

DENTAL REGISTRATION FORM



Date & Time : 29/3/24

Registration No. : 24-24-0054651

Name : Rameshbhai H. Prajapati
Age : 56
Sex : M

Contact No. : _____
Emergency Contact No. : _____
Address : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complaint : Routine checkup.

Family History :

- Diabetes
- Hypertension
- IHD
- Others (Specify) : _____
- Habits : Tobacco

- Hypertension
- Diabetes
- Epilepsy
- Bleeding Disorder
- Smoking

Medical/Other History :

- IHD
- Asthma
- AIDS/HIV
- Pregnancy
- Other (Specify) : _____
- T.B.
- Hepatitis B
- Food Allergy
- Others (Specify) : _____
- Jaundice
- Hepatitis C
- Drug Allergy

સંમતિ પત્રક

હું, નીચેના સહી કરનાર વ્યક્તિ, આ સંસ્થાની પુરવઠા માટે, સ્વસ્થ-વ્યસ્થ, દાખલ કે ઉપચારની સલાહ આપે તે સંસ્થાની સંમતિ, સિફારત વિના અને તમાર તમા સંબંધિતને સચ્ચી સંમતિ છે. મેં સંસ્થાને મારી વાર્ષિક વિભાગ તમા તેને સચ્ચી દવા વિના સંપૂર્ણ સહી કરી સંમતિ છે. મેં સંસ્થાને સંબંધિત સંસ્થા સચ્ચી સંમતિ કે અનિચ્છીત સહી તો તેની સિફારત માટે સંસ્થા કે સચ્ચી સંમતિના પુરવઠા માટે. તમા સંસ્થાની સિફારત વિના સંસ્થાને સલાહ આપે તે સંસ્થાની સંમતિ, સિફારત વિના અને તમાર તમા સંબંધિતને સચ્ચી સંમતિ છે. મેં સંસ્થાને મારી વાર્ષિક વિભાગ તમા તેને સચ્ચી દવા વિના સંપૂર્ણ સહી કરી સંમતિ છે. મેં સંસ્થાને સંબંધિત સંસ્થા સચ્ચી સંમતિ કે અનિચ્છીત સહી તો તેની સિફારત માટે સંસ્થા કે સચ્ચી સંમતિના પુરવઠા માટે.

વહીવટ : _____
સ્થાન : _____

રસી / સગાની રસી

CONSENT

I hereby request and authorize Doctor _____ to perform the required dental treatment. Doctor has informed me and my relatives about the treatment plan in details with success and failure of the treatment with all expenditure, possible complications from medicines or local anesthesia. I have informed the Doctor about my medical history and drug history in details. If in any circumstances, I am irregular or leave the treatment in between, the doctor and CHARUSAT Hospital will not be responsible for the same and treatment charges will not be returned back.

I give my consent to proceed with my dental treatment.

Date : _____
Time : _____

Patient's / Relative's Sign.

Investigation Advised : _____

Final Diagnosis : Stomach +

Treatment Plan : _____

Date : 29/3/24
Time : _____

Name of Doctor : Dr. Mashwals
Signature : _____



LALITABEN P.D. PATEL OPD SERVICES

REGISTRATION FORM (OPD)

Dr Pavan

Date & Time : 29/3/24

Registration No. : CH-24-0054645

Name : Rameshbhai H Prajapati Contact No. : (M) _____

Age : 56 Sex : M (O) _____

Address : _____

B.P. : 130/80 mmHg Pulse : 80/min SpO₂ : 99% on RA

BMI : _____ Height : _____ Weight : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : _____

came for health checkup

↓
NO ACN OR

CASE ANALYSIS

Past History : _____

~~HTN~~ HTN on IP

Present History : _____

G/E Vitals : _____

Systemic Examination : _____

FAMILY HISTORY :

- Diabetes
- IHD
- Hypertension
- Others (Specify) : _____

PATIENT'S MEDICAL/OTHER HISTORY :

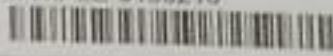
- Hypertension
- Epilepsy
- Food Allergy
- Drug Allergy
- IHD
- Asthma
- AIDS/HIV
- Pregnancy
- T.B.
- Hepatitis B
- Bleeding Disorder
- Jaundice
- Hepatitis C

HABBITTS : Smoking Alcohol Tobacco Others (Specify) : _____



CHARUSAT HOSPITAL



Patient Name :	RAMESHBHAI H PRAJAPATI	Sample No. :	SAMPLE-0108216 
Patient ID :	CH-2024-0054645	Visit No. :	OPD/2024/03/0001451
Age/Sex :	56y/Male	Call. Date :	29-Mar-2024 09:01
Referred By :	RIPAL PATEL	S. Coll. Date :	29-Mar-2024 09:39
Ward :	-	Report Date :	29-Mar-2024 12:06

T4

Investigation	Result	Normal Value
T4-thyroxine	53.4 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

LIPID PROFILE

Investigation	Result	Normal Value
Serum Cholesterol (Chol)	168.3 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride	115.8 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S HDL Cholesterol :	41.5 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	93.14 mg/dl	
VLDL :	33.66 mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	2.24 - [NORMAL]	< 3.5
TC / HDL Ratio :	4.06 - [NORMAL]	4.0 to 6.0
LDL (DIRECT) :	120.7 mg/dl	< 100.0 (Optimal), 100.0 to 120.0 (Near Optimal), 130.0 to 159.0 (Border line high), 160.0 to 189.0 (High), > 190.0 (Very high)

LIVER FUNCTION TEST

Investigation	Result	Normal Value
Total Bilirubin :	0.80 mg/dl [NORMAL]	0.0 to 1.2

ચારસેટ સારથી

OPHTHALMIC REGISTRATION FORM



Reg No. CH-24-6054645

Date 29/3/24

Patient's Name Rameshbhai K Prajapati Age 56

Address : _____ Mobile No. : _____

Telephone No. _____

Referred by / Care of : _____

Profession : Banker

Type of work in daily routine Driving / Watching TV / Computer / Reading /

History / Complain of : Diminution of Vision / Pain / Waterying / Redness / Eyeache / Headache / Itching /

Stickness / Swelling / Irritation / Burning / F. B. Sensation / Photophobia /

Diplopia / Squinting / Blackout / Floaters / Flashes / Injury /

Eye Involve : RE / LE / BE Duration : _____

Ophthalmic History : Surgery / Laser / FFA / Oct / Glaucoma / RP / Corneal Opacity / Injury / Amblyopia /

Treatment _____

Any Surgery : Cataract / Glaucoma / ~~Cataract~~ / RE / LE / BE 6 months back,

Family History : Glaucoma / RP / DM / at mahavir eye

SYSTEMIC : DM / HT / IHD / COPD / PROSTATE / WROID / ALLERGY / SMOKING / ALCOHOL hospital

since 6 yrs & medication

EYE DETAILS : RE LE

V/A with PH 6/6 - MG 6/6 - MG

IOP 9 mm / Hg 10 mm / Hg

OWN GLASS : _____

AR : -1.50 / -1.25 x 100° -1.25 / -1.25 x 80°

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	<u>Same PGP</u>					
Nr.						
Comp						

Bifocal / Distant / Near only / Constant / Progressive / Photocromatic

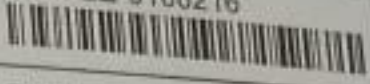
Remark : _____
Signature : _____

Charusat Hospital



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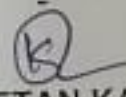
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Urobilinogen : Absent -
 Microscopic Examination :
 Pus Cells : 8-10 -
 RBCs : 1-2 -
 Epithelial cells : 2-3 -
 Casts : Absent -
 Crystals : Absent -


PSA

Investigation	Result	Normal Value
PSA	1.20	0.0 - 4.0 ng/ml 4.0 - 10.0 ng/ml Gray Z 10.0 - 30.0 ng/ml suspic of malignancy Above 30 ng/ml Highly suspicious of malignant
FREE PSA	-	ng/ml

DR. NAIK BHATIA
 CONSULTANT PATHOLOGIST
 (M.B.B.S,D.C.P)


 DR. KETAN KAPADIA
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 (M.B.B.S,M.D)

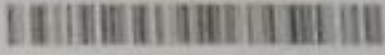


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Direct Bilirubin (DBIL) :	0.27 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	19.2 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	17.2 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	59.2 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP) :	7.1 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	4.3 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.53 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	2.8 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.5	

URINE R & M

Investigation	Result	Normal Value
Physical Examination :		
Quantity :	25 ml	
Colour :	Yellow -	
Appearance :	Sl.Turbid -	
Odour :	URINIOD -	
Reaction :	Acidic -	
Specific Gravity :	1.025 -	
Chemical Examination :		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	
Acetone :	Absent -	

