आधार

भारत सरकार
Government of India

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

नामांकन क्रम/ Enrolment No.: 2079/91198/02739

To
विभा सिंह
Vibha Singh
D/O: Shashi Bhushan Singh
KURJEE
KURJEE VIKASH NAGAR
P M MALL
PATNA
Phulwari
Patna Bihar - 800010
9570316749

Signature Not Verified

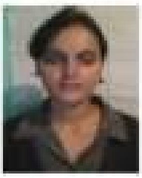
आपका आधार क्रमांक / Your Aadhaar No. :

7315 8326 7713

VID : 9171 2710 1641 9172

मेरा आधार, मेरी पहचान

भारत सरकार
Government of India



विभा सिंह
Vibha Singh
जन्म तिथि/DOB: 24/10/1995
महिला/ FEMALE

7315 8326 7713

VID : 9171 2710 1641 9172

मेरा आधार, मेरी पहचान

Government of India

AADHAAR

सूचना / INFORMATION

- आधार पहचान का प्रमाण है, नागरिकता का नहीं।
- आधार विशिष्ट और सुरक्षित है।
- सुरक्षित क्यूआर कोड/ऑफलाइन एक्सएमएल/ऑनलाइन प्रमाणीकरण का उपयोग करके पहचान सत्यापित करें।
- आधार के सभी रूप जैसे आधार पत्र, पीवीसी कार्ड, ई-आधार और एम-आधार समान रूप से मान्य हैं। १२ अंकों की आधार संख्या के स्थान पर आभासी (वर्चुअल) आधार पहचान (VID) का भी उपयोग किया जा सकता है।
- १० साल में कम से कम एक बार आधार अपडेट जरूर करें।
- आधार आपको विभिन्न सरकारी और गैर-सरकारी योजनाओं /सेवाओं का लाभ उठाने में मदद करता है।
- आधार में अपना मोबाइल नंबर और ई-मेल आईडी अपडेट रखें।
- आधार सेवाओं का लाभ उठाने के लिए स्मार्टफोन पर mAadhaar ऐप डाउनलोड करें।
- आधार/बायोमेट्रिक्स को लॉक/अनलॉक करने की विशेषता का उपयोग सुरक्षा सुनिश्चित करने के लिए करें।
- आधार (पत्र/ नंबर) चाहने वाली संस्थायों को उचित सहमति लेने के लिए बाध्य किया गया है।
- Aadhaar is a proof of identity, not of citizenship.
- Aadhaar is unique and secure.
- Verify identity using secure QR code/offline XML/online Authentication.
- All forms of Aadhaar like Aadhaar letter, PVC Cards, eAadhaar and mAadhaar are equally valid. Virtual Aadhaar Identity (VID) can also be used in place of 12 digit Aadhaar number.
- Update Aadhaar at least once in 10 years.
- Aadhaar helps you avail various Government and Non- Government benefits/services.
- Keep your mobile number and email id updated in Aadhaar.
- Download mAadhaar app on smart phones to avail Aadhaar Services.
- Use the feature of lock/unlock Aadhaar/biometrics to ensure security.
- Entities seeking Aadhaar are obligated to seek due consent.

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता:
D/O: शशि भूषण सिंह, केपुअरजेईई, केपुअरजेईई विकास नगर, पी एम एमएलएल, पटना, फुलवारी, पटना,
बिहार - 800010

Address:
D/O: Shashi Bhushan Singh, KURJEE, KURJEE VIKASH NAGAR, P M MALL, PATNA, Phulwari, Patna,
Bihar - 800010

7315 8326 7713

VID : 9171 2710 1641 9172

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MEDICAL EXAMINATION FORM

Confidential without Prejudice Report. To Be Filled In Strictly By the Physician/Diagnostic Center

PART I: GENERAL DETAILS

NAME OF THE PATIENT: Mrs. Vibha Singh

D.O.B: 24/10/1995 Age: 28 Sex: F Phone number 7979810760

PART II: MEDICAL EXAMINATION REPORT (Strictly to be filled by Medical Examiner)

(Kindly tick wherever applicable)

