

NAME: <i>Ms. Nilima Pawar</i>	UHID:
AGE: <i>32</i>	DATE OF HEALTHCHECK: <i>14/11/2023</i>
GENDER: <i>M</i>	

HEIGHT: <i>166</i>	MARITAL STATUS: <i>M</i>
WEIGHT: <i>52.5</i>	NO OF CHILDREN: <i>1</i>
BMI: <i>19.1</i>	

C/O: *Cervical pain, eyes*

K/C/O: PRESENT MEDICATION: *- No*

P/M/H: *- No*

P/S/H: *- None*

ALLERGY: *- No*

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER: *- No*
MOTHER: *- No*

ALCOHOL: *- No*

TOBACCO/PAN: *- No*

LYMPHADENOPATHY: *- No*

O/E:

BP: *110/80* PULSE: *- 70/min*

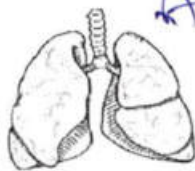
PALLOR/ICTERUS/CYNOSIS/CLUBBING: *- No*

TEMPERATURE: *- 37.5* SCARS:

OEDEMA:

S/E:

RS:



P/A: *- No*

CVS: *- No*

Extremities & Spine: *- No*

CNS: *- Normal, no tremor*

ENT:

Skin: *- No*

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

Name: Nilima Pawar Age: 32 Date of Health check-up: 14/10/2023

Findings and Recommendation:

Findings:-

EBC - Eosinophilia
S. Uric acid - 1.7mg/dl
ECG - Sinus Bradycardia
Ref reports come

Recommendation:-

Pradnya
DR. PRADNYA P. DANI
(M.B.B.S)
Reg. No. 87541

Signature:

Consultant -

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 14/10/23

Name: Miss Nilima Age: 32 Gender: Male/Female

Without Correction : myopia 1 axis
pc axis - 5.0
post axis 2.75 - 3.0 ✓

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

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	-2.75	-0.50	10°			-3.0	-0.50	135°		
Near						prefers blur				

Colour Vision : NO (BO)

Anterior Segment Examination : NO (BO)

Pupils : _____

Fundus : myopic fundus

Intraocular Pressure : 12 mm (BE)

Diagnosis : _____

Advice : wear glasses

Re-Check on 6 mths (This Prescription needs verification every year)

V.D.

Dr. R
 (Consultant Ophthalmologist)

DR. RUCHIRA SHARMA
 M. S. (OPHTH)
 CONSULTING OPHTHALMOLOGIST
 MICRO SURGEON

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry ■ REG. No. 3262/09/02

Name: Ms Nilima Pawa Age: 32 Sex: f UHID No.: _____ Date: 14/10/23

32 year / married :: Symp / P, G (FSD)

No complaints
writing for PAP smear

LMP : 9/10/2023

O/R

GCFair


Mucoid

P- 88/min

No clots

PA - sgtm

P/S : cx } Healthy
ny }
(PAP smear taken)


Dr. TRUPTI SHINDE



Apollo Clinic DR. TRUPTI VIJAY SHINDE
VASHI MBBS, M.S. (OBS & GYNAE)
REG. NO.: 2014/07/3301

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: Mrs. Nilina Paven	MR NO:
Age/Gender: 32yrs / F	Date: 1/10/23

Medical history: Diabetes Hypertension NRH.

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains	✓		✓	
Mobility		✓		✓
Caries (Cavities)				
a) Class 1 (Occlusal)				
b) Class 2 (Proximal)			37	48
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling			37	38
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: Adv. change amalgam restoration.

Ali

Name : Mrs. Nilima Pawar Gender : Female Age : 32 Years
UHID : FVAH 8860. Bill No : Lab No : V-1256-23
Ref. by : SELF Sample Col.Dt : 14/10/2023 09:25
Barcode No : 1481 Reported On : 14/10/2023 17:04

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)

Haemoglobin(Colorimetric method)	12	g/dl	11.5 - 15
RBC Count (Impedance)	4.17	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	38.1	%	35 - 55
MCV:(Calculated)	91.4	fl	78 - 98
MCH:(Calculated)	28.9	pg	26 - 34
MCHC:(Calculated)	31.6	gm/dl	30 - 36
RDW-CV:	13.1	%	10 - 16
Total Leucocyte count(Impedance)	5760	/cumm.	4000 - 10500
Neutrophils:	45	%	40 - 75
Lymphocytes:	40	%	20 - 40
Eosinophils:	11	%	0 - 6
Monocytes:	04	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	3.02	Lakhs/c.mm	1.5 - 4.5
MPV	9.6	fl	6.0 - 11.0
ESR(Westergren Method)	10	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic, Normocytic		
WBCs:	Eosinophilia		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

Tejal Dighe
Entered By

Ms Kaveri Gaonkar
Verified By

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Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST

RESULTS

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

ABO Group:

:O:

Rh Type:

Positive

Method :

Matrix gel card method (forward and reverse)

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M.D(Path)
Chief Pathologist**

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.6 % 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 : 114.02 mg/dL

Correlation 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 correlate 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 than the routine chromatographic methods & also for the diabetic pts. having HEMOGLBINOPATHIES OR UREMIA as Hb variants 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 diabetics .
- * 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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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	96	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 :	84	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

LIPID PROFILE - Serum

S. Cholesterol(Oxidase)	131	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	67	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	13.4	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	41.3	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	76.3	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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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	6.96	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.57	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.39	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.91		0.9 - 2
S.Total Bilirubin (DPD):	0.40	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.17	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.23	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	13	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	9	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	65	U/L	35 - 105
S.GGT(IFCC Kinetic):	14	U/L	07 - 32

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Kidney screening test-Serum			
S.Urea(Urease-GLDH)	16.3	mg/dL	10.0 - 45.0
S. Urea Nitrogen(Calculated)	7.6	mg/dL	5 - 20
S.Creatinine(Jaffe's Kinetic)	0.59	mg/dL	0.50 - 1.1
S.Uric Acid(Uricase-POD)	<u>1.7</u>	mg/dL	2.4 - 5.7

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Thyroid (T3,T4,TSH)- Serum

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.75	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	98.81	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	2.08	□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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End of Report
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UHID	: FVAH 8860.	Bill No	:	Lab No	: V-1256-23
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CYTOPATHOLOGY REPORT

Specimen No: AP-1763-23

Specimen Adequacy: ADEQUATE

CELLS

ENDOCERVICAL: Absent

ENDOMETRIAL: Absent

SQUAMOUS: **SUPERFICIAL(++), INTERMEDIATE(++)& PARABASAL(Few) 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

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

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
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URINE REPORT

PHYSICAL EXAMINATION

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

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	6.5		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	1 - 2/hpf		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	2 - 3 /hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

Anushka Chavan
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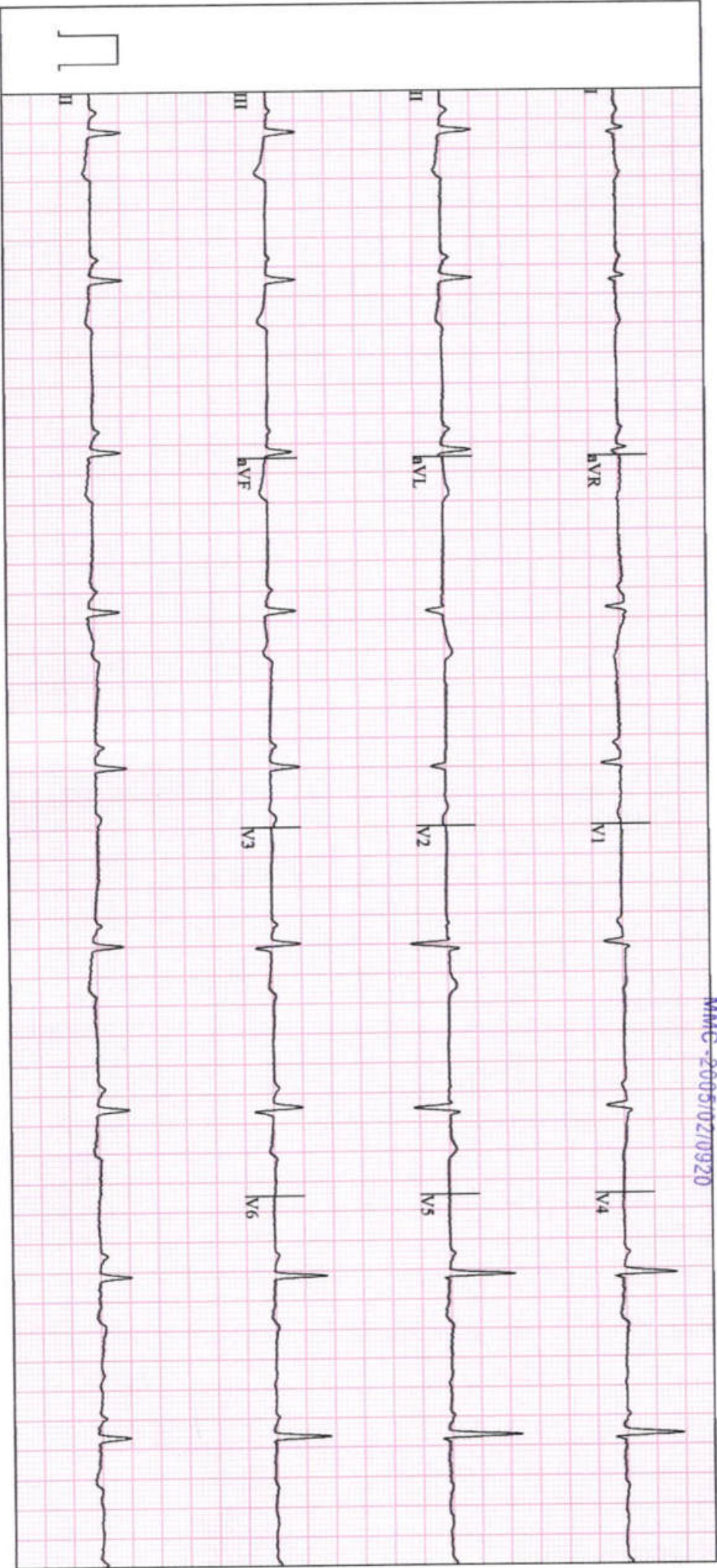
End of Report
Results are to be correlated clinically

QRS : 82 ms
QT/QTcBaz : 430/407 ms
PR : 138 ms
P : 96 ms
RR/PP : 1106/1111 ms
P/QRS/T : 57/85/-31 degrees

Sinus bradycardia
T wave abnormality, consider inferior ischemia
Abnormal ECG

*Sinus Bradycardia
- ST changes in lead leads + lead leads*

Dr. ANIRBAN DASGUPTA
M.B., B.S., D.N.B. Medicine
Diploma Cardiology
MMC-2005/02/09920



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

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: NILIMA, PAWAR
Patient ID: 8860
Height:
Weight:

DOB: 14.11.1990
Age: 32yrs
Gender: Female
Race: Asian

Study Date: 14.10.2023
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR. ANIRBAN DASGUPTA
Technician: Anita Gaikwad

Medications:
NIL

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	00:40	0.00	0.00	60	110/80	
	STANDING	00:14	0.00	0.00	64		
	HYPERV.	00:15	0.00	0.00	65		
	WARM-UP	00:18	0.90	0.00	64	110/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	106	120/80	
	STAGE 2	03:00	2.50	12.00	130	140/80	
	STAGE 3	01:02	3.40	14.00	164	150/80	
RECOVERY		01:04	0.00	0.00	125	160/90	

The patient exercised according to the BRUCE for 7:02 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 59 bpm rose to a maximal heart rate of 166 bpm. This value represents 88 % of the maximal, age-predicted heart rate. The resting blood pressure of 110/80 mmHg, rose to a maximum blood pressure of 160/90 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. ANIRBAN DASGUPTA

Anirban Dasgupta
Dr. ANIRBAN DASGUPTA
M.B., B.S., D.N.B. Medicine
Diploma Cardiology
MMC - 2005/02/0920

PATIENT'S NAME	NILIMA PAWAR	AGE :- 32 Y/F
UHID	8860	DATE :- .14 Oct. 23

X-RAY CHEST PA VEIW

OBSERVATION:

Patient is in positional obliquity.
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. CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg No. 073826

PATIENT'S NAME	NILIMA PAWAR	AGE :- 32Y/F
UHID	8860	14 Oct 2023

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 10.7 x 4.5 cm. **LEFT KIDNEY** measures 9.0 x 3.7 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. It measures 7.1 x 4.4 x 3.8 cm; ET measures 9.8 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.



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