Reaction is irreverdible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications).
nephropathy(Kidney-complications) & neuropathy(never complications) are potentially serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.

tigation	Result	Normal Value
:	1.17 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

tigation	Result	Normal Value
iodothyronine :	1.57 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

igation	Result	Normal Value
roxine :	55.4 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

PROFILE

gation	Result	Normal Value

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erum Cholesterol (Chol) :	224.3 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
erum Triglyceride :	109.9 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
HDL Cholesterol :	55.3 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
DLC :	124.14 mg/dl	
/LDL :	44.86 mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
DL/HDL Ratio :	2.24 - [NORMAL]	< 3.5
C / HDL Ratio :	4.06 - [NORMAL]	4.0 to 6.0
DL (DIRECT) :	185.1 mg/dl [High]	< 100.0 (Optimal), 100.0 to 120.0 (Near Optimal), 130.0 to 159.0 (Border line high), 160.0 to 189.0 (High), > 190.0 (Very high)

IVER FUNCTION TEST

Investigation	Result	Normal Value
otal Bilirubin :	0.61 mg/dl [NORMAL]	0.0 to 1.2
irect Bilirubin (DBIL) :	0.18 mg/dl [NORMAL]	0.0 to 0.30
LT (SGPT) :	17.0 IU/L [NORMAL]	[0.0 - 40]
ST (SGOT) :	11.2 IU/L [NORMAL]	<= 45.0
lkaline Phosphatase (ALP) :	77.3 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0

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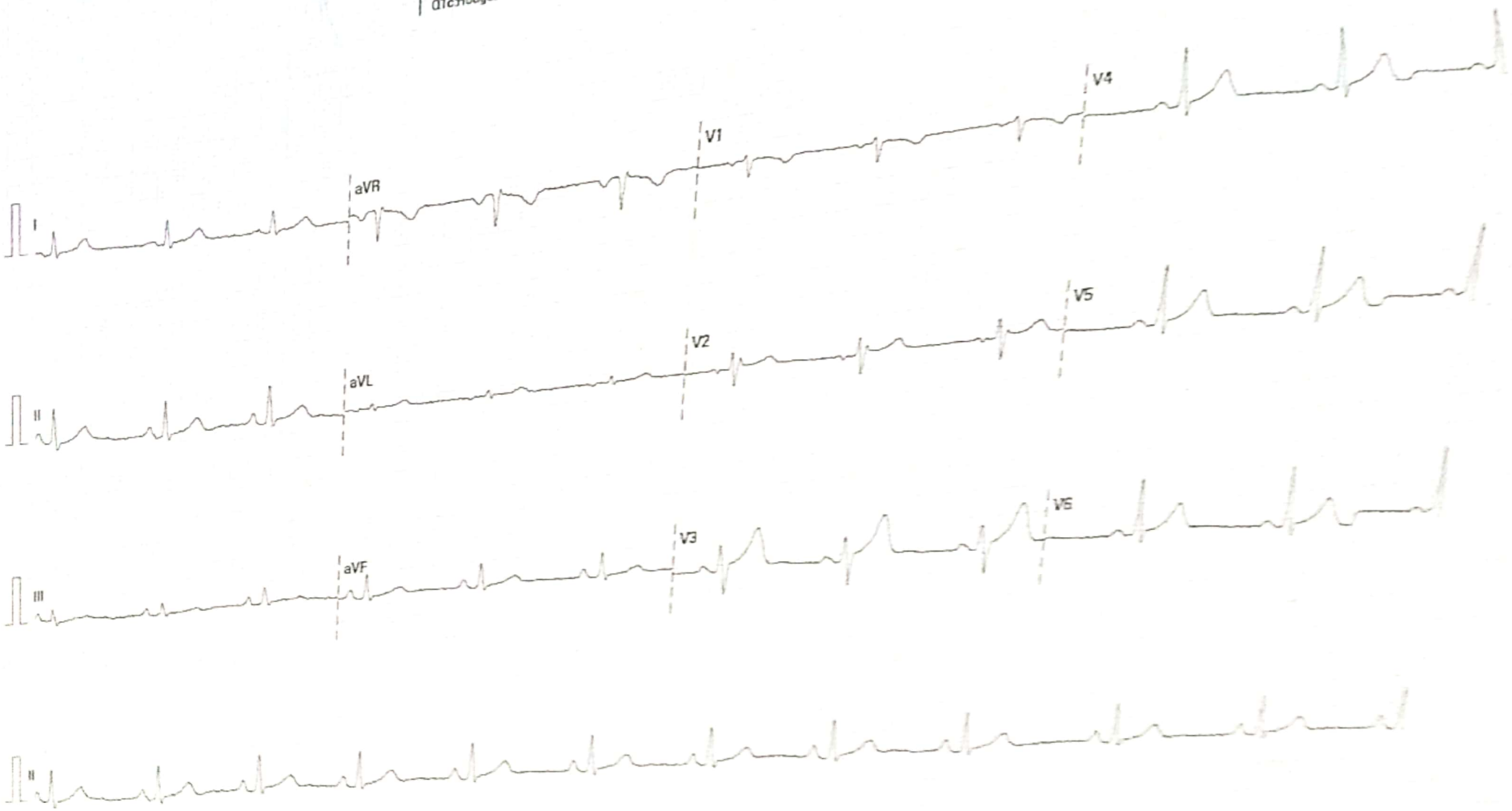
otal Protein (TP) :	6.7 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
bumin (ALB) :	4.1 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
direct Bilirubin (IBIL) :	0.43 [NORMAL]	0.0 to 0.75 (mg/dl)
lobulins :	2.60 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
G Ratio :	1.6	

RINE R & M vestigation	Result	Normal Value
hysical Examination :		
uantity :	15 ml	
olour :	Pale Yellow -	
ppearance :	Clear -	
dour :	URINIOD -	
eaction :	Acidic -	
pecific Gravity :	1.030 -	
hemical Examination :		
bumin :	Absent -	
ugar :	Absent -	
le Salts :	Absent -	
le Pigments :	Absent -	
etone :	Absent -	
robilinogen :	Absent -	
icroscopie Examination :		
us Cells :	1-2 -	
BCs :	Absent -	
pithelial cells :	1-2 -	

ID: 0054568
Name: Khristi, Vishal.S
Age: 37 Years
Gender: Male

Vent. Rate	136 ms
PR Interval	87 ms
QRS Duration	378/390 ms
QT/QTc Interval	71/53/44 deg
P/QRS/T Axes	

QTcHodges



25 mm/s 10 mm/mV 50 Hz BDR 20 Hz

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LALITABEN P. D. PATEL OPD SERVICES
REGISTRATION FORM (OPD)

Dr. Jainish sir

Date & Time : 23-03-24

Registration No. : CH-2024-005468

Name : Vishal Samuel Khristi Contact No. : (M) _____

Age : 27 Sex : M (O) _____

Address : Not known

Pulse : Regular SpO$_2$: 99 on RA

Height : _____ Weight : 52 kg

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : Came for Health checkup

CASE ANALYSIS

Past History : Nil

Present History : _____

G/E Vitals : _____

Systemic Examination : _____

FAMILY HISTORY :

- ☐ Diabetes
- ☐ IHD
- ☐ Hypertension
- ☐ Others (Specify) : _____

PATIENT'S MEDICAL/OTHER HISTORY :

- ☐ Hypertension ☐ IHD ☐ T.B. ☐ Jaundice
- ☐ Epilepsy ☐ Asthma ☐ Hepatitis B ☐ Hepatitis C
- ☐ Food Allergy ☐ AIDS/HIV ☐ Bleeding Disorder
- ☐ Drug Allergy ☐ Pregnancy

HABBITS : ☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Others (Specify) : _____

CHRF/OPD/5083

OPHTHALMIC REGISTRATION FORM

HARIKRISHNA HOSPITAL

Reg. No. : CHD-24-0054568

Date : 23-03-24

Patient's Name : Vishal S. Khristi Age : 37/M

Address :

Telephone No. : Mobile No. :

Referred by / Care of :

Profession :

Type or work in daily routine : Driving / Watching TV / Computer / Reading /

History / Complain of : Diminution of Vision / Pain / Watering / Redness / Eyeache / Headache / Itching / Stickness / Swelling / Irritation / Burning / F. B. Sensation / Photophobia / Diplopia / Squinting / Blackout / Floaters / Flashes / Injury / wearing gl. since 2004.

Eye Involve : RE / LE / BE Duration :

Ophthalmic History : Surgery / Laser / FFA / Oct / Glaucoma / RP / Corneal Opacity / Injury / Amblyopia /

Treatment Retinal treatment. using lubrication, Reticure

Any Surgery : Cataract / Glaucoma / lasik (RE) / LE / BE — 2008

Family History : Glaucoma / RP / DM /

SYSTEMIC : DM / HT / IHD / COPD / PROSTATE / WROID / ALLERGY / SMOKING / ALCOHOL

EYE DETAILS :	RE	LE
V/A with PH	6/18	6/6.
IOP	13 mm/Hg	12 mm/Hg.
OWN GLASS :	-2.75 DSph	plano
AR :	-2.75/-1.25 x 90°	-1.25/-0.25 x 140°

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	same	PGP				
Nr.						
Comp						

Bifocal / (Distant) / Near only / Constant / Progressive / Photocromatic

Remark :

Signature :