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

OPD ASSESSMENT FORM

Name: Mrs. Krishna p. Kathodiya Age.Sex: 31/F MR.No.: S1492ll

Doctor: Dr Krunal Gajjar Date: 27/01/2024

Ht: 149 cm Wt.: 80 kg Temp: 97 F Pulse: 96 B/m BP: 137/89 mm of Hg

SPO2: 99 % Post of walk SPO2:

Chief Complaints :

Not - Any.

Drug / Food Allergy :

NO.

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

RS } NAD.
CVS }

Past History :

— N.S. —

Provisional Diagnosis :

Nutritional Assessment :

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

Treatment and further Advices :
(Write in Capital Letters)

℞

→ Tab. Glycomet - SR (500)
1—0—1 × (02) months.

(R/W/C to Surgeon)

Investigation advised :

Dr. Krunal Gajjar
M.B.B.S., MD (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No. G-20[illegible]
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/OPD007 | DOI 14/08/2014 | Rev. No. 0.0

MRNO. S144024

ECHO CARDIOGRAPHIC REPORT

Patient's Name : Mrs Krishna katrodiya Date : 27/7/24 11:15Am

Sex : f Age : 31 Ref. by Dr. : Done by Dr. Surendra singh

LV Size : (N)

LVEF : 66 % (VISUAL)

DIASTOLIC DYSFUNCTION : No

LVH : No

RWMA : ANTERIOR WALL
ANTERIOR SEPTUM
IVS
LV APEX
POSTERIOR WALL
LATERAL WALL
INFERIOR WALL

No Rwma

MITRAL VALVE :
PULMONARY VALVE : (N)

AORTIC VALVE
TRICUSPID VALVE (N)

PAH : —

PASP : 8 mmhg

RA :
RV : (N)

LA :
IVC : (N)

IAS :
IVS : Intact

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

CONCLUSION :

No negligible IPE

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

GYNAECOLOGICAL CONSULTATION

MR. NO. S149024

Name: Mrs. Krishna P. Katrodiya   Date: 23/01/24

Age: 31   Ht.: 149 cm   Wt.: 80 kg   B.P.: 137/89 mmHg

Clinical Evaluation / History / Presenting Complain:

Routine R

Gynecological History :

	Yes	No
1. Have you ever noticed any bleeding between menstrual periods ? માસિક ના સમય સિવાય વચ્ચે અનિયમીત બ્લીડીંગ થાય છે ?	☐	☑
2. Are / were your periods Irregular ? પીરીયડ રેગ્યુલર 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 દુઃખાવો / 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 ?	☐	☐

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

   d. 3 wk

   Last menstrual Period (LMP): 30 days

2. Obstetric History :
   - Gravida .... Pare .... Abortion ....1.... Live ....1....
   - Married life with cohabitation..............................
   - Children M: 2/4 F: Last Delivery: Yrs back
   - Any bad Obstetric event / history Yes / No
   - If yes Describe:

Anomaly (handwritten, illegible)

History of Contraception & Family Planning:

Examination

a. Breast Examination - Right   Left

b. Per abdomen examination

c. Local examination   Vulva :   Vagina

d. Per Speculum Examination

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

Followup Date

Gynaecologist's Signature

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

OPD ASSESSMENT FORM

Name: Mrs. Krishna P. Kataodiya Age.Sex: 31/F MR.No.: S149024

Doctor: Dr Hardik Shroff Date: 27/01/24

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

SPO2 : ______ Post of walk SPO2 : ______

Chief Complaints :

c/o. Dim. Vision neck

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination : BE Ant. seg NAD

Vn (6/6, 6/6 N:6 Fundi (Central) BE NAD

Past History :

Provisional Diagnosis :

Nil ophthalmic

Nutritional Assessment :

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

Treatment and further Advices :
(Write in Capital Letters)

Rx

–

Investigation advised :

Dr. Hardik Shroff
DOMS, DNB (Op...
SUNSHINE GLOB...
Piplod, SURAT

Follow Up : SOS Date : ______ Signature

In case of emergency Please report to Emergency Department of Hospital OR
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MR No.	: S149024	Collection Date	: 27/01/2024 9:10AM
Patient Name	: Mrs. Krishna Pradipbhai Katrodiya	Age	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	Report Date	: 27/01/2024 12:21 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
POST PRANDIAL BLOOD GLUCOSE [PPBS]			
POST PRANDIAL BLOOD GLUCOSE (Hexokinase)	109	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

27/01/2024 12:21PM

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PAT. NAME : Krishna Katrodiya	
	Date : 27/01/2024
REF. DOCTOR : Hosp. Dr.	AGE : 31 Yrs / F
INV. : USG Abdomen & Pelvis	MR NO. : S149024

Findings:

Liver is normal in size, shape and shows mild increase in parenchymal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is distended and appears normal. No e/o calculus, sludge or mass lesion is seen. CBD and Portal Vein appears normal is size and calibre.

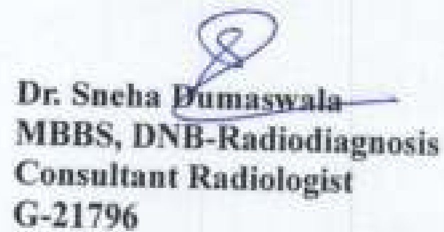
Pancreas appears normal in size and shows normal echopattern to the extent assessed. Spleen appears normal in size, shape and homogenous echopattern.

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:

- **Grade I fatty liver.**



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

Transcribed By: Asha

Date & Time of report: 27/01/2024 – 11:51 AM

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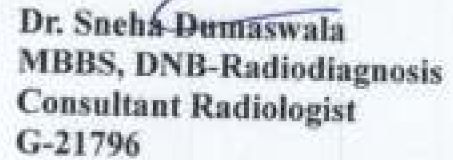
PAT. NAME : Krishna Katrodiya	Date : 27/01/2024
REF. DOCTOR : Hosp. Dr.	AGE : 31 Yrs / F
INV. : Radiograph of Chest PA	MR NO. : S149024

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: 27/01/2024 – 11:47 AM

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MR No.	**: S149024**	**Collection Date**	: 27/01/2024 9:10AM
Patient Name	**: Mrs. Krishna Pradipbhai Katrodiya**	**Age**	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 27/01/2024 11:38AM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	14.0	gm/dl	12.0 - 15.0
PCV	42.2	%	36 - 46
RBC COUNT	4.76	mill/cmm	4.0 - 5.0
MCV	88.7	fl	76 - 96
MCH	29.4	pg	26 - 32
MCHC	33.2	%	32 - 36
RDW	12.6	%	11 - 15
PLATELET COUNT	4.10	lacs/cmm	1.5 - 4.5
WBC COUNT	**14240**	/cmm	4000 - 11000
ESR	12	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	70	%	40 - 70
LYMPHOCYTES	20	%	20 - 40
EOSINOPHILS	02	%	1 - 6
MONOCYTES	08	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Normochromic Normocytic		
WBC MORPHOLOGY	Leucocytosis		
PLATELET ON SMEAR	Adequate		
HEMOPARASITES	Not Seen		

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

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

27/01/2024 11:38AM

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MR No.	: S149024	**Collection Date**	: 27/01/2024 9:10AM
Patient Name	: Mrs. Krishna Pradipbhai Katrodiya	**Age**	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 27/01/2024 11:33AM

HAEMATOLOGY

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

CLINICAL CHEMISTRY

THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.50	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	9.47	ug/dl	5.1 - 14.0
TSH (CLIA)	1.72	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.

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

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

27/01/2024 11:33AM

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MR No.	: S149024	**Collection Date**	: 27/01/2024 9:10AM
Patient Name	: Mrs. Krishna Pradipbhai Katrodiya	**Age**	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 27/01/2024 11:33AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	5.3	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**105.41**	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.

Parameter	Result	Units	Normal Range
FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	101	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

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

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

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MR No.	: S149024	**Collection Date**	: 27/01/2024 9:10AM
Patient Name	: Mrs. Krishna Pradipbhai Katrodiya	**Age**	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 27/01/2024 11:34AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	163	mg/dl	50 - 200
HDL CHOLESTEROL Direct	54	mg/dl	40 - 60
LDL CHOLESTEROL Direct	95.2	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	67	mg/dl	50 - 150
VLDL Calc	13.4	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	3.02		0 - 5
LDL / HDL RATIO	1.76		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 *******

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

27/01/2024 11:34AM

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MR No.	: **5149024**	**Collection Date**	: 27/01/2024 9:10AM
Patient Name	: **Mrs. Krishna Pradipbhai Katrodiya**	**Age**	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 27/01/2024 11:35AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	**160**	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.9	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.4	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.5	mg/dl	0.0 - 0.8
SGPT (IFCC)	22	U/L	5 - 41
SGOT (IFCC)	21	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.1	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.5	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.6	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	1.73	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	0.5	mg/dl	0.5 - 1.2
SERUM URIC ACID			
SERUM URIC ACID (Uricase)	**6.2**	mg/dl	2.4 - 5.7
BUN [BLOOD UREA NITROGEN]			
BUN	16.7	mg/dl	8 - 23

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

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

27/01/2024 11:36AM

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MR No.	: 5149024	**Collection Date**	: 27/01/2024 9:10AM
Patient Name	: **Mrs. Krishna Pradipbhai Katrodiya**	**Age**	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 27/01/2024 11:36AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	**25.4**	mg/L	
URINE CREATININE (JAFFE)	**189.7**	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	0.013	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

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

Dr. Shobha Choksi
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Reg. No.: G-9074

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MR No.	: S149024	**Collection Date**	: 27/01/2024 9:10AM
Patient Name	: Mrs. Krishna Pradipbhai Katrodiya	**Age**	: 31 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 27/01/2024 11:38AM

CLINICAL PATHOLOGY

Parameter	Result		Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION			
TYPE OF SPECIMEN - URINE	Random		
PHYSICAL EXAMINATION			
QUANTITY	20	ml	
COLOUR	Yellow		
APPEARANCE	Sl.Turbid		
REACTION (pH)	6.5		
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	4-5	/hpf	
EPITHELIAL CELLS	3-5	/hpf	
RBC	Absent	/hpf	
CASTS	Absent		
CRYSTALS	Absent		
BACTERIA	Absent		
YEAST CELLS	Absent		

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

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DOB:
yr, FEMALE

mrs: krishna p kalavadiya

Vent rate: 89 BPM
PR int: 144 ms
QRS dur: 81 ms
QT/QTc: 348/394 ms
P-R-T axes: 57 54 30

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

Reviewed by ________________