A. PERSONAL HISTORY:

1. Previous history if any:

Disease	Yes/ No	Medicine & Surgery Details	Disease	Yes/ No	Medicine & Surgery Details
Diabetes Mellitus	No		Cancer	No	
Hypertension	No		Tumor/Benign	No	
IHD	No		Genital urinary disorder	No	
Stroke	No		Rheumatic joint diseases or symptoms	No	
Surgeries	No		Asthma	No	
Tuberculosis	No		Pulmonary Disease	No	
Congenital Disease	No		Anemia	No	
Arrhythmia	No		Bleeding disease or Disorder.	No	
Aids (HIV)	No		Mental Stress	No	

2. Habits:

Diet	Veg / Non-veg	Alcohol	Occasionally	Tobacco/Smoking	No	Medicine	T. Levipil 500

3. Major complaints/Relevant past history if any: H/O seizure in 2015 & Regular medication T. Levipil 500mg

4. Previous Illness (Hospitalization Investigation, consultation) H/O Seizure

5. Family history: No any family history

B. MEDICAL EXAMINERS FINDING AND ASSESMENT: (Please answer each question and where appropriate provide particulars. You are asked not to give any information to the person, assured, about the results

1. Anthropometry:

Height	158 cm	Weight	63.80 kg	BMI	

2. Vital Parameters:

(i)

Respiratory Rate	22/min	Pulse Rate	73 BPM

(ii) Blood Pressure (Three consecutive Reading):

Systolic	110		
Diastolic	80		
Further readings at 10 minute interval if the first reading exceeds 140/90			

3. Skin

Is there is any evidence of:

Chronic Ulcer:	☐	YES	☑	NO	Eczema	☐	YES	☑	NO
Swelling	☐	YES	☑	NO	Varicose Veins	☐	YES	☑	NO
Skin Discoloration	☐	YES	☑	NO	Psoriasis	☐	YES	☑	NO

Any Other skin problem and specific location describe H/O Acne & Rx

EXAMINATION FINDINGS DETAILS

4. Cardiovascular System: S1S2 (N)

5. Genito-Urinary System: NA

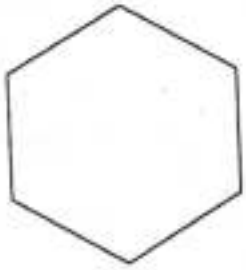
6. Respiratory System: AEBE Clear

7. Gastro-Entrology System: NA

(a) Oropharyngeal: NA

(b) Abdomen:

soft
Non tender



Evidence of Hernia, Hydrocele, Fissure, Fistula & piles, NO

If yes, please describe

8. Nervous System: consious & oriented

9. Eye Check-up

10. ENT (N)

12. For Female Clients Only:

1. Is there any disease of breast? _____
2. (I) Is there any evidence of pregnancy? _____
   (II) If Pregnant, are any complications to be expected? NO
3. Do you suspect any disease of uterus, cervix of ovaries? _____
4. Any menstrual complaints? NO any complaints

C. SUMMARY of the examination findings:

Positive Findings if any: (Please Specify)

Advice:

Conclusion on the fitness of the client:

Clinically & Medically Fit.

D. DOCTOR'S DECLARATION:

I confirm that I have examined this CLIENT and the findings stated above are true and correct to the best of my knowledge.

1. Name of the Medical Examiner: DR. ANAND PRAKASH CAUR MBBS, CCMH, CCEBDM (Consulting Physician) MMC Reg. No. 2005/02/0965

Signature of the Medical Examiner:

Stamp of the Medical Examiner: DR. ANAND PRAKASH CAUR MBBS, CCMH, CCEBDM (Consulting Physician) MMC Reg. No. 2005/02/0965

Registration Number: 2005/02/0965

Date of medicals conducted: 30/12/

Place: Ghansoli

2. Name of the Client: Vibha Singh.

Signature of the Client:

NOTE: NAME AND SIGNATURE OF MEDICAL EXAMINER AND THE CLIENT IS MANDATORY ON THIS FORM

Singh, Vibha

30.12.2023 9:10:02

Location:
Room:
Order Number:
Indication:
Medication 1:
Medication 2:
Medication 3:

65 bpm
– / – mmHg

Female

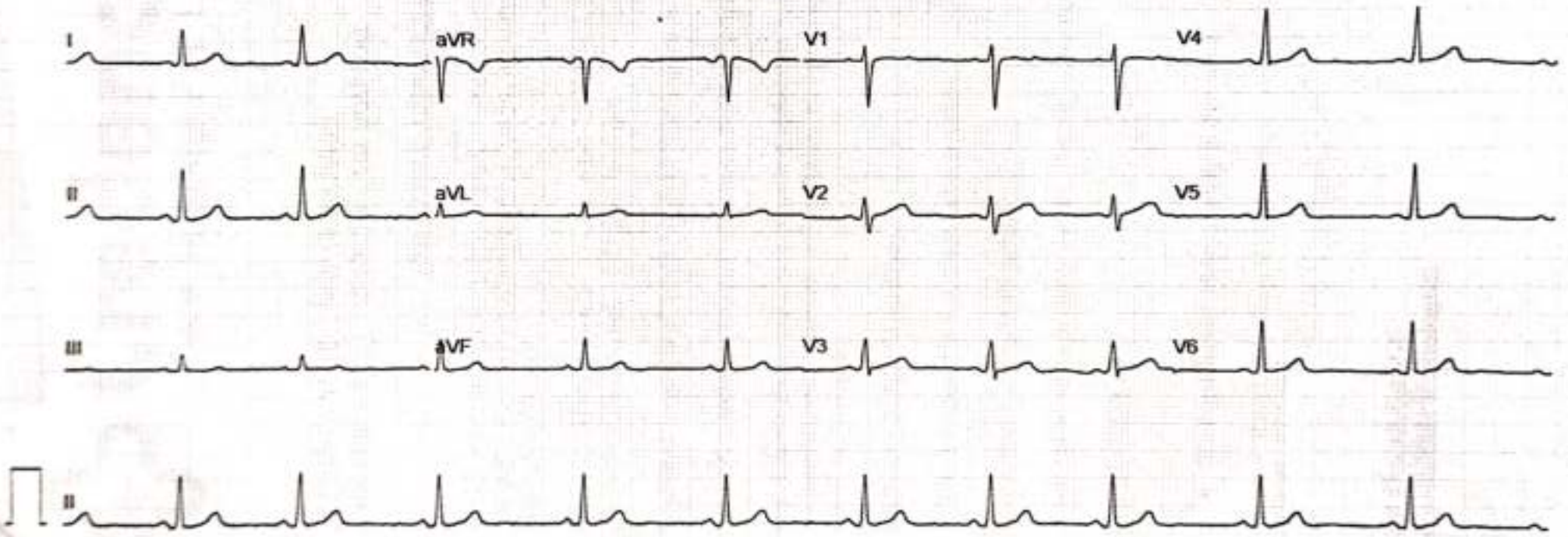
28 Years

QRS :	74 ms
QT / QTcBaz :	368 / 382 ms
PR :	114 ms
P :	96 ms
RR / PP :	922 / 923 ms
P / QRS / T :	48 / 46 / 34 degrees

Normal sinus rhythm
Normal ECG

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

DR. ANJU PRAKASH GAUR
MBBS, DCMH, CCEBDM
(Consulting Physician)
MMC Reg. No.
2005/02/0965



Unconfirmed

GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 60 Hz 4x2.5x3_25_R1 1/1

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN &
DIAGNOSTIC CENTER

PATIENT'S NAME	MRS. VIBHA SINGH	AGE :- 28y/F
REFERRED BY	CREDENCE CARE HOSPITAL	DATE : 30/12/2023

USG WHOLE ABDOMEN & PELVIS

LIVER is normal in size, normal in shape and echotexture. No evidence of any focal lesion seen. 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. PD is not dilated.

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
calculi or mass seen.

URINARY BLADDER is empty.

UTERUS is normal in size, shape and echotexture.

Both ovaries and adnexa are normal.

Visualised bowel loops appear normal. There is no free fluid seen in abdomen and pelvis.

IMPRESSION :

- **No Significant abnormality is detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

DR SAGAR GARGE
(consultant Radiologist)

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN & DIAGNOSTIC CENTER

Patient Name	: MRS.VIBHA SINGH	Patient ID: 2017
Age /Gender :	28 YRS/FEMALE	Date: 30/12/2023

X-RAY CHEST PA

Plain P.A. Radiograph of chest shows: -
The hilar shadows are normal in size, position and density.
Both Cardio phrenic and Costophrenic angles are clear.
The Cardiac silhouette is within normal
limits. Aortic shadow is normal.
Rest of the visualized mediastinum shadows are
normal. Both domes of diaphragms are normal.
The visualized bony thorax is normal.

CONCLUSION:

NO SIGNIFICANT ABNORMALITY DETECTED

DR. Nikunj Kothia
MBBS, DMRD Reg-2009093218

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN & DIAGNOSTIC CENTER

Name: Mrs. Vibha Singh **Age/Sex: 28Y/Female**

Date: 30/12/2023

2 D Echocardiography & color Doppler Study

FINDINGS:

- No left ventricle regional wall motion abnormality.
- No left ventricle diastolic dysfunction.
- No left ventricle wall hypertrophy. No LV dilation.
- Normal left ventricle systolic function. LVEF apprx-60%.
- No mitral regurgitation.
- No aortic regurgitation.
- No TR. No pulmonary hypertension.
- Cardiac valves are structurally normal.
- Normal size of cardiac chambers.
- Intact IAS & IVS.
- No LV clot/vegetation/pericardial effusion.
- Normal RV systolic function. No hepatic congestion.

Conclusion:

Normal 2D echo & color Doppler Study.

for

DR. KUMAR RAJEEV
M.D.(Med),DNB(Cardiology)

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN &
DIAGNOSTIC CENTER

Name: Mrs. Vibha Singh **Age/Sex: 28Y/Female**

Date: 30/12/2023

2D Measurements:

LA	35 mm
AORTIC ROOT	28 mm
EF SLOPE	90 mm/sec
LVIDD	40 mm
LVIDS	29 mm
IVS(D)	09 mm
PW(D)	09 mm
RVID	28 mm
LVEF	60%

Doppler study:

AV max -	1.1 m/sec	E vel	0.9 m/sec
PV max -	0.9 m/sec	A vel	0.7 m/sec
PASP		E/A	1.3

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN & DIAGNOSTIC CENTER

Patient Name : MRS. VIBHA SINGH
Referral Doctor: HEALTH CHECKUP
Pt.Type / ID : OPD/ 19701

Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

Complete Blood Count (CBC)

Test Description	Value(s)	Unit	Reference Range
Hemoglobin	**11.6**	gms/dl	12 - 15
RBC Count	3.86	mil./cmm	3.8 - 5.8
Haematocrit (HCT)	**34.0**	%	37 - 47
	RBC Indices		
MCV	88.08	fL	80 - 100
MCH	30.05	pg	27 - 34
MCHC	34.12	gm/dl	32 - 36
RDW-CV	12.1	%	11 - 16
Total WBC Count	5300	/uL	4000 - 10000
	DIFFERENTIAL COUNT		
Neutrophil	63	%	40 - 70
Lymphocytes	32	%	20 - 40
Eosinophil	02	%	1 - 6
Monocytes	03	%	2 - 8
Basophils	00	%	0 - 1
	Platelet Indices		
Platelet Count	170000	/cmm.	150000 - 450000
RBC Morphology	Normocytic Normochromic		
WBC Morphology	Within Normal Limits		
Platelet	Adequate on smear		

Done on fully Automated cell counter-ERBA H360

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416

Patient Name : MRS. VIBHA SINGH
Referral Doctor: HEALTH CHECKUP
Pt.Type / ID : OPD/ 19701

Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

ESR (ERYTHROCYTE SEDIMENTATION RATE)

Test Description	Value(s)	Unit	Reference Range
Erythrocyte Sedimentation Rate (Wintrobe method)	10	mm/hr	< 20

Interpretation: It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

Signature

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MD Pathologist
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Collection Date : 30/12/2023 09:30 AM
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BLOOD GROUP (BG)

Test Description	Value(s)	Unit	Reference Range
Sample Type : WHOLE BLOOD EDTA			
Blood Group :	A Rh Positive		

METHOD : Monoclonal blood grouping (Agglutination test) by slide method

KIT : Span diagnostics.

Signature

Dr. Disha Sorde
MD Pathologist
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Pt.Type / ID : OPD/ 19701

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Collection Date : 30/12/2023 09:30 AM
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URINE ROUTINE REPORT

Test Description	Value(s)	Unit	Reference Range
	Physical Examination		
Quantity	**20**	ml	-
Colour	Pale Yellow		Pale yellow/Yellow
Appearance	Slightly Hazy		Clear
Specific Gravity	1.025		1.005-1.030
pH	Acidic		Acidic
Deposit	Absent		Absent
	Chemical Examination		
Protein	Absent		Absent
Sugar	Absent		Absent
Ketones	Absent		Absent
Bile Salt	Absent		Absent
Bile Pigment	Absent		Absent
Urobilinogen	Normal		Normal
	Microscopic Examination (/hpf)		
Pus Cell	2-4		Upto 5
Epithelial Cells	1-2		Upto 5
Red Blood Cells	Absent		Absent
Casts	Absent		Absent
Crystals	Absent		Absent
Bacteria	Absent		Absent

Signature

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BLOOD GLUCOSE LEVEL (FASTING & POST PRANDIAL)

Test Description	Value(s)	Unit	Reference Range
Glucose Fasting (Plasma)	84.0	mg/dl	70 - 110
Glucose Urine	Absent		

Interpretation : Fasting Blood Sugar more than 126 mg/dl on more than one occasion can indicate Diabetes Mellitus.

Signature

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Collection Date : 30/12/2023 09:30 AM
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GLYCOSYLATED HAEMOGLOBIN (GHB / HBA1c)

Test Description	Value(s)	Unit	Reference Range
HbA1c H.P.L.C	5.0	%	Below 6.0% - Normal Value 6.0% - 7.0% - Good Control 7.0% - 8.0% - Fair Control 8.0% - 10% - Unsatisfactory Control Above 10% - Poor Control

Interpretation: Glycosylated Haemoglobin is acurate and true index of the " Mean Blood Glucose Level in the body for the previous 2-3 months.HbA1c is an indicator of glycemic control. HbA1c represent average glycemia over the past six to eight weeks. Glycation ofhemoglobin occurs the entire 120 days life span of the red blood cell, but with in this 120 days. Recent glycemia has the largestinfluence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in themouth before sampling, 25% in the month before that, and the remaining 25% in months 2-4.

Signature

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Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

THYROID FUNCTION TEST (TFT)

Test Description	Value(s)	Unit	Reference Range
TOTAL TRIIODOTHYRONINE (T3) Competitive Chemi Luminescent Immuno Assay	121.0	ng/dl	60 - 181
TOTAL THYROXINE (T4) Competitive Chemi Luminescent Immuno Assay	6.35	µg/dL	4.5 - 12.6
THYROID STIMULATING HORMONE (TSH) SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY	1.33	uIU/mL	0.3 - 5.5

SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY

Reference range for < 18 years

TEST	1 - 3 D	4 - 30 D	31 - 60 D	61 D - 12 M	1 - 5 Y	6 - 10 Y	11 - 14 Y	15 - 18 Y
TSH	0.1-9.2	0.2-8.5	0.2-7.8	0.30-5.9	0.4-4.8	0.5-4.7	0.5-4.6	0.6-4.5
T3	41.7-272.1	48.2-272.1	54.7-272.1	76.8-272.1	89.2-246.7	87.2-218.1	86.6-199.8	85.3-188.8
T4	4.9-15.8	5-15.3	5.2-14.8	5.7-13.3	5.7-11.7	5.4-10.7	5.2-10	5.1-9.6
FT3	1.5-5.3	1.6-5.2	1.6-5.1	1.8-4.8	2-4.5	2.1-4.4	2.3-4.4	2.3-4.3
FT4	0.84-2.08	0.85-1.98	0.85-1.89	0.89-1.62	0.89-1.48	0.85-1.46	0.84-1.45	0.84-1.45

Signature

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Reg No. 2016/08/3416

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Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

LIPID PROFILE

Test Description	Value(s)	Unit	Reference Range
Total Cholesterol	142.0	mg/dl	Low < 125 Desirable : < 200 Borderline High : 201 - 240 High : > 240
Triglycerides	139.0	mg/dl	Low < 25 Normal : < 150 Borderline High : 151 - 199 High : > 200
HDL Cholesterol	45.0	mg/dl	< 35 Low >80 High
Non HDL Cholesterol	97.00	mg/dl	Desirable : < 130 Boderline high : 130 - 159 High : > 160
LDL Cholesterol	69.20	mg/dl	Low < 85 Optimal : <100 Near/Above Optimal : 101 - 129 Borderline High : 130 - 159 High : >160
VLDL Cholesterol	27.80	mg/dl	Below 40
TOTAL CHOL/HDL Ratio	3.16	-	Desirable/Low Risk : 3.3 - 4.4 Borderline/Middle Risk : 4.5 - 7.1 Elevated/High Risk : 7.2 - 11.0
LDL/HDL Ratio	1.54	-	Desirable/Low Risk : 0.5 - 3.0 Borderline/Middle Risk : 3.1 - 6.0 Elevated/High Risk : >6.1
Appearance of Serum	Clear		

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416

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RAMAN CT SCAN & DIAGNOSTIC CENTER

Patient Name : MRS. VIBHA SINGH
Referral Doctor: HEALTH CHECKUP
Pt.Type / ID : OPD/ 19701

Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

LIVER FUNCTION TEST (LFT)

Test Description	Value(s)	Unit	Reference Range
Bilirubin Total	0.66	mg/dL	0.3 - 1.5
Bilirubin Direct	0.24	mg/dL	0.0 - 0.5
Bilirubin Indirect	0.42	mg/dL	0.2 - 0.9
SGOT (AST)	21.0	U/L	0 - 45
SGPT (ALT)	27.0	U/L	0 - 45
Alkaline Phosphatase	172.0	U/L	80 - 306
Protein Total	6.8	g/dL	6 - 8
Albumin	3.7	g/dL	3.2 - 5.0
Globulin	3.1	g/dL	2.5 - 3.3
A/G Ratio	1.19	-	1.0 - 2.1

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416

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Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

GAMMA GT

Test Description	Value(s)	Unit	Reference Range
Gamma Glutaryl Trans Peptidase	22.0	U/L	5 - 40

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416

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Care Hospital Pvt. Ltd.

RAMAN CT SCAN & DIAGNOSTIC CENTER

Patient Name : MRS. VIBHA SINGH
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Pt.Type / ID : OPD/ 19701

Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

URIC ACID

Test Description	Value(s)	Unit	Reference Range
Uric Acid	4.88	mg/dl	2.6 - 6.0

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416

Patient Name : MRS. VIBHA SINGH
Referral Doctor: HEALTH CHECKUP
Pt.Type / ID : OPD/ 19701

Age / Gender : 28 Years / Female
Collection Date : 30/12/2023 09:30 AM
Reporting Date : 30/12/2023 04:50 PM

BLOOD UREA NITROGEN

Test Description	Value(s)	Unit	Reference Range
BUN* Serum,Calculated	9.0	mg/dL	7 - 18.0

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416

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CREATININE

Test Description	Value(s)	Unit	Reference Range
CREATININE Jaffe IDMS	0.7	mg/dl	0.6 - 1.4

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN & DIAGNOSTIC CENTER

Patient Name : MRS. VIBHA SINGH
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BUN/CREATININE RATIO

Test Description	Value(s)	Unit	Reference Range
BUN/CREATININE RATIO	12.9	Mg/dL	5 - 20

END OF REPORT

Signature

Dr. Disha Sorde
MD Pathologist
Reg No. 2016/08/3416