



STAR HOSPITAL

(A unit of Magadh Nursing Home)

An ISO 9001:2015 Certified Hospital

Between East of Alok Petrol Pump &
West of Mahindra Show Room in
Bypass Fourlane, Fatuha Road,
Bari Pahari, Patna
Ph.: 9431046838, 9334269730, 7488893768

Rakha Devi

57 yr

WT 46kg
HT - 151cm
Yr 90
BMI - 20.2

Came for annual Health Check up
Pulse 62/r
BP $\frac{110}{70}$ mmHg
SpO2 99%

Heart
Lungs / nil.
Jctm

RA STP2

Liver
Spleen / N/A

Chest / N/A

W/In Paw $\left\{ \begin{array}{l} R 6/6 \\ L 6/6 \end{array} \right.$ Near $\left\{ \begin{array}{l} R N-10 \\ L NIP \end{array} \right.$ C/Pmv - Abdom

ECG - Sinus Brady Cardia - within Normal limit

Chest xray PA view. within Normal limit

Echocardiogram - Normal

USG of ut + Unremarkable study

Blood investigation - within Normal limit



Dr. L
27/07/2024



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DR. ASHISH RANJAN SINGH

BDS (Hon) MU

Consultant Oral & Dental Surgeon

Ph.: 9470585838, 9852542738

DR. VINAY KUMAR

BDS, MIDA

Consultant Oral Dental Surgeon

Not for Medico Legal Purpose

Name: Rekha Devi

Date: 27/7/24

Add: _____

Age/Sex: 51y / M

GC:- Pt comes for Dental check up

GE:-
- Stain +
- calculus ++

Adv:- Scaling to be done

Ashish
27/7/24





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Reluwa Devi
51 yr F

27/7/24

Uo came for annual health check up

HT - 151 cm

Pulse - 62/min

WT - 46 kg

BP - 110/70 mmHg

BMI - 20.2

SPO₂ - 99%

Palpation / auscultation / w/o

TAH done about 20 yr ago

chest / w/o

DM 1⁺ All 1 WD $\left\{ \begin{array}{l} 20^{\uparrow} \\ 30^{\downarrow} \end{array} \right.$ L-Child
22 yr old

PIA - Abdomen soft
w/o spleen / w/o

PIE - Vagina x vulva - Normal

Pap smear - Not done
TAH done 20 yr ago

Pushpata Luman
27/7/24





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Collection Date/Time : 27/07/2024/ 9:45:11 AM

Bill No : 24255300

Patient's Name : REKHA DEVI

Referred By : Dr. Self

Reporting Date/Time 27/07/2024/ 4:45:29 PM

Uhid/Lab ID : 24251024 /

Age / Sex : 51 Years/Female

Bed No : //

BIO-CHEMISTRY EXAMINATION

Investigation Name	Result	Reference Range
BLOOD SUGAR FASTING	95.0 mg/dl	70 — 110
BLOOD SUGAR PP	102 mg/dl	70 — 140
GAMMA-GT	34.0 U/Lt	9 — 52 (Male:<55 (Female:<38

KIDNEY FUNCTION TEST

BLOOD UREA	24.0 mg/dl	5.0 — 40.0
SERUM CREATININE	0.82 mg/dl	0.6 — 1.4
SERUM URIC ACID	5.69 mg/dl	2.5 — 6.0
BUN	11.21 mg/dl	7.5 — 23.0

LIPID PROFILE

TOTAL CHOLESTEROL	172 mg/dl	140 — 200
TRIGLYCRIDE	92.0 mg/dl	30 — 160
HDL CHOLESTEROL	49.0 mg/dl	35 — 90
VLDL CHOLESTEROL	18.4 mg/dl	06 — 32
LDL CHOLESTEROL	104.6 mg/dl	85 — 130
LDL /HDL RATIO	2.13	1.5 — 3.0
TC / HDL	3.51	< 3.0 - Low Risk 3.0 - 5.0 Avg. Risk > 5.0 High Risk





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Patient's Name : REKHA DEVI

Referred By : Dr. Self

Reporting Date/Time 27/07/2024/ 4:52:15 PM

Uhid/Lab ID : 24251024 /

Age / Sex : 51 Years/Female

Bed No : //

BIO-CHEMISTRY EXAMINATION

Investigation Name	Result	Reference Range
URINE SUGAR	Nil(Pp)	

HAEMATOLOGY EXAMINATION

BLOOD GROUP

ABO GROUP

RH TYPE

E S R

"A"

POSITIVE

20 mm/hr

0 — 15

-\$ End of Report \$:-



LAB TECHNICIAN

Dr. T.K. Chakraverti
M.B.B.S. M.D
(Microbiology)
Reg. No. -35997/06

PATHOLOGIST
DR. T. K. CHAKRAVERTI
MBBS, MD(MICRO)



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BIO-CHEMISTRY EXAMINATION

Investigation Name	Result	Reference Range
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LIVER FUNCTION TEST

SERUM BILIRUBIN

TOTAL 0.70 mg/dl 0.3 — 1.0

DIRECT 0.28 mg/dl 0.1 — 0.3

INDIRECT 0.42 mg/dl 0.2 — 0.7

SGPT 17.0 lu/LT 05 — 40

SGOT 22.0 U/Lt 05 — 40

SERUM ALKALINE PHOSPHATASE 198 U/Lt Adult :- 39 - 137 U/L

New born : 95 - 368 U/L

(<14 yrs) :- 58 - 460 IU/L

SERUM PROTEIN

PROTEIN 6.90 gm/dl 6.0 — 8.0

ALBUMIN 3.82 gm/dl 3.7 — 5.3

GLOBULIN 3.08 gm/dl 2.3 — 3.6

A : G RATIO 1.24 1.0 — 2.3



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Age / Sex : 51 Years/Female

Bed No : //

HAEMATOLOGY EXAMINATION

Investigation Name	Result	Reference Range
HGB	10.9 gm/dl	12 — 15
R.B.C	3.85 million/Cu mm	3.5 — 5.5
H.C.T	33.2 %	36 — 50
M.C.V	86.3 fl	73 — 91
M.C.H	28.3 pg	27 — 32
M.C.H.C	32.8 g/dL	31.5 — 34.5
PLATELET COUNT	1.34 Lakh's/Cu. mm	1.50 — 4.50
W.B.C	6300 /cu mm	4000 — 11000
DIFFERENTIAL COUNT		
NEUTROPHILS	57 %	40 — 70
LYMPHOCYTES	36 %	20 — 40
EOSINOPHILS	04 %	01 — 06
MONOCYTES	03 %	02 — 10
BASOPHILS	00 %	00 — 02



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HAEMATOLOGY EXAMINATION

Investigation Name	Result	Reference Range
GLYCOCYLATED HAEMOGLOBIN (HbA1c)	5.00 %	Normal < 8.0 % Good Control : 8.0 - 9.0 % Fair Control : 9.0 - 10.0 % Poor Control : > 10.0 %

INTERPRETATION :

HbA1c is an indicator of glycaemic control .HbA1c has been thought to represent average glycaemia over the past 6-8 wks.A pt. in stable control will have 50 % of their HbA1c formed in the month before sampling, 25 % is in the month before that & the remaining 25 % in the month 2-4.

LEVEL OF HbA1c : < 5.3 % :- may represent an acute & chronic possibility for severe hypoglycaemia events < 5.4-5.7 % :-Represents a very good level of diabetic control (caution should be used to avoid hypoglycaemia).5.8-7.2 % :- Represents a good level of diabetes control (continue to monitor frequently and strive for a reduction of HbA1c level to between 5.8 - 7.0) .- 8.0 % : - Represents a fair level of diabetes control(Suggest physician//patient / evaluation to determine where improvement can be made. >8.0 % :- Represents a sub-optimal level of diabetic control.(This level represents a significant increase in the risk for developing possible chronic complications).Effective intervention is strongly suggested, along with specific diagnostic tests.



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Age / Sex : 51 Years/Female

Bed No : //

IMMUNOLOGY EXAMINATION

Investigation Name	Result	Reference Range
THYROID PROFILE		
T3	0.80 ng/ml	0.52 - 1.90 ng/ml.
T4	8.39 µg/dL	M- 4.4 - 10.8 µg/dL F - 4.8 - 11.6 µg/dL
TSH	3.10 µIU/ml	0.30 - 6.02 µIU/ml.

Method :- Enhanced Pulse Chemiluminescence Assay by Lumax

Quality Control :- by appropriate lyphochek Immunoassay Plus Control(BIO-RAD,U.S.A).

The guidelines for pregnancy related reference ranges for T3,T4 & TSH :-

Levels in Pregnancy	Total T3 (ng/ml)	Total T4 (µg/dL)	TSH (µIU/ml)
1 st Trimester	0.52 - 1.90	6.6 - 12.4	0.1 - 2.5
2 nd Trimester	0.52 - 1.90	6.6 - 15.5	0.2 - 3.0
3 rd Trimester	0.52 - 1.90	6.6 - 15.5	0.3 - 3.0

The guidelines for age related reference ranges of T3,T4 & TSH :-

AGE	TOTAL T3 (ng/ml)	TOTAL T4 (µg/dL)	TSH (µIU/ml)
Premature Infants			0.8 - 5.2
CORD BLOOD	0.4 - 1.3	6.0 - 13.1	1.0 - 17.4
1 - 2 days	0.8 - 2.6	10.7 - 25.8	1.0 - 17.4
3 - 30 days	0.7 - 2.0	7.8 - 19.7	1.7 - 9.1
1 - 12 Months	1.0 - 2.3	5.4 - 13.8	0.8 - 9.1
1 - 7 years	1.2 - 2.0	5.3 - 12.3	0.8 - 8.2
7 - 13 years	1.1 - 2.0	6.0 - 11.1	0.7 - 7.0
13 - 18 years	1.0 - 1.8	4.9 - 10.7	0.7 - 5.7

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Bed No : //

CLINICAL PATHOLOGY EXAMINATION

REPORT ON THE EXAMINATION OF URINE

PHYSICAL EXAMINATION

Volume	25 ml
Colour	Straw
Appearance	Clear
Sediments	Nil

CHEMICAL EXAMINATION

Specific Gravity	1.010
PH	6.5
SUGAR	Nil
ALBUMIN	Nil

MICROSCOPIC EXAMINATION

Erythrocytes / RBC	Nil /hpf
Pus Cells	1-2 /hpf
Epithelial Cells	0-3 /hpf
Casts	Nil
Crystals	Nil
YEAST CELLS	Absent
MICRO-ORGANISM	Absent
Others	Nil

-\$ End of Report \$:-



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Age / Sex : 51 Years/Female

Referred By : Dr. Self

Bed No : //

HAEMATOLOGY EXAMINATION

Investigation Name	Result	Reference Range
--------------------	--------	-----------------

* PERIPHERAL BLOOD PICTURE, WHOLE BLOOD

Microscopy

RBCs are predominantly normocytic normochromic. No nucleated cell is noted.

Anisocytosis + Poikilocytosis +

Reticulocyte count is normal, indicating normal bone marrow response.

WBC: Normal in count and morphology. No immature cell is noted.

IMPRESSION: Normal Study

-\$ End of Report \$-



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Collection Date/Time	: 27/07/2024/9:53:29 AM	Reporting Date/Time	: 27/07/2024/4:58:14 PM
Bill No	: 24255300	Uhid/Lab ID	: 24251024/
Patient's Name	: REKHA DEVI	Age / Sex	: 51 Years/ Female
Referred By	: Dr. Self	Bed No	: //

PAP SMEAR

Cytopath	:	01
Specimen	:	Cervical /Vaginal
Microscopic intermediate	:	The smear show mainly superficial and Squamous cell with few Polymorphs. No Trichomonas or fungal organisms seen.
Impression	:	Negative for intraepithelial lesion and malignancy

-\$ End of Report \$:-

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No: 01.

Mrs. Rekha Devi. 52/F.

Refd. by Star Hospital.

July 27, 2024.

U. S. G. of Whole Abdomen

LIVER: Normal in shape, size and echotexture. Intra hepatic ducts and vessels are of normal caliber. Right lobe measures 112 mm and left lobe measures 70 mm in cranio caudal length.

GALL BLADDER: Normal in shape and size. Lumen is echofree. Wall thickness is normal.

C.B.D. & PORTAL VEIN: No abnormality seen. CBD measures 3.0 mm and PV 8.3 mm in caliber.

PANCREAS: Normal in shape, size and echotexture.

BOTH KIDNEYS: Right kidney measures 90 mm x 42 mm. Left kidney measures 96 mm x 45 mm. No mass, cyst or calculus. P C S Not Dilated. No Hydronephrosis. The C M D is well maintained.

SPLEEN: Normal in shape, size and echopattern. Size measures 89 x 36 mm. SV – Normal.

URINARY BLADDER: Echofree and no abnormality seen. UB wall is of normal thickness. Pre void urine volume 260 ml and the post void residual urine 15 ml (insignificant)

UTERUS & OVARIES: Not visualised. H/O, Hysterectomy.

OTHER: POD (Culde sac) is free from any collection. No evidence of ascites. No basal pleural effusion. No enlarged lymph nodes. No mass, lump or abscess in iliac scan.

OPINION: Unremarkable Study.



Mh
Consultant Sonologist



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ECHOCARDIOGRAPHY & COLOR DOPPLER REPORT

Patient's Name : MrS REKHA DEVI

Age/Sex :52yr/F

DATE :27/07/2024

ECHOCARDIOGRAPHIC WINDOW :Good

2D & M MODE ECHOCARDIOGRAPHY

Left ventricle

EDD:	42	mm (20 - 28 mm / m ²)	ESD:	27	mm(13 - 21 mm /m ²)
IVS :	10	mm (6 - 11 mm)	PW:	10	mm(6 -11 mm)
Ejection fraction:	65% (67 ± 8%)		FS:	35%	(34 - 44 %)
IVS:	Intact		LV clot	Absent	

Left atrium/ Aorta 35/28mmhg

Right ventricle Normal

Right atrium Normal

Pericardium Normal

2D:

Normal LA & LV cavity ,and normally contracting left ventricle.
No RWMA,

Mitral valve

AML/ PML: Normal

Tricuspid valve Normal

Aortic valve Normal

Pulmonary valve Normal

Continuous & Pulse Wave Doppler study

Valve	Velocity (m/sec)			Gradient (mmHg)			Valve area (PHT Method)	Regurg.
	Peak	Mean	EDV	Peak	Mean	EDG		
Mitral	E=0.6 A=1.0			4.0	2.0			NIL
Tricuspid	E=0.5 A=0.3			1	0.2			NIL
Aortic	1.12			5.0	2.5			Nil
Pulmonary	0.9			3.5	1.7			NIL





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Colour Flow Imaging

No PR, No AR/ MR/ NIL TR

No shunt flow

COMMENTS :

- ◆ Normal LA & LV cavity
- ◆ Normal LV filling Pressure
- ◆ Normal RWMA
- ◆ Normal LV systolic function
- ◆ Grade I diastolic dysfunction(E/A-1.3, E/e'-11)
- ◆ Global LVEF = 65%
- ◆ All cardiac valves are normal
- ◆ No MS / TS / AS / PS /PR
- ◆ No clot / vegetation.

IMPRESSION:

Normal LA & LV cavity

No RWMA,

Grade I LV Diastolic Dysfunction

Normal LV systolic function, LVEF -65%

Please correlate clinically

Not valid for medico legal purposes

SIGNATURE
DR. RANJEET KUMAR
(CONSULTANT CARDIOLOGY)
MBBS, PGDCC, CCEBDM

EX-Senior Registrar, RTIICS, KOLKATA





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MRS. REKHA DEVI 51 YRS /F.
Refd. by Star Hospital

27 JULY, 2024.

X-Ray Chest PA View:-

The lung fields are clear.
Both C P angles are clear.
The heart is normal.



27/01/2024 10:17:37 AM

ID: 3

rekha devi

Female 52 Years

cm kg / mmHg

Room No. :

HR	: 57	bpm
P	: 105	ms
PR	: 136	ms
QRS	: 88	ms
QTc	: 398/390	ms
P/ORSI	: 56/65/30	°
RV5/SV1	: 1.48/0.531	mV

Diagnosis Information:
Sinus Bradycardia

Report Confirmed by:

