DENTAL REGISTRATION FORM

CHARUSAT HOSPITAL

Date & Time : 29/3/24

Registration No : CH-24-0054651

Name : Rameshbhai H Prajapati

Age : 56

Sex : M

Contact No. :

Emergency Contact No. :

Address :

OPD-INITIAL ASSESSMENT FORM

Chief Complain : 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

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હું ______________ [illegible]

[illegible]

____

[illegible] : ______________

[illegible] : ______________

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 : Staining +

Treatment Plan :

Date : 29/3/24

Time : ______________

Name of Doctor : Dr Mashwali

Signature : [signature]

CHARUSAT HOSPITAL

LALITABEN P.D. PATEL OPD SERVICES

REGISTRATION FORM (OPD)

Dr Pavan

Date & Time : 29/3/24

Registration No. : CH-24-005465

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

Age : 56 Sex : M (O) _____

Address : _____

B.P. : 130/80 mm Hg Pulse : 80/min SpO₂ : 99 on RA

BMI : _____ Height : _____ Weight : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : _____

Come for Health checkup

↓

NO Acm OD

CASE ANALYSIS

Past History : _____

K/C HTN on Rx

Present History : _____

G/E Vitals : _____

Systemic Examination : _____

FAMILY HISTORY :

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

PATIENT'S MEDICAL/OTHER HISTORY :

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

HABBITS : ☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Others (Specify) : _____

CHIF/OPD/5083

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	Coll. 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

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CHARUSAT HOSPITAL

OPHTHALMIC REGISTRATION FORM

Reg. No : CH-24-0054645
Date : 29/3/24

Patient's Name : Ramesbhai K Prajapati Age : 56

Address :

Telephone No. : Mobile 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 / Watering / 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 / Phacoemulsification / RE / LE / (BE) 6 months back.

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

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

since 6 yrs ✓ medication.

EYE DETAILS :

	RE	LE
V/A with PH	6/6 – N6.	6/6 – N6.
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	Same	PGP				
Nr.						
Comp						

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

Remark :

Signature : _____

Mobile : 95370

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Urobilinogen : Absent -

Microscopie Examination :

Pus Cells : 8-10 -

RBCs : 1-2 -

Epithelial cells : 2-3 -

Casts : Absent -

Crystals : Absent -

PSA

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

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

DR. KETAN KAPADIA
CONSULTANT PATHOLOGIST
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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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Patient Name :	RAMESHBHAI H PRAJAPATI	Sample No. :	SAMPLE-0106216
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

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-Triodothyronine :	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

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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 infilteration 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 HOSPITAL

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Referred By :	RIPAL PATEL	**S. Coll. Date :**	29-Mar-2024 09:39
Ward :	-	**Report Date :**	29-Mar-2024 14:59

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,parenchymel echotexture & no evidence of f
solid or cystic mass lesion seen.Normal hepatic vasculature seen with no evide
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 & spleenic vein size are normal.

Spleen size & parenchymel echotexture is normal with no focal mass lesion see
Pancreas show evidence of normal size & parenchymel echotexture with no evid
of focal mass lesion.

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

Right kidney show evidence of normal size,position,corticomedullary differentia
parenchymel echotexture. No evidence of obvious calcification or hydronep
seen.
No evidence of focal solid or cystic mass lesion seen.

Left kidney show evidence of normal size,position,corticomedullary differentia
parenchymel echotexture. No evidence of obvious calcification or hydronep
seen.
No evidence of focal solid or cystic mass lesion seen.

Bladder walls are normal & no evidence of stone or mass seen.
Prostate show evideance of normal size & parenchymel echotexture.
No evidence of ascitis or abnormal bowel loops seen.

Size cm app

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

COMMENTS: