



OPD ASSESSMENT FORM



Name Mrs. Alpa Patel Age.Sex 34/F MR.No. 3150814
Doctor Dr Hardik Shroff Date 9/3/24
Ht : _____ Wt. : _____ Temp : _____ Pulse : _____ BP : _____
SPO2 : _____ Post of walk SPO2 : _____

Chief Complaints :

Drug / Food Allergy :

Go Down LE.

Prior Medication Reviewed : Yes No

On examination :

Past History :

since childhood
RFLNL
LE Exotropia
Nebular K. Opacity

Vr C 6/6
3mre 2/6

Provisional Diagnosis :

Nutritional Assessment :

LE K. opacity E

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

Treatment and further Advices :
(Write in Capital Letters)

low vision

Rx

Investigation advised :

[Signature]
Dr. Hardik Shroff

DOMS, DNB (Ophthalmology)

Regd. No. G28802

SUNSHINE GLOBAL HOSPITAL
Piplod, SURAT.

Follow Up : *svs* Date : _____



OPD ASSESSMENT FORM



Name Mrs. Alpy Patel Age.Sex 34/F MR.No. 3150814
 Doctor Dr. Krunal Gujar Date 9/3/24
 Ht : 166 Wt. : 75 kg Temp : 98°F Pulse : 106 b/m BP : 110/80 mmHg
 SPO2 : 98% Post of walk SPO2 : _____

Chief Complaints :

Not - Any

Drug / Food Allergy :

NO

Prior Medication Reviewed : Yes No

On examination :

R } NAD
LVS }

Past History :

KID DM.

Provisional Diagnosis :

Nutritional Assessment :

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

**Treatment and further Advices :
(Write in Capital Letters)**

Rx

Investigation advised :

→ Tab. Zovamet (50/500) 1-0-1
BBF BD.

→ Tab. Atorsave (10) 0-0-1 x (03)
AD months.

[Handwritten Signature]

Follow Up : Date : _____

Signature



MR No. SIS0814



ECHO CARDIOGRAPHIC REPORT

Patient's Name : Ms. Alap. Patel. Date : 4/3/24

Sex : f Age : 34 Ref. by Dr. : _____ Done by Dr. Sumanendra 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 : (n)

AORTIC VALVE (n)

PULMONARY VALVE : (n)

TRICUSPID VALVE (n)

PAH : _____

PASP : 10 mmHg

RA : _____

LA : _____

RV : (n)

IVC : (n)

IAS : Intact

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

CONCLUSION :

No reg/cut / PC

2D echo

for Health

checkups



MR No. : S150814	Collection Date : 09/03/2024 9:27AM
Patient Name : Mrs. Alpa Patel	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 09/03/2024 12:54 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
POST PRANDIAL BLOOD GLUCOSE [PPBS]			
POST PRANDIAL BLOOD GLUCOSE (Hexokinase)	261	mg/dl	100 - 140
POST PRANDIAL URINE GLUCOSE	SNR		
POST PRANDIAL URINE KETONE	SNR		

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

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PAT. NAME : Alpa Patel	Date : 09/03/2024
REF. DOCTOR : Hosp. Dr.	AGE : 34 Yrs / F
INV. : USG Whole Abdomen	MR NO. : S150814

Findings:

Liver is enlarge in size (17.8 cm), shape and shows moderate 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.

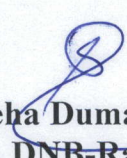
Pancreas appears normal in size and shows normal echopattern to the extent assessed. Spleen appears normal in size, shape and homogenous echopattern.

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. No e/o free fluid in abdomen.

IMPRESSION:

- **Hepatomegaly with grade II fatty liver.**


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

Transcribed By: Asha

Page: 1 out of 1
Date & Time of report: 03/09/2024 – 12:17 PM

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PAT. NAME : Alpa Patel	Date : 09/03/2024
REF. DOCTOR : Hosp. Dr.	AGE : 34 Yrs / F
INV. : Radiograph of Chest PA	MR NO. : S150814

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

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Date & Time of report: 09/03/2024 – 12:13 PM

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MR No. : S150814	Collection Date : 09/03/2024 9:27AM
Patient Name : Mrs. Alpa Patel	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 09/03/2024 12:33 PM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	14.2	gm/dl	12.0 - 15.0
PCV	44.5	%	36 - 46
RBC COUNT	5.21	mill/cmm	4.0 - 5.0
MCV	85.4	fl	76 - 96
MCH	27.3	pg	26 - 32
MCHC	31.9	%	32 - 36
RDW	12.5	%	11 - 15
PLATELET COUNT	3.30	lacs/cmm	1.5 - 4.5
WBC COUNT	7950	/cmm	4000 - 11000
ESR	11	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	51	%	40 - 70
LYMPHOCYTES	39	%	20 - 40
EOSINOPHILS	02	%	1 - 6
MONOCYTES	08	%	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. : S150814	Collection Date : 09/03/2024 9:27AM
Patient Name : Mrs. Alpa Patel	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 09/03/2024 12:24 PM

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)	168	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

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

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Ref By : Dr. Hospital A Doctor	Report Date : 09/03/2024 12:24 PM

BIOCHEMISTRY

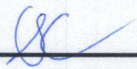
Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	8.2	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	188.64	mg/dl	

