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

OPD ASSESSMENT FORM

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Name Mrs. Rani Kumari Age.Sex 30/F MR.No. 5150921

Doctor Dr Krunal Gajjar Date 12/3/24

Ht : 158 cm Wt. : 70.8kg Temp : 97°F Pulse : 82 b/m/n BP : 108/67 mmHg

SPO2 : 97% Post of walk SPO2 : —

Chief Complaints :

Not - Any

Drug / Food Allergy :

NO.

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

B
CVS | NAD

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)

Rx

→ Tab. Hbline 1-0-0 x (02) months.
ABF

Investigation advised :

Dr. Krunal Gajjar
M.B.B.S., MD (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No. G-20422
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

MRNo: S1S0927

ECHO CARDIOGRAPHIC REPORT

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Patient's Name : mrs. Rani Kumari Date : 12/3/24

Sex : f Age : 30 Ref. by Dr. : Done by Dr. Surendra Singh

LV Size : (n)

LVEF : 65 % (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)

PAH : —

RA :

RV : (n)

IAS : Intact

IVS :

AORTIC VALVE

TRICUSPID VALVE (n)

PASP : 10 mm

LA :

IVC : (n)

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

CONCLUSION :

No veg / clot IPS

2D echo for
Health checkup pln

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MR No.	: **S150921**	**Collection Date**	: 12/03/2024 11:05AM
Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 12:36 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
POST PRANDIAL BLOOD GLUCOSE [PPBS]			
POST PRANDIAL BLOOD GLUCOSE (Hexokinase)	102	mg/dl	100 - 140
POST PRANDIAL URINE GLUCOSE	SNR		
POST PRANDIAL URINE KETONE	SNR		

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

Dr. Shobha Choksi
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12/03/2024 12:36PM
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PAT. NAME : Rani Kumari	**Date** : 12/03/2024
REF. DOCTOR : Hosp. Dr.	**AGE** : 30 Yrs / F
INV. : USG Whole Abdomen	**MR NO.** : S150921

Findings:

Liver is enlarge in size (16.7 cm), shape and shows normal 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.
No e/o free fluid in abdomen.

IMPRESSION:

- **Hepatomegaly.**

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

Transcribed By: Asha

Date & Time of report: 03/12/2024 – 10:53 AM

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PAT. NAME : Rani Kumari	**Date** : 12/03/2024
REF. DOCTOR : Hosp. Dr.	**AGE** : 30 Yrs / F
INV. : Radiograph of Chest PA	**MR NO.** : S150921

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: 12/03/2024 – 10:50 AM

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MR No.	: **S150921**	**Collection Date**	: 12/03/2024 11:05AM
Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 11:27AM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	**9.6**	gm/dl	12.0 - 15.0
PCV	**32.6**	%	36 - 46
RBC COUNT	4.45	mill/cmm	4.0 - 5.0
MCV	**73.3**	fl	76 - 96
MCH	**21.6**	pg	26 - 32
MCHC	**29.4**	%	32 - 36
RDW	**17.8**	%	11 - 15
PLATELET COUNT	2.45	lacs/cmm	1.5 - 4.5
WBC COUNT	7360	/cmm	4000 - 11000
ESR	**32**	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	65	%	40 - 70
LYMPHOCYTES	26	%	20 - 40
EOSINOPHILS	02	%	1 - 6
MONOCYTES	07	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Hypochromasia(+), Microcytosis(+), Anisocytosis(+)		
WBC MORPHOLOGY	Within Normal Range		
PLATELET ON SMEAR	Adequate		
HEMOPARASITES	Not Seen		

SYSMEX XN-550

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

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MR No.	: **S150921**	**Collection Date**	: 12/03/2024 11:05AM
Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 11:23AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	4.8	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**91.06**	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.

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

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MR No.	: **S150921**	**Collection Date**	: 12/03/2024 11:05AM
Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 11:22AM

HAEMATOLOGY

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

BIOCHEMISTRY

SERUM URIC ACID			
SERUM URIC ACID (Uricase)	3.2	mg/dl	2.4 - 5.7
FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	98	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

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

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MR No.	: **S150921**	**Collection Date**	: 12/03/2024 11:05AM
Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 11:23AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	171	mg/dl	50 - 200
HDL CHOLESTEROL Direct	53	mg/dl	40 - 60
LDL CHOLESTEROL Direct	89	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	144	mg/dl	50 - 150
VLDL Calc	28.8	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	3.23		0 - 5
LDL / HDL RATIO	1.68		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 *******

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MR No.	: **S150921**	**Collection Date**	: 12/03/2024 11:05AM
Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 11:25AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	**213**	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.5	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.3	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.2	mg/dl	0.0 - 0.8
SGPT (IFCC)	**46**	U/L	5 - 41
SGOT (IFCC)	30	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.5	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.5	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	3	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	1.5	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	0.5	mg/dl	0.5 - 1.2
BUN [BLOOD UREA NITROGEN]			
BUN	**6.3**	mg/dl	8 - 23
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	**4.6**	mg/L	
URINE CREATININE (JAFFE)	**29.9**	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	15.3	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

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

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MR No.	: **S150921**	**Collection Date**	: 12/03/2024 11:05AM
Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 11:24AM

CLINICAL CHEMISTRY

Parameter	Result	Units	Normal Range
THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.68	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	9.81	ug/dl	5.1 - 14.0
TSH (CLIA)	**4.55**	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 *******

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Patient Name	: **Mrs. Rani Kumari**	**Age**	: 30 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 12/03/2024 11:37AM

CLINICAL PATHOLOGY

Parameter	Result	Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION		
TYPE OF SPECIMEN - URINE	Random	
PHYSICAL EXAMINATION		
QUANTITY	**50**	ml
COLOUR	Pale Yellow	
APPEARANCE	Sl.Turbid	
REACTION (pH)	6.0	
SPECIFIC GRAVITY	1.05	
CHEMICAL EXAMINATION		
PROTEIN	Absent	
GLUCOSE	Absent	
KETONE	Absent	
BILE SALT	Absent	
BILE PIGMENT	Absent	
OCCULT BLOOD	Absent	
NITRITE	Absent	
MICROSCOPIC EXAMINATION		
PUS CELLS	1-2	/hpf
EPITHELIAL CELLS	20-25	/hpf
RBC	Absent	/hpf
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

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

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DOC. No.	SGHS/FMT/IPD041	DOI	14/06/2014	Rev. No.	0.0

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12/3/24

Rx

Tab Tranek c (15)

1 — + — 1

[illegible]

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MD,DGO
REG. NO.-10538
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GYNAECOLOGICAL CONSULTATION

MR. NO. S150921

Name : Mrs. Rani Kumari Date : 12/3/24

Age : 30 Ht. : 158cm Wt. : 70.8 B.P. : 108/67 mmHg

Clinical Evaluation / History / Presenting Complain:

Routine.

Gynecological History :

	Yes	No
1. Have you ever noticed any bleeding between menstrual periods ? માસિક ના સમય સિવાય વચ્ચે અનીયમીત 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 piils? તમે ગર્ભનિરોધક ગોળીલો છે ?	☐	☑
6. Do you have a lump in your beast ? સ્તનમાં દુ:ખાવો / સોજો / ગાઠ છે ?	☐	☑
7. Did anyone in your family suffer from beast cancer ? કુટુંબમાં કોઈએ 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 14 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
   Last menstrual Period (LMP): 24/2/24

2. Obstetric History :
   Gravida ..... Pare ..... Abortion ..... Live 2.
   Married life with cohabitation.....
   Children M: 0 F: 0 Last Delivery: Yrs back
   Any bad Obstetric event / history Yes / No
   If yes Describe:

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

DR. BHAVNA DESAI
MD,DGO
REG. NO.-10538
SUNSHINE GLOBAL HOSPITAL
SURAT.

Followup Date

Gynaecologist's Signature

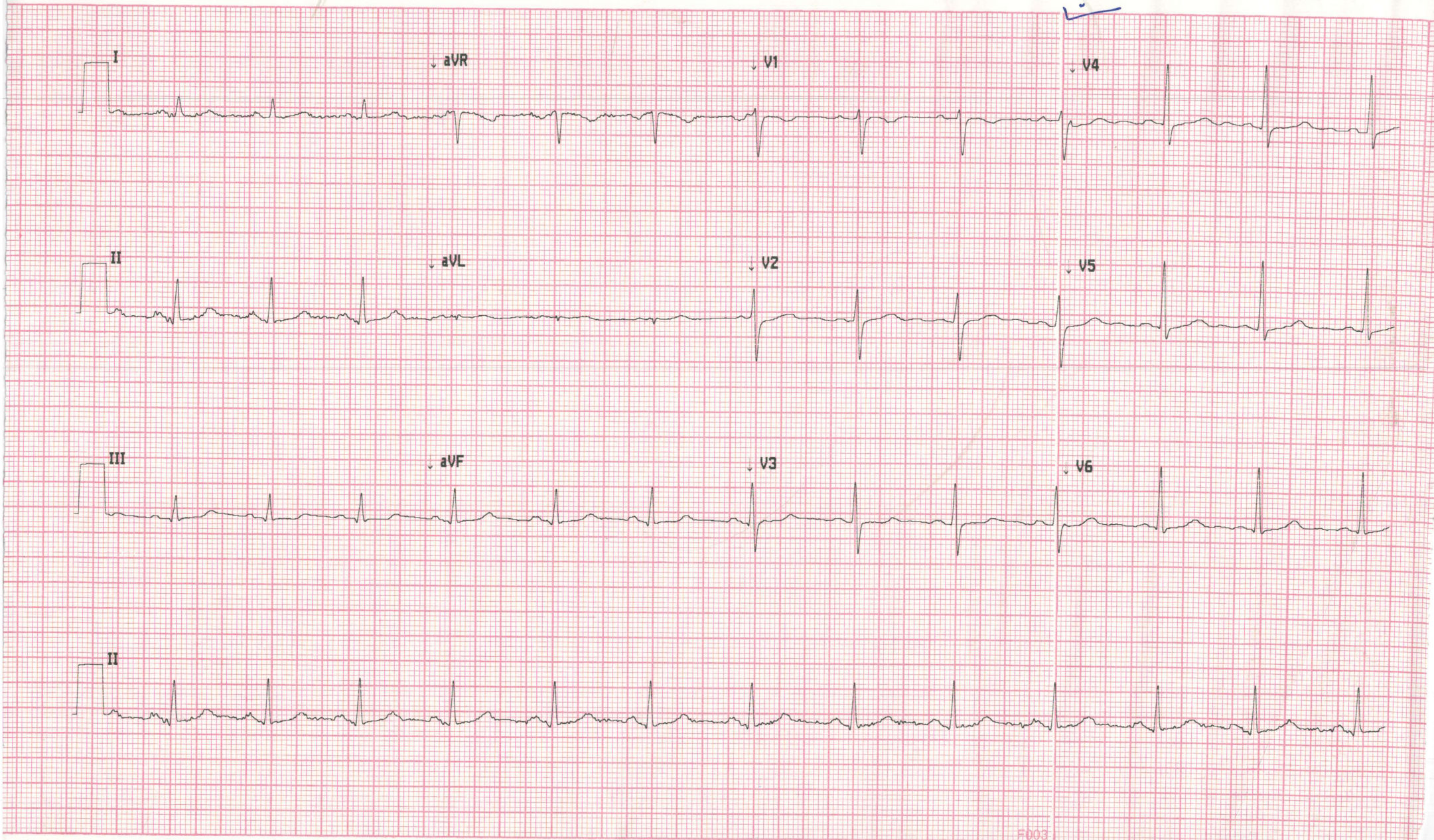
DOB:
yr, FEMALE

Vent rate	77 BPM
PR int:	158 ms
QRS dur:	97 ms
QT/QTc:	386/418 ms
P-R-T axes:	52 67 63

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

Reviewed by _____

Mrs. Rani Kumari 30/F



Version 1.20.02 Sequence #20885 25mm/s 10mm/mV 0.05-40 Hz 50Hz