

NAME:	Mrs. Anurima Biswas	UHID:	
AGE:	39	DATE OF HEALTHCHECK:	11/9/2024
GENDER:	F		

HEIGHT:	1.60	MARITAL STATUS:	M
WEIGHT:	96.2	NO OF CHILDREN:	1
BMI:	37.6		

C/O: Acidity

K/C/O:

PRESENT MEDICATION:-

CCM tablets
0-0-1

P/M/H: Covid-19 - 2021 & 2022

P/S/H: -

- cholecytectomy
- LSC

ALLERGY: - no

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER:-

Type I-DM

ALCOHOL:

MOTHER:- HTN.

TOBACCO/PAN:

O/E:

LYMPHADENOPATHY:

BP: 110/80 PULSE: - 74/min

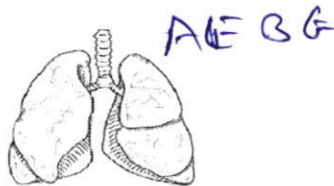
PALLOR/ICTERUS/CYNOSIS/CLUBBING:

TEMPERATURE: N SCARS:

OEDEMA:

S/E:

RS:



P/A:



CVS: S1, S2 +

Extremities & Spine: - LA - knee pain

CNS: Conscious, oriented, responsive.

ENT: - NAD

Skin: - NAD

Vision:

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

Name: Arunima Biswas	Age: 39y	Date of Health check-up: 11/04/2024
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Findings and Recommendation:

Findings:-

- Bulky ovaries
- Cholesterol

Recommendation:-

- Diet / Exercise
- T-Rozavel 10 once a day
- Gynae ref

Signature:

Consultant -



DR. ANIRBAN DASGUPTA
MBBS, D.N.B MEDICINE
DIPLOMA CARDIOLOGY
MMC-2005/02/0920

OPHTHALMIC EVALUATION

UHID No.: _____ Date: 11/12/24

Name: Arunima Bhowar. Age: 37 Gender: Male/Female Male

Without Correction :

Distance: Right Eye 6/12 Left Eye 6/12

Near : Right Eye M'G Left Eye M'G

With Correction :

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

Near : Right Eye M'G Left Eye M'G

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	<u>-2.75</u>	<u>-0.75</u>	<u>10°</u>	<u>/</u>	<u>6/6</u>	<u>-2.50</u>	<u>-0.75</u>	<u>15°</u>	<u>/</u>	<u>6/6</u>
Near										

Colour Vision: (Normal)

Anterior Segment Examination: ✓

Pupils: _____

Fundus: with

Intraocular Pressure: _____

Diagnosis: _____

Advice: _____

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

DR. SHETH NIKET PRASHANT
 M.B.B.S. D.O.M.S.
 (Consultant Ophthalmologist)
 Regn. No 2008/10/3646

Name: Arunima Bhaswas Age: 39 Sex: F UHID No.: _____ Date: 11/4/2024

39 year / P, G (HND)
No complaints

CMT- 26/3/2024

Uctavi

Metformin

R 78/min

PA - soft

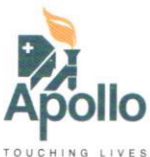
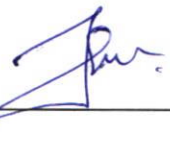
CVS } Healthy
VJ }

(PAP smear taken)

Rx

TAB SHELAC 110
100

DR. TRUPTI VIJAY SHINDE
MBBS, M.S. (OBS & GYNAE)
REG. NO.: 2014/07/3301



Apollo Clinic
VASHI

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

SHINDE
YNAE)
3301

Name : Mrs. Arunima Biswas Gender : Female Age : 39 Years
UHID : FVAH 11376. Bill No : Lab No : V-1368-23
Ref. by : SELF Sample Col.Dt : 11/04/2024 09:20
Barcode No : 5587 Reported On : 11/04/2024 17:20

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)			
Haemoglobin(Colorimetric method)	12.4	g/dl	11.5 - 15
RBC Count (Impedance)	4.62	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	38.7	%	35 - 55
MCV:(Calculated)	83.7	fl	78 - 98
MCH:(Calculated)	26.9	pg	26 - 34
MCHC:(Calculated)	32.2	gm/dl	30 - 36
RDW-CV:	14.2	%	10 - 16
Total Leucocyte count(Impedance)	6120	/cumm.	4000 - 10500
Neutrophils:	57	%	40 - 75
Lymphocytes:	37	%	20 - 40
Eosinophils:	03	%	0 - 6
Monocytes:	03	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.47	Lakhs/c.mm	1.5 - 4.5
MPV	10.5	fl	6.0 - 11.0
ESR(Westergren Method)	10	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic, Normocytic		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

Ms Kaveri Gaonkar
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Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

Name : Mrs. Arunima Biswas Gender : Female Age : 39 Years
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TEST

RESULTS

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

ABO Group: **:O:**
Rh Type: **Positive**
Method : Matrix gel card method (forward and reverse)

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.0 %
 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 : 96.8 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 then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints 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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Chief Pathologist

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Indira Health And Lifestyle Private Limited.
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 :	89	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 :	72	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)	219	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	99	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	19.8	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	47.6	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	151.6	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4.6		3.5 - 5
Ratio of LDL/HDL	3.2		2.5 - 3.5

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
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	6.91	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.01	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.9	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.38		0.9 - 2
S.Total Bilirubin (DPD):	0.28	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.12	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.16	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	13	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	13	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	92	U/L	35 - 105
S.GGT(IFCC Kinetic):	14	U/L	07 - 32

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	16.9 mg/dl	10.0 - 45.0
BUN (Calculated)	7.88 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.72 mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	10.94	9:1 - 23:1
S.Uric Acid(Uricase Method)	3.8 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)	1.60	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	95.61	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	3.42	□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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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Slightly Hazy		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)


REACTION(PH)	6.5	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	4 - 5 / hpf	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	8 - 10 / hpf	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Present(Few)	Absent

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CYTOPATHOLOGY REPORT
Conventional - PAP Smear

Specimen No: AP-804-24
Specimen Adequacy: ADEQUATE
CELLS
ENDOCERVICAL: **Present**
ENDOMETRIAL: Absent
SQUAMOUS: **SUPERFICIAL(++) AND INTERMEDIATE(++) SQUAMOUS CELLS**
HISTIOCYTES: **Present**
RBCs: Absent
POLYMORPHS: **Present(++)**
FLORA
TRICHOMONAS VAGINALIS: Absent
FUNGI: Absent
LACTOBACILLI: Absent
CELLULAR CHANGES
METAPLASIA: Absent
DYSPLASIA: Absent
MALIGNANT CELL: Absent
ATROPHIC CHANGES: Absent
BARE NUCLEI: Absent
COMMENTS: **INFLAMMATORY SMEAR**
IMPRESSION: **NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY**

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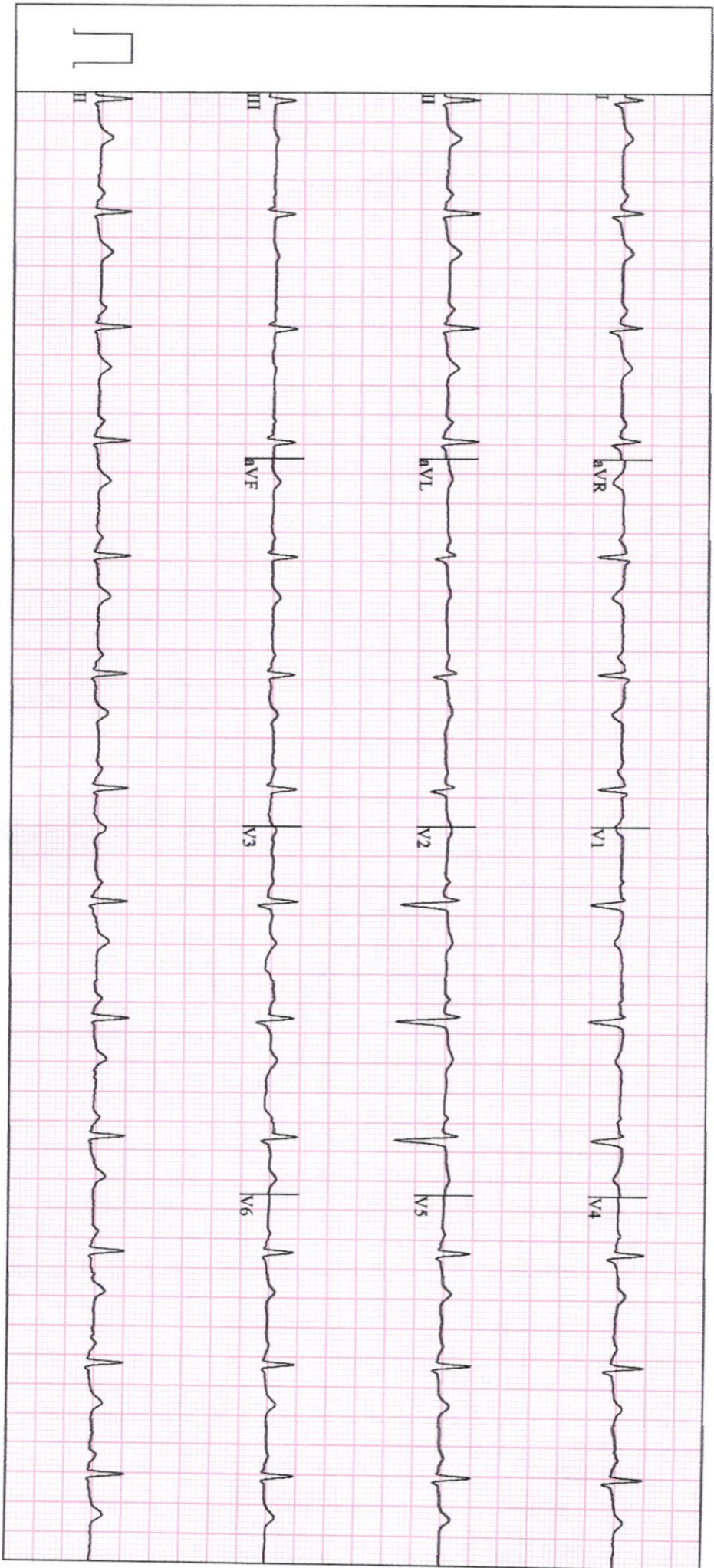
End of Report
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QRS : 84 ms
QT / QTcBaz : 396 / 448 ms
PR : 134 ms
P : 98 ms
RR / PP : 780 / 779 ms
P / QRS / T : 32 / 67 / 31 degrees

Normal sinus rhythm
Normal ECG

NORMAL ECG

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



PATIENT'S NAME	ARUNIMA BISWAS	AGE :- 39Y/F
UHID	11376	DATE :- 11-04-24

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

Trivial MR, TR

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.

No diastolic dysfunction.

Measurements

Aorta annulus	16 mm
Left Atrium	31 mm
LVID(Systole)	26 mm
LVID(Diastole)	39 mm
IVS(Diastole)	09 mm
PW(Diastole)	10 mm
LV ejection fraction.	55-60%

Conclusion

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



Performed by: Dr. Anirban Dasgupta
D.N.B. Internal Medicine, Diploma Cardiology (PGDCC-IGNOU).

PATIENT'S NAME	ARUNIMA BISWAS	AGE :- 39 Y/F
UHID	11376	DATE :- .11 Apr. 24

X-RAY CHEST PA VEIW

OBSERVATION:

Patient is in positional obliquity.
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. CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg No. 073826

PATIENT'S NAME	ARUNIMA BISWAS	AGE :- 39Y/F
UHID	11376	11 Apr 2024

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 not visualised, consistent with post-operative status. 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 11.6 x 4.3 cm. **LEFT KIDNEY** measures 11.3 x 4.5 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 4.6 x 3.5 cm; ET measures 9.7 mm.

Both ovaries are enlarged in size.

RIGHT OVARY measures : 3.4 x 3.1 x 1.8 cm (Vol: 10.5 ml),

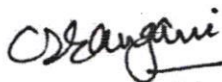
LEFT OVARY measures : 3.1 x 2.4 x 2.7 cm (Vol: 11.0 ml).

Visualised BOWEL LOOPS appear normal. There is no free fluid seen.

IMPRESSION –

- **Bilateral bulky ovaries.**
- **No other 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