The test is done on Cobas Integra 400plus-Turbidimetric Inhibition ImmunoAssay

Note:- Criteria for the diagnosis of diabetes HbA1c $\geq 6.5\%$

- HbA1c is important test for the assessment of long term blood glucose control (also called glycemic control).
- HbA1C reflects mean glucose concentration over past 6-8 weeks and provides a much better indication of long term glycemic control than blood glucose determination.
- HbA1C is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy, nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.
- 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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Ref By : Dr. Hospital A Doctor	Report Date : 09/03/2024 12:25 PM

BIOCHEMISTRY

<u>Parameter</u>	<u>Result</u>	<u>Units</u>	<u>Normal Range</u>
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	243	mg/dl	50 - 200
HDL CHOLESTEROL Direct	35	mg/dl	40 - 60
LDL CHOLESTEROL Direct	179	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	160	mg/dl	50 - 150
VLDL Calc	32	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	6.94		0 - 5
LDL / HDL RATIO	5.11		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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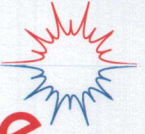
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MR No. : S150814
Patient Name : Mrs. Alpa Patel
Ref By : Dr. Hospital A Doctor

Collection Date : 09/03/2024 9:27AM
Age : 34 Y Sex : Female
Report Date : 09/03/2024 12:28 PM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	78	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.7	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.3	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.4	mg/dl	0.0 - 0.8
SGPT (IFCC)	17	U/L	5 - 41
SGOT (IFCC)	18	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.5	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	5.2	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.3	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	2.26	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFPE)	0.5	mg/dl	0.5 - 1.2
BUN [BLOOD UREA NITROGEN]			
BUN	3.5	mg/dl	8 - 23
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	4.3	mg/L	
URINE CREATININE (JAFPE)	17.6	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	24.4	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

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


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MR No. : S150814	Collection Date : 09/03/2024 9:27AM
Patient Name : Mrs. Alpa Patel	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 09/03/2024 12:26 PM

CLINICAL CHEMISTRY

Parameter	Result	Units	Normal Range
THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.36	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	8.58	ug/dl	5.1 - 14.0
TSH (CLIA)	2.69	uIU/ml	0.2 - 4.5

ce:-

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism 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 while in secondary and tertiary hypothyroidism, TSH levels are low.

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

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MR No. : S150814	Collection Date : 09/03/2024 9:27AM
Patient Name : Mrs. Alpa Patel	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 09/03/2024 12:34 PM

CLINICAL PATHOLOGY

<u>Parameter</u>	<u>Result</u>	<u>Normal Range</u>
URINE ROUTINE & MICROSCOPIC EXAMINATION		
TYPE OF SPECIMEN - URINE	Random	
PHYSICAL EXAMINATION		
QUANTITY	50	ml
COLOUR	Pale Yellow	
APPEARANCE	Clear	
REACTION (pH)	6.0	
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	1-2	/hpf
EPITHELIAL CELLS	2-3	/hpf
RBC	Absent	/hpf
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

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

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GYNAECOLOGICAL CONSULTATION

MR. NO. 5150814
 Name: Mrs. Adpa Patel
 Age: 34/F Ht.: 166cm Wt.: 75.kg B.P.: 110/80

Date: 9/03/24

Clinical Evaluation / History / Presenting Complain:

Runtax

Rt. 15/4

Gynecological History :

	Yes	No
1. Have you ever noticed any bleeding between menstrual periods ? માસિક ના સમય સિવાય વચ્ચે અનીયમીત બ્લીડીંગ થાય છે ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Are / were your periods Irregular ? પીરિયડ રેગ્યુલર છે ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Are you pregnant now ? અત્યારે તમે પ્રેગનન્ટ છો ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Have you had your change of life (Menopause)? મેનોપોઝ ની કોઈ લક્ષણ ની તકલીફ છે ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Are / were you taking birth control pills? તમે ગર્ભનિરોધક ગોળીઓ છે ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Do you have a lump in your breast ? સ્તનમાં દુઃખાવો / સોજો / ગાઠ છે ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Did anyone in your family suffer from breast cancer ? કુટુંબમાં કોઈએ બ્રેસ્ટ કેન્સર છે ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Did anyone in you family suffer from any other cancer ? કુટુંબમાં કોઈને કોઈ પણ પ્રકારનું કેન્સર હતું ?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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 6/2nd 8
 Last menstrual Period (LMP): 8/2/24

2. Obstetric History :

Gravida Pare Abortion Live 1
 Married life with cohabitation.....
 Children M: F: 8/4 Last Delivery: Yrs back
 Any bad Obstetric event / history Yes / No
 If yes Describe:

History of Contraception & Family Planning:

Examination

- a. Breast Examination - Right N/A Left N/A
- b. Per abdomen examination slow & soft
- c. Local examination Vulva: N/A Vagina N/A
- d. Per Speculum Examination Normal

e. Per vaginal examination :

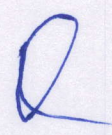
Cervi : Uterus : AV/RV : Normal / Bulky
Adnexa : ✓
PAP's Smear Taken Yes / No

Clinical Impression:

Recommendation:

A. Additional Inv. / Referral Suggested

B. Therapeutic Advice



1 week
Followup Date

Gynaecologist's Signature