MEDICOVER HOSPITALS | KLE Belagavi

Place Label Here
Pt. Name :
UMR :
Age : Sex :
IP :
If lable not available, write Pt. Name, IP No., Sex, Date, Name of Treating Physician

OPD Nursing Assessment - Adult

Name: Meghana Bini Date of Birth : — Age/Sex: 45/f UMR No.: 21632

Assessment :

Height: 147 cm cms Weight: 57.80 kg. BMI: 26.7 Respiration: 20 /min Pulse H/R : 86 /min

BP: 145/82 mmHG Temperature : — °F/°C SpO2 98 % BSL —

Chief Complaints : Regular check up

Tick Appropriate :

Interpreter Needed	☐ Yes	☑ No	
Nutritional Status: Weight Loss/Gain in Last 3 Months	☐ Yes	☑ No	
If Weight Loss / ain-Dietary Referral	☐ Yes	☑ No	
Psychological Assessment Agitated Anxious	☐ Yes	☑ No	☐ Normal
(If Agitated, Inform Physician)	☐ Irritable		

Any Allergies Known Including Drugs : Nil

Past History: Any Surgeris Explain : Nil

Any Other illness: Explain : HTN, DM.

Pain Score: Numerical Scales (1-10) — Location — Characteristics —

Need to be seen immediately by the Doctor — ☐ Yes ☑ No

Fall risk: Age 65Yrs. — Tremors — High Grade Fever — H/O Fall in last 3 months —

Cardiac Medicines — Seizure Medications — Fall Prevention Education Done —

Name of Nurse	ID No. of Nurse	Signature of Nurse	Date & Time
Keerthana	021384		18/4/24

MEDICOVER HOSPITALS | KLE Pune

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MEGHNA BINI	**Age /Gender**	: 45 Y(s)/Female
Bill No/ UMR No	: PUBC21809/PUU21632	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 18-Apr-24 12:07 pm	**Report Date**	: 18-Apr-24 01:47 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals
CUE(COMPLETE URINE EXAMINATION)			
GENERAL EXAMINATION			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.025	1.010 - 1.030
PH		5.0	4.5 - 8.0
CHEMICAL EXAMINATION			
PROTEIN	Urine	ABSENT	ABSENT
GLUCOSE		+	ABSENT
BLOOD		ABSENT	ABSENT
LEUCOCYTES		NEGATIVE	NEGATIVE
UROBILINOGEN		NORMAL	NORMAL
KETONE		ABSENT	ABSENT
BILIRUBIN		NEGATIVE	NEGATIVE
NITRITE		NEGATIVE	NEGATIVE
MICROSCOPIC EXAMINATION			
PUS CELLS	Urine	0-1	0 - 5 /hpf
RBC		NIL	0 - 2 /hpf
EPITHELIAL CELLS		0-1	0 - 5 /hpf
CRYSTALS		NIL	ABSENT
CASTS		ABSENT	ABSENT
OTHERS		ABSENT	ABSENT

*** End Of Report ***

System Name : M

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MEDICOVER HOSPITALS | KLE Pune

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MEGHNA BINI	**Age /Gender**	: 45 Y(s)/Female
Bill No/ UMR No	: PUBC21809/PUU21632	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 18-Apr-24 12:07 pm	**Report Date**	: 18-Apr-24 01:47 pm

FINAL REPORT

Parameters	Specimen	Result		Method
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" B "		
RH TYPE		POSITIVE		SLIDE AGGLUTINATION
ESR		11	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA	13.0	11.7 - 16.0 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		7,450	4000 - 11000 Cells/cumm	Impedance
PLATELET COUNT		259000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.52	3.9 - 5.0 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		38.6	36 - 46 %	Analogical integration
MCV		85.4	82 - 95 fl	Calculated
MCH		28.8	27 - 32 pg	Calculated
MCHC		33.7	32 - 36 g/dL	Calculated
RDW(cv)		12.4	11.5 - 14.0 %	Calculated
MPV		10.8	6 - 9.5 fl	Calculated
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA	67.9	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		22.7	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		3.8	00 - 06 %	DHSS/Microscopy
MONOCYTES		5.2	00 - 10 %	DHSS/Microscopy
BASOPHILS		0.4	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA	Normocytic Normochromic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate on smear		

*** End Of Report ***

System Name : M

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MEGHNA BINI	**Age /Gender**	: 45 Y(s)/Female
Bill No/ UMR No	: PUBC21809/PUU21632	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 18-Apr-24 12:07 pm	**Report Date**	: 18-Apr-24 01:47 pm

Parameter	Specimen	Result Values	Biological Reference	Method

System Name : M

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MEGHNA BINI	**Age /Gender**	: 45 Y(s)/Female
Bill No/ UMR No	: PUBC21809/PUU21632	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 18-Apr-24 12:07 pm	**Report Date**	: 18-Apr-24 01:47 pm

FINAL REPORT

Specimen

BUN(BLOOD UREA NITROGEN)			
BUN (Blood Urea Nitrogen.)	10.1	7.0 - 21.0 mg/dL	Calculatead
HBA1C (GLYCOSYLATED HAEMOGLOBIN)			
HBA1C	5.8	Normal < 5.7 Pre diabetic 5.7 - 6.5 Diabetic > 6.5 : 5.7 - 6.5	TINIA
PPBS (POST PRANDIAL BLOOD SUGAR)			
PPBS (POST PRANDIAL BLOOD SUGAR)	179.8	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase
LIPID PROFILE			
TOTAL CHOLESTEROL	169.8	Borderline High : 200 - 240 mg/dL High risk : > 240 mg/dL Desirable: : < 200 mg/dL	Enzymatic
HDL CHOLESTEROL	49.1	Major risk factor for heart disease : : < 40 mg/dL Negative risk factor for heart disease : : > 60 mg/dL	Homogeneous enzymatic colorimetric assay
LDL CHOLESTEROL	104.78	Optimal - < 100 mg/dL	Homogeneous enzymatic colorimetric assay
VLDL	15.92	6 - 38 mg/dl	Calculation
SERUM TRYGLYCERIDES	79.6	Borderline High 150 - 199 mg/dL	Enzymatic colorimetric test
CHO/HDL RATIO	3.46	Normal - < 3.5	Calculation
LDL/HDL RATIO	2.13	2.5 - 3.5	Calculation
COMMENT	10-12 hours fasting is mandatory for Lipid profile parameters. If not ,Values may not be accurate.		
FBS (FASTING BLOOD SUGAR)			
FASTING BLOOD GLUCOSE	110.0	Normal Range 70 - 99 mg/dL	Hexokinase
SERUM CREATININE	0.55	0.6 - 1.2 mg/dL	Jaffe
T3,T4 AND TSH			
T3	0.677	0.8 - 2.0 ng/mL	Method : ECLIA
T4	5.25	5.1 - 14.1 ug/dL	Method : ECLIA

System Name : M

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MEGHNA BINI	**Age /Gender**	: 45 Y(s)/Female
Bill No/ UMR No	: PUBC21809/PUU21632	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 18-Apr-24 12:07 pm	**Report Date**	: 18-Apr-24 01:47 pm

Parameters	Specimen	Result	Biological Reference In	Method
TSH(THYROID STIMULATING HORMONE)		1.95	0.27 - 4.2 uIU/mL	Method : ECLIA
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.31	0.1 - 1.2 mg/dL	Colorimetric diazo method
DIRECT BILIRUBIN		0.15	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.16	<= 1.0 mg/dL	Calculated
SGPT (ALT)		15.6	<= 33 U/L	Enzymatic
SGOT (AST)		13.3	<= 32 U/L	Enzymatic
ALKALINE PHOSPHATASE (ALP)		41	35 - 104 U/L	PNPP
TOTAL PROTEINS		7.51	6.4 - 8.3 g/dL	Method : Biuret method
SERUM ALBUMIN		4.86	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.65	1.8 - 3.6 g/dL	Calculation
A/G RATIO		1.83	1.1 - 2.2	Calculation
GAMMA GLUTAMYL TRANSFERASE(GGT)		12	6 - 42 U/L	Enzymatic colorimetric assay (IFCC)

*** End Of Report ***

Lab Incharge

Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PATHOLOGIST
Pathology

Test results related only to the item tested.

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System Name : M

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Patient ID:	*PUU21632*	*Patient Name:*	*MEGHNA BINI*
Age:	*45 Years*	*Sex:*	*F*
Accession Number:	*PUR21632-PK*	*Modality:*	*DX*
Referring Physician:	*HC*	*Study:*	*CHEST*
Study Date:	*13-Apr-2024*		

X RAY CHEST PA VIEW

FINDINGS : Chest PA view with no comparison study shows.

- The visualized lung fields are clear.
- No obvious consolidation is seen.
- There is no pleural effusion or pneumothorax seen.
- No pneumoperitoneum is seen.
- The cardiac silhouette appears within normal limits.
- The diaphragmatic shadow and mediastinal structures are within normal limits.
- Visualized osseous structures demonstrate no obvious abnormality.

IMPRESSION :

- **No radiographically evident acute cardiopulmonary process in the present study.**

Dr. Madhuri Avhad (MBBS DMRD)
Consultant Radiologist
(typed by sk)

Patient Name : Mrs. Meghna Bini	Age : 45 yrs / F
Ref. By : Dr. Health check up	OPD/IPD No: PUU: 21632
Date of USG: 12/04/2024	Date of Reporting: 12/04/2024

USG ABDOMEN AND PELVIS

Liver : is **mildly enlarged** in size (measures 15.8 cm in craniocaudal axis) and shape, echo texture. No focal lesion is seen. No IHBRD. **Grade I fatty infiltration of liver.**

CBD : Visualized part is normal in caliber at the porta.

Portal Vein: is normal in caliber at the porta. No evidence of thrombosis of the visualized part at the porta.

Gall Bladder : is not visualised, post cholecystectomy status.

Pancreas : Visualized part of head and body appears normal in caliber and echogenicity.

Spleen : is normal in size, shape and echogenicity. No focal lesion is noted.

Kidneys : Right Kidney: 109 x 3.8 cm. Left Kidney: 10.7 x 4.8 cm.
Both kidneys appear normal in size, shape, echogenicity and corticomedullary differentiation. No evidence of hydronephrosis.No focal lesion or calculus is noted.

Urinary Bladder :is well distended and show normal wall thickness.
No calculus/focal lesion is seen.

Uterus : is normal in size and shape. It measures 9.1 x 4.4 x 5.4 cm.
Endometrium measures: 13.3 mm.
No focal lesion is seen.

Ovaries : Both the ovaries are normal in size, shape and morphology.
No adnexal mass lesion is seen.

Retro peritoneum isobscured by bowel gases.
No free fluid is noted. No pleural effusion.
Visualized bowel loops are gaseous.

IMPRESSION:

- **Mild hepatomegaly with grade I fatty infiltration.**
- **No other significant abnormality seen in the present study.**

Suggested clinical & pathology correlation.

Dr. Amaya Mahajan MBBS.DMRD.DNB
Consultant Radiologist

MEDICOVER HOSPITALS | KLE Pune

DEPARTMENT OF RADIOLOGY

Patient Name : Mrs. Meghna Bini	**Age : 45 yrs / F**
Ref. By : Dr. Health check up	**OPD/IPD No: PUU: 21632**
Date of USG: 12/04/2024	**Date of Reporting: 12/04/2024**

USG OF BOTH BREASTS

- The breast show mixed fibro-fatty and glandular parenchymal composition.
- No dominant suspicious mass lesion or architectural distortion is seen on either side.
- No dilated duct or cystic lesion or collection is noted in the present study.
- The retromammary soft tissue appear normal on both sides.
- No obvious enlarged axillary lymphnodes are evident.
- Underlying muscles appear unremarkable.

IMPRESSION :

❖ **No significant abnormality seen in present study.**

BIRADS CATEGORY I – (Negative)
Advised clinical correlation and follow up Sonomammography.

Dr. Amaya Mahajan MBBS.DMRD.DNB
Consultant Radiologist

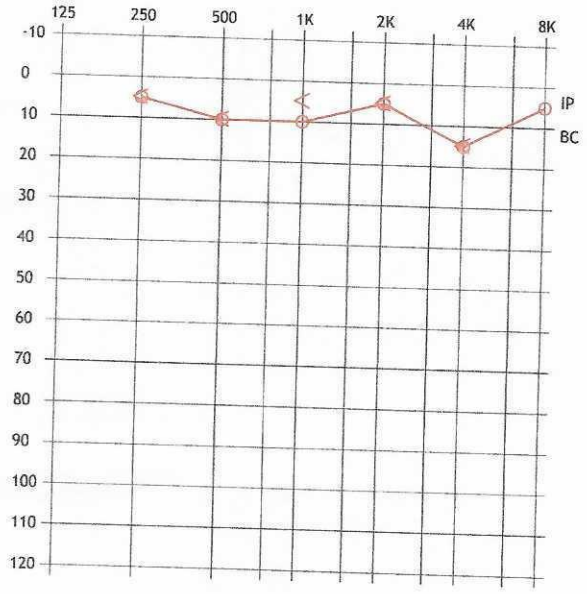
MEDICOVER HOSPITALS

amplifon

noah4

Patient Name	Bini, Meghna	**Date of birth**	02-02-1979
		Test date:	13-04-2024

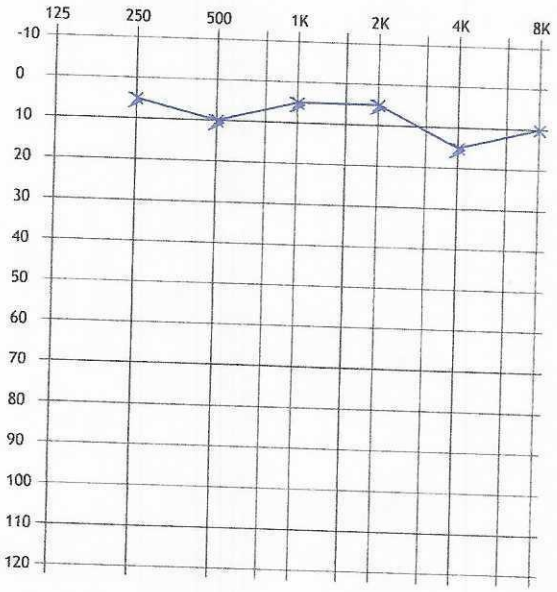
Rt ear



Legend

R	B	L
O	X	
<	>	

Lt ear.



Report comments:

PTA Average:-
Rt Ear -9 dbHL Lt Ear -7 dbHL

Provisional Diagnosis :-

Bilateral hearing sensitivity within normal limits

Recommandation :-
ENT Consultation
Follow up

Name
Audiologist

13-04-2024

NAME OF PATIENT: MEGHNA BINI	AGE/SEX: 45YRS/F
REF BY: HC	DATE: 13/4/2024

2D ECHOCARDIOGRAPHY & COLOR DOPPLER STUDY

All chambers normal sized.
No regional wall motion anomaly at rest.
Good LV and RV systolic function, LVEF= 60 %
IAS/IVS intact.
Mild degenerative affection of Aortic and Mitral Valve
Mild AR, No AS
Great artery origins normal.
No clot/vegetation/effusion.
No coarctation of aorta.
IVC collapsible.

COLOR DOPPLER STUDY: -

Grade I DD
No pulmonary hypertension.

CONCLUSION:-

Normal chamber dimensions.
Good biventricular function. (LVEF = 60%).
No pulmonary hypertension.
IVC collapsible.

Dr. SURAJ PATIL
MD.DM. (Cardiology)
Consultant and interventional Cardiologist

ID: 20240413113439 60
Name: meghna bini
Age: 45 Years
Gender: Female

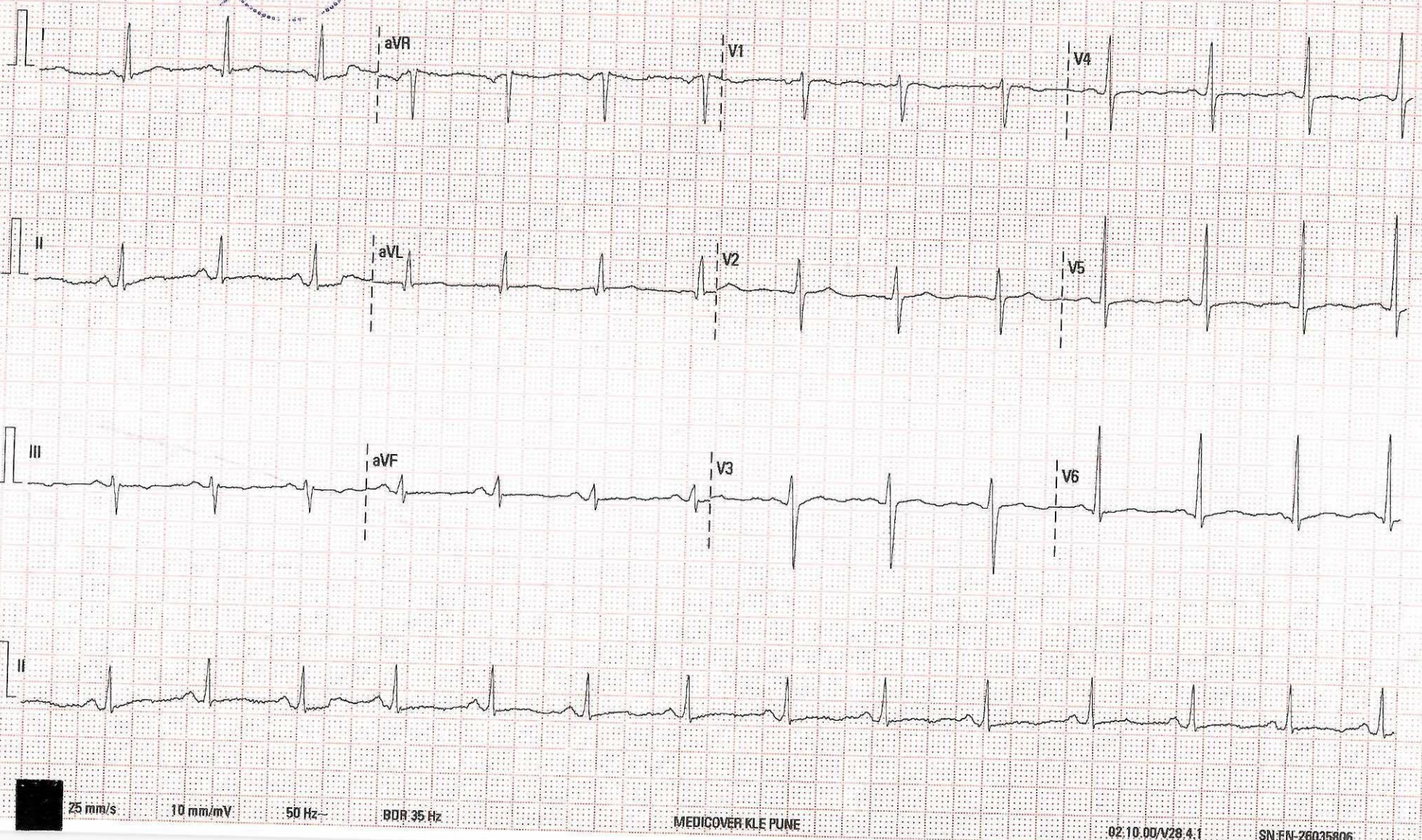
13-04-2024 11:34:29 AM

Vent. Rate	84 bpm
PR Interval	148 ms
QRS Duration	84 ms
QT/QTc Interval	346/388 ms
P/QRS/T Axes	61/18/23 deg
QTc:Hodges	

Sinus rhythm

Normal ECG

Unconfirmed Diagnosis



25 mm/s 10 mm/mV 50 Hz~ BDR 35 Hz

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02.10.00/V28.4.1

SN:FN-26035806

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13/4/2022.

Mrs. Meghna Bini 45/f

Pt for regular ENT checkup.

- Surecal D3 60k IU
1 — 0
Daily in milk
x 8 days.

R/c ear
Tinnitus

TFT - Normal

Adv
pure tone Audiometry

DR. SURAJ GIRI
M.B.B.S., MS-ENT
Reg. No. 08/2010/2603