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Investigation	Result	Normal Value
Serum Creatinine	1.03 mg/dl [NORMAL]	Male : 0.9 to 1.5 mg/dl Female : 0.8 to 1.2 mg/dl

BUN		
Investigation	Result	Normal Value
BUN :	11 [NORMAL]	8.0 to 23.0 (mg/dl)

URIC ACID		
Investigation	Result	Normal Value
Serum Uric Acid	6.13 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

ESR		
Investigation	Result	Normal Value
ESR - After One Hour	06 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

Blood Group		
Investigation	Result	Normal Value
ABO :	B	
Rh :	Positive	

FASTING BLOOD GLUCOSE		
Investigation	Result	Normal Value
Fasting Blood Sugar :	92.8 mg/dl [NORMAL]	70 - 110


TSH		
Investigation	Result	Normal Value
TSH :	2.18 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3		
Investigation	Result	Normal Value
T3-Triiodothyronine :	1.85 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)



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Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	14.9 gm/dl [NORMAL]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	5.24 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	6880 /c.mm [NORMAL]	4000 - 10000

Platelet count

Investigation	Result	Normal Value
Platelets	2.88 Lakh/cmm [NORMAL]	1.5 - 4.5

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	57 % [NORMAL]	40 - 70
Lymphocytes	27 % [NORMAL]	20 - 40
Eosinophils	06 % [NORMAL]	1 - 6
Monocytes	10 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	22.1 mg/dl [NORMAL]	15 - 40

S.Creatinine



CHARUSAT HOSPITAL



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DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR	INVESTIGATION
29-03-2024	RAMESHBHAI H PRAJAPATI	56	M	BODY PROFILE	X-RAY

X-ray CHEST PA view.

No evidence of consolidation or infiltration seen involving both lungs.

Costophrenic sinuses are clear.

Vascular shadows are normal on both sides.

Hilar shadows show evidence of normal size, position & opacity.

Heart & aortic shadows show evidence of normal position & size.

Position of domes of diaphragm is normal. Bony cage show no abnormality.

COMMENTS:

NO EVIDENCE OF ABNORMALITY DETECTED.



CHARUSAT




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29-03

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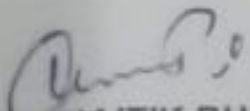
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Referred By :	RIPAL PATEL	S. Coll. Date :	29-Mar-2024 09:39
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HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	125.5 mg/dl	
Hb A 1c	6.0 %	> 8 : Action Suggested 7-8 : Good Control < 7 : Goal 6-7 : Near Normal Glycemia < 6 : Non-diabetic Level

Comments

Hb A1C also know asGlycosylated Haemoglobin is the most important test for the assessment of longterm Blood glucose control (also called glycemic control).
Hb A1C reflects mean glucose concentration over past 69-8 week and provides a much better indicationn of longterm glycemic contril than blood glucose determination.
This Reaction is irreverdible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications).
nephropathy(Kidney-complications) & neuropathy(never complications) are potentially serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.


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DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR	INVESTIGATION
29-03-2024	RAMESHBHAI H PRAJAPATI	56	M	BODY PROFILE	UM-TOTAL ABDOMEN USG

USG ABDOMEN report.

Liver: show evidence of normal size, parenchymal echotexture & no evidence of focal solid or cystic mass lesion seen. Normal hepatic vasculature seen with no evidence of intrahepatic biliary dilatation seen.

Gall bladder contracted with no evidence of calculus or sludge. Thickness of bladder wall is normal with no evidence of pericholecystic fluid collection. CBD, portal vein & splenic vein size are normal.

Spleen size & parenchymal echotexture is normal with no focal mass lesion seen. Pancreas show evidence of normal size & parenchymal echotexture with no evidence of focal mass lesion.

Aorta show normal caliber & no evidence of paraaortic mass lesion seen.

Right kidney show evidence of normal size, position, corticomedullary differentiation, parenchymal echotexture. No evidence of obvious calcification or hydronephrosis seen.

No evidence of focal solid or cystic mass lesion seen.

Left kidney show evidence of normal size, position, corticomedullary differentiation, parenchymal echotexture. No evidence of obvious calcification or hydronephrosis seen.

No evidence of focal solid or cystic mass lesion seen.

Bladder walls are normal & no evidence of stone or mass seen.

Prostate show evidence of normal size & parenchymal echotexture.

No evidence of ascitis or abnormal bowel loops seen.

Size cm app

Right Kidney	Left Kidney	Prostate
9.79x3.67	11.2x5.0	Vol/Wt cc/gms
		18.6

COMMENTS: