

MEDICAL SUMMARY

NAME:	Ms. Anuradha Karmacharya	UHID:	5192
AGE:	38 Yrs	DATE OF HEALTHCHECK:	25/12/2023
GENDER:	Female		

HEIGHT:	152.5 cm	MARITAL STATUS:	M
WEIGHT:	49.9 kg	NO OF CHILDREN:	2
BMI:	21.6		

C/O: ~~weakness~~, fatigue

K/C/O: PRESENT MEDICATION: - NO

P/M/H: Subdural haemorrhage seen in right parietal region in July/2020
Parietal region - July/2020

P/S/H: - U.S.

ALLERGY: - None

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING: - None

FAMILY HISTORY FATHER: - None

ALCOHOL: - None

MOTHER: - None

TOBACCO/PAN: - None

O/E:

LYMPHADENOPATHY: - None

BP: 100/70 PULSE: - 68/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING: - None

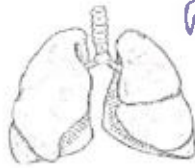
TEMPERATURE: - Normal SCARS: - None

OEDEMA: - None

S/E:

P/A: - None

RS:



CVS: - Subst

Extremities & Spine: - None

ENT:

CNS: - Conscious, oriented

Skin: - None

Vision:

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

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OPHTHALMIC EVALUATION

UHID No.: 5192

Date: 25/2/23

Name: Mrs Archana Age: 30 Gender: Male/Female ✓

Without Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye N6 Left Eye N6

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 : _____

Fundus : NFB (BC)

Intraocular Pressure : 12 mmHg (30)

Diagnosis : _____

Advice : _____

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

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

Dr. _____
 (Consultant Ophthalmologist)

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: Mrs. Akshara	MR NO:
Age/Gender: 36 / 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

hl

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

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Name: Mrs Archana Age: 30yr Sex: F UHID No.: Date: 25/2/2023

30yr F, P2L2
for pap smear

nil - HPV - 14/2/2023

o/n + P/M

R+ nil

cu - for

atenule

cu / AD

PIA - soft

normal

H.S. pap smear
taken

Dr. _____



Apollo Clinic
VASHI

- Consultation
- Diagnostics
- Health Check-Ups
- Dentistry

Name : Mrs. Archana Komuravelly Gender : Female Age : 36 Years
UHID : FVAH 5192. Bill No : Lab No : V-2058-23
Ref. by : SELF Sample Col.Dt : 25/02/2023 09:50
Barcode No : 6754 Reported On : 25/02/2023 18:32

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

CBC (Complete Blood Count)-WB (EDTA)

Haemoglobin(Colorimetric method)	8	g/dl	11.5 - 15
RBC Count (Impedance)	4.18	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	27.2	%	35 - 55
MCV:(Calculated parameter)	65.1	fl	78 - 98
MCH:(Calculated parameter)	19.1	pg	26 - 34
MCHC:(Calculated parameter)	29.3	gm/dl	30 - 36
RDW-CV:	20.3	%	10 - 16
Total Leucocyte count(Impedance)	5170	/cumm.	4000 - 10500
Neutrophils:	51	%	40 - 75
Lymphocytes:	44	%	20 - 40
Eosinophils:	02	%	0 - 6
Monocytes:	03	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	3.56	Lakhs/c.mm	1.5 - 4.5
MPV	9.7	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)	Hypochromasia(++),Microcytosis(++),Anisocytosis(++)		
RBCs:			
WBCs:	Lymphocytosis		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter.		

Ms Kaveri Gaonkar
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Verified By

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

End of Report
Results are to be correlated clinically

Name : Mrs. Archana Komuravelly Gender : Female Age : 36 Years
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL
ESR(Westergren Method)

Erythrocyte Sedimentation Rate:- **29** mm/1st hr 0 - 20

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TEST

RESULTS

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

ABO Group:

:O:

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 : 5.5 % 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 : 111.15 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 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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NABL Accredited Laboratory
The Emerald, 1st Floor, Plot No. 195, Sector-12,
Besides Neel Siddhi Tower, Vashi-Navi Mumbai-400703.
Tel.: (022) - 2788 1322 / 23 / 24 ☎ 8291490000
Email: apolloclinicvashi@gmail.com




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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	81	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 :	77	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)	84	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	36	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	7.2	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	<u>38.4</u>	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	38.4	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	<u>2.2</u>		3.5 - 5
Ratio of LDL/HDL	<u>1</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)	7.26	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.13	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.13	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.32		0.9 - 2
S.Total Bilirubin (DPD):	0.26	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.12	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.14	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	18	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	7	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	86	U/L	35 - 105
S.GGT(IFCC Kinetic):	10	U/L	07 - 32

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	13.1 mg/dl	10.0 - 45.0
BUN (Calculated)	6.11 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.56 mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	10.91	9:1 - 23:1
S.Uric Acid(Uricase Method)	3.2 mg/dl	2.4 - 5.7

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	2.13	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	104.7	nmol/L	66 - 181 nmol/L
TSH (Thyroid-stimulating hormone) (ECLIA)	2.03	□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

End of Report
Results are to be correlated clinically

Name	: Mrs. Archana Komuravelly	Gender	: Female	Age	: 36 Years
UHID	: FVAH 5192.	Bill No	:	Lab No	: V-2058-23
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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)	6.0		4.6 - 8.0
SPECIFIC GRAVITY	1.005		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	Occasional		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	1 - 2 / hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

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CYTOPATHOLOGY REPORT

Specimen No: AP-327-23

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
Entered By

Ms Kaveri Gaonkar
Verified By



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

Page 1 of 1

End of Report
Results are to be correlated clinically

Archana, Komuravelly
5192

30 Years

Female

25.02.2023 13:30:26
Apollo Clinic
1st Flr, The Emerald, Sector-12,
Vashi, Mumbai-400703

67 bpm
--/-- mmHg

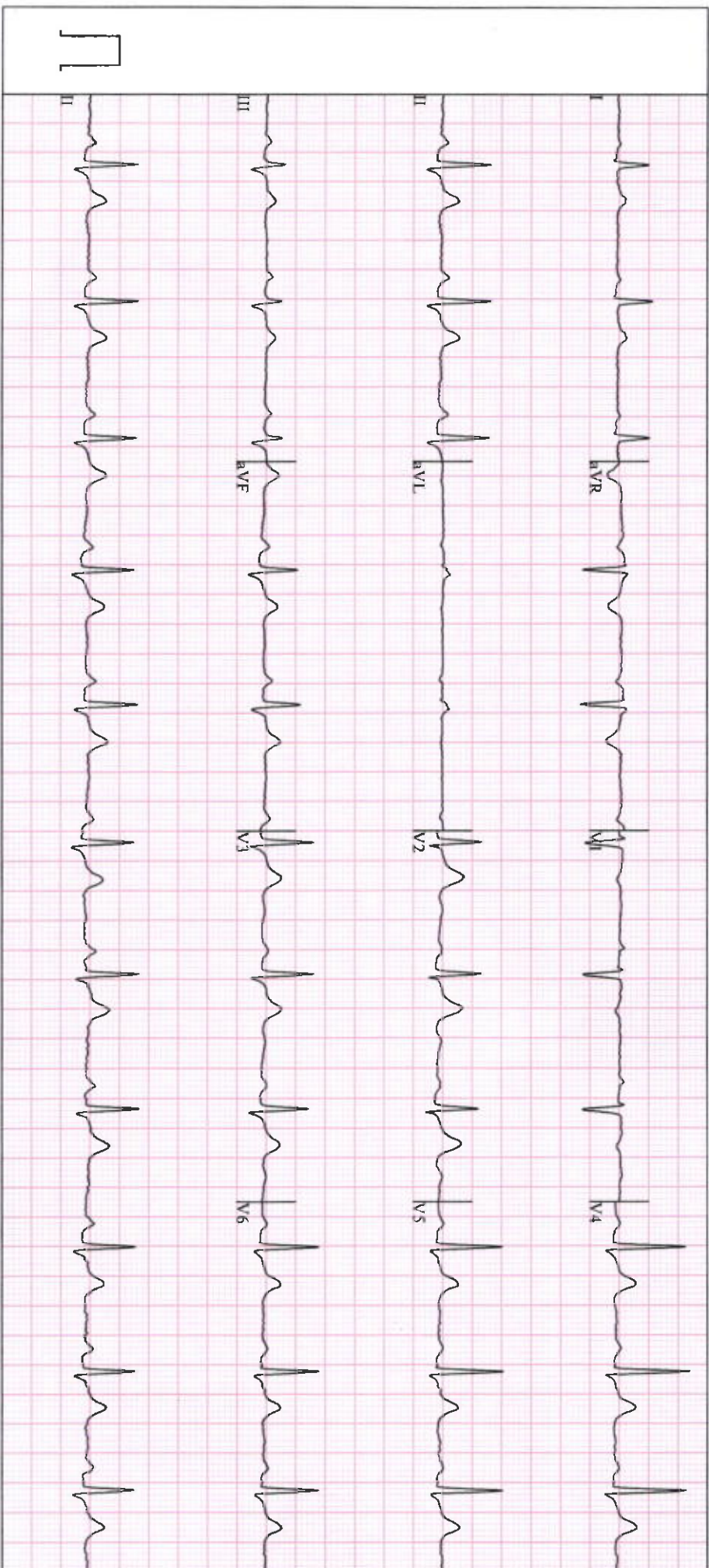
QRS : 90 ms
QT / QTcBaz : 384 / 405 ms
PR : 172 ms
P : 98 ms
RR / PP : 896 / 895 ms
P / QRS / T : 79 / 52 / 64 degrees

Normal sinus rhythm
Normal ECG

W-R

NORMAL ECG

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



GE MAC2000

I.I

12SL™ v241

25 mm/s

10 mm/mV

ADS

0.56-20 Hz

50 Hz

Unconfirmed
4x2.5x3_25_R1

1/1

PATIENT'S NAME	MRS ARCHANA KOMURAVELLY	AGE :- 36Y/F
UHID	5192	DATE :- .25 Feb. 23

2D Echo and Colour doppler report

- All cardiac chambers are normal in dimension.
- No obvious resting regional wall motion abnormalities (RWMA).
- Interatrial and Interventricular septum – Appears Normal
- Valves – Structurally normal.
- Good biventricular function.
- IVC is normal.
- Pericardium is normal.
- Great vessels - Origin and visualized proximal part are normal.
- No coarctation of aorta.

Doppler study

- Normal flow across all the valves.
- No pulmonary hypertension.
- PASP – 18 mmHg.
- No diastolic dysfunction.
- Peak systolic gradients across LVOT/AV – 06 mmHg.

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Measurements

Aorta annulus	17 mm
Left Atrium	24 mm
LVID(Systole)	22 mm
LVID(Diastole)	35 mm
IVS(Diastole)	11 mm
PW(Diastole)	11 mm
LV ejection fraction.	60%

Conclusion

- Good biventricular function
- No RWMA
- Valves – Structurally normal
- No diastolic dysfunction
- No PAH.



DR. RISHI BHARGAVA

MD DM

CONSULTANT INTERVENTIONAL CARDIOLOGIST

PATIENT'S NAME	ARCHANA KOMURAVELLY	AGE :- 36Y/F
UHID	5192	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)

PATIENT'S NAME	ARCHANA KOMURAVELLY	AGE :- 36Y/F
UHID	5192	25 Feb 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 9.8 x 3.5 cm. **LEFT KIDNEY** measures 9.5 x 4.2 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 7.8 x 3.3 x 3.5 cm; ET measures 6.6 mm.

Both ovaries are normal in size, shape and position.

RIGHT OVARY measures : 2.1 x 1.4 cm, **LEFT OVARY** measures : 2.1 x 1.5 cm.

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.CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg: No. 073826

• ANDHERI • COLABA • NASHIK • VASHI

Name: Mrs. Archana Komuravelly Age: 36Y Date of Health check-up: 25/2/23


Findings and Recommendation:

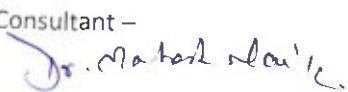
Findings:-

- HB - 8
- PCV - 27.2
- Hb - 65.1
- MCV - 19.1
- MCHC - 28.3

Recommendation:-

- Cap Demorange 1-2 x month
- Haematologist opinion

Signature: 

Consultant - 

**DR MAHESH NAIK
PHYSICIAN**