

**DR. HARIN VADODARIA MD**  
M.D. (Internal Medicine)  
Consultant Physician  
Reg No: G 3394,  
Mo: 9898053714  
OPD Days:

**OPR NO:**

**Shalby MD Physician Clinic**

Patient Name:-  
Age / Sex :-  
Chief Complaints:-

Prati Dhanu  
37/F

Date: 16/3/23  
Weight:- 49.81 kg  
Height:- 150 cm

efo headache  
on and off  
- 2 mo.

Nutritional assessment:-

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

Pulse:- 98b/min  
BP:- 120/80 mmHg  
SpO2:- 90.0%

Drug / Food Allergy:-  
Past History :-

None

Family History:-  
Systemic Examination:-

de Rx -  
ast hly  
hr  
ev

Provisional Diagnosis:-

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Investigation :-

Hb - 7.6 g/dl.

→

Ad

Hb electrophoresis

Treatment and further advices:-  
(Write in Capital Letters)

Rx 1. TONOPRIN 2 0 1-0 (20)

1. FOLIC 12 1-0-0 (20)

Rx

1. O3 PRIN 1200 2x 1ml - (4)

જરૂરી

Signature

લક્ષ્મી

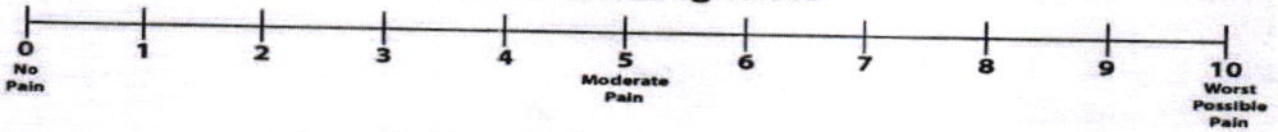
Follow Up:

બધી દવાઓ ડોક્ટરને બતાવીને લેવી.

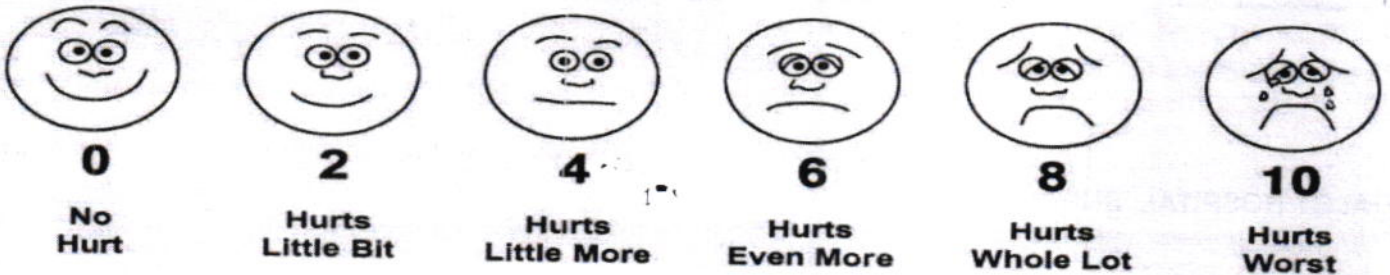
Date:- \_\_\_\_\_

Incase of emergency please report to Emergency Department of Hospital OR Call:- 0261-7190000 / 9512660096

**Numeric Rating Scale**



**Wong-Baker FACES® Pain Rating Scale**



Patient ID:	SUR0000337781	Patient Name:	PRITIBEN PARMAR
Age:	37 Years	Sex:	F
Accession Number:	3367	Modality:	DX
Referring Physician:		Study:	CHEST PA
Study Date:	16-Mar-2023		

**CHEST X-RAY (PA)**

Both lung fields appear normal.

No evidence of consolidation or cavitation is seen.

Both costo-phrenic angles appear clear.

Cardiac size is within normal limits.

Both domes of diaphragm appear normal.

Bony thoracic cage and soft tissue shadow appear normal.

**IMPRESSION:**

- No significant abnormality seen.

Thanks for referral.

Dr. Nimit R Desai  
Consultant Radiologist

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PID : SUR0000337785 OP-001

REPORT STATUS : Interim



Patient Name : Mrs. Priti D Parmar /

Registered On : 16-Mar-2023 11:13 AM

Lab ID : 303901224

Collected On : 16-Mar-2023 11:25 AM

Gender/Age : Female / 37 Years

DOB : 29-May-1985

Received On : 16-Mar-2023 11:37 AM

Ref. By : Dr. Health Check Up . Shalby

Sample Type : EDTA Whole Blood

Parameter	Result	Unit	Biological Ref. Interval
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**BLOOD COUNT AND INDICIES**

HAEMOGLOBIN	Colorimetric Non Cyanide	7.6	g/dL	12.0 - 15.0
RBC COUNT	Electrical Impedance	4.79	mill/cmm	3.8 - 4.8
HCT	Calculated	29.4	%	36 - 46
MCV	Calculated based on the RBC histogram	61.4	fL	83 - 101
MCH	Calculated	15.9	pg	27 - 32
MCHC	Calculated	25.8	g/dL	31.5 - 34.5
RDW	Calculated	18.7	%	11.6 - 14.0

**TOTAL LEUCOCYTE COUNT**

Total WBC Count	Electrical Impedance	4380	cells/cmm	4000 - 10000
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**DIFFERENTIAL LEUCOCYTE COUNT (Manual by Microscopy)**

NEUTROPHILS	Flow Cytometry	54	%	40 - 80
LYMPHOCYTES	Flow Cytometry	38	%	20 - 40
EOSINOPHILS	Flow Cytometry	3	%	1 - 6
MONOCYTES	Flow Cytometry	5	%	2 - 10
BASOPHIL	Flow Cytometry	0	%	0 - 2

**PLATELET INDICES**

PLATELET COUNT	Electrical Impedance	346000	/cmm	150000 - 410000
MPV	Calculated based on PLT Histogram	8.4	fL	7.5 - 12.0

**PERIPHERAL SMEAR EXAMINATION**

RBCs

**Hypochromic microcytic with anisopoikilocytosis.**

WBCs

Total and differential leucocyte counts are within normal limit

PLATELETs

Adequate in number and normal in morphology.

MALARIAL PARASITE

Malarial parasites are not seen on smear examination.

EDTA Whole Blood - Tests done on Automated Five Part Cell Counter. (WBC, RBC, MCV & Platelet count by classical impedance method, Hb by cyanide-free colorimetric method, WBC differential by Chemical dye, Flowcytometry, Semi-conductive Laser scatter Method, independent Basophil channel & other parameters calculated). All Haemograms are reviewed & confirmed microscopically.

Reference Interval: Dacie and Lewis practical haematology 11th edition.

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Consulting Pathologist

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**BLOOD GROUP**

(Tube agglutination: Forward &amp; reverse)

ABO Type

"B"

RH Type

POSITIVE

ESR 1st hour \*

16

mm in 1 hour 0 - 20

Modified Westergren Method

**HBA1C**

HbA1c - Glycated Haemoglobin \*

5.6

%

Non-diabetic: &lt;= 5.6

Pre-diabetic: 5.7-6.4

Diabetic: &gt;= 6.5

Therapeutic goals for glycemc control

Age &gt; 19 years Goal of therapy:

&lt; 7.0 Action suggested: &gt; 8.0

Age &lt; 19 years Goal of therapy:

&lt;7.5

Estimated Average Glucose (eAG) (mg/dL) \* 114

mg/dL

Calculated

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 Ref. By : Dr. Health Check Up . Shalby Sample Type : Serum, Urine (PP),  
 Urine, Serum

Parameter	Result	Unit	Biological Ref. Interval
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**PLASMA GLUCOSE LEVEL****FASTING PLASMA GLUCOSE**

<b>Plasma Glucose (F)</b>	95	mg/dL	74 - 106
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GOD/POD (Glucose Oxidase/Peroxidase), Colorimetric

<b>Urine Sugar (F)</b>	ABSENT	mg/dL	ABSENT
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Glucose-oxidase/oxidase reaction

**POST PRANDIAL PLASMA GLUCOSE**

<b>Plasma Glucose (PP)</b>	120	mg/dL	Normal: 100-140 Impaired: 140-199 Diabetic :>=200
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GOD/POD (Glucose Oxidase/Peroxidase), Colorimetric

<b>Urine Sugar (PP)</b>	ABSENT	mg/dL	ABSENT
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Glucose-oxidase/oxidase reaction

**Liver Function Test****Liver Function Test**

<b>SGPT (ALTV)</b>	23	U/L	9 - 52
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Multi Point Rate with P-5-P

<b>SGOT (AST)</b>	21	U/L	14 - 36
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Multi Point Rate with P-5-P

<b>Alkaline Phosphatase</b>	67	U/L	20-50 yrs.: 42 - 98
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PNPP, AMP Buffer

4-19 yr : 54 - 369  
>=51 yr : 56 - 119

<b>GGT *</b>	19	U/L	12 - 43
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L-gamma-glutamyl-4-nitroanilide/glycylglycine Kinetic

<b>S. PROTEIN</b>	7.4	g/dL	6.3 - 8.2
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Biuret (Alkaline cupric sulfate), End Point

<b>Albumin</b>	3.9	g/dL	3.5 - 5.0
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Bromocresol Green (BCG), Colorimetric

<b>S. GLOBULIN</b>	3.5	g/dL	2.3 - 3.6
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Calculated

<b>A/G Ratio</b>	1.1	Ratio	1.0 - 2.3
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Calculated

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Ref. By : Dr. Health Check Up . Shalby Sample Type : Serum, Urine (PP),  
Urine,Serum

**Liver Function Test**

<b>Bilirubin Total</b> <i>Azobilirubin/Dyphylline/Diazonium Salt</i>	0.4	mg/dL	0-1 day (premature) 1.0 - 8.0 0-1 day (full term) : 2.0 - 6.0 1-2 day (premature) : 6.0 - 12.0 1-2 day (full term) : 6.0 - 10.0 3-5 day (premature) : 10.0 - 14.0 3-5 day (full term) : 4.0 - 8.0  Adult : 0.2 - 1.3
<b>Bilirubin Unconjugated</b> <i>End-point Colorimetric (Dual wavelength spectrophotometric)</i>	0.4	mg/dL	Unconjugated bilirubin Adults: 0.0-1.1 Neonates: 0.6-10.5
<b>BILIRUBIN DIRECT</b> <i>Calculated</i>	0.0	mg/dL	Conjugated bilirubin and Delta bilirubin (Bilirubin covalently bound to albumin) 0.0-0.4

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Ref. By : Dr. Health Check Up . Shalby		Sample Type : Serum

Parameter	Result	Unit	Biological Ref. Interval
<b>LIPID PROFILE</b>			
<b>LIPID PROFILE</b>			
<b>Cholesterol</b> <i>Cholesterol Esterase, Oxidase, Peroxidase</i>	114	mg/dL	Desirable: <200 Borderline High: 200 - 239 High >=240
<b>SERUM TRIGLYCERIDE</b> <i>Lipase/GK/GPO/POD</i>	50	mg/dL	Normal : <150 Borderline High : 150-199 High : 200-499 Very High : > 500
<b>HDL CHOLESTEROL DIRECT *</b> <i>Phosphotungstic Acid/Mgcl2 - Enzymatic</i>	41	mg/dL	Major risk factor for heart disease : < 40 Negative risk factor for heart disease : >= 60
<b>Non HDL Cholesterol</b> <i>Calculated</i>	73	mg/dL	Optimal : <130 Desirable : 130-159 Borderline high : 159-189 High : 189-220 Very High : >=220
<b>S.LDL</b> <i>Calculated</i>	63	mg/dL	Optimal: <100 Near to above Optimal: 100 - 129  Borderline High: 130 - 159 High: 160 - 189 Very High: > 190
<b>VLDL</b> <i>Calculated</i>	10	mg/dL	6 - 38
<b>LDL/dHDL *</b> <i>Calculated</i>	1.5		2.5 - 3.5
<b>Chol/dHDL *</b> <i>Calculated</i>	2.8	Ratio	3.5 - 5.0

Note: Reference interval as per National Cholesterol Education Programme (NCEP) Adult Treatment Panel III Report. VLDL, CHOL/dHDL RATIO, LDL/dHDL RATIO, LDL Cholesterol, Non HDL Cholesterol are calculated parameters. Estimation of LDL by direct method is recommended when TG>400 mg/dL.

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Parameter	Result	Unit	Biological Ref. Interval
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**RENAL FUNCTION TEST**

**RENAL FUNCTION TEST**

<b>Urea Nitrogen (BUN)</b> <i>Urease, colorimetric</i>	6	mg/dL	7 - 17
<b>UREA</b> <i>Calculated</i>	13	mg/dL	15 - 36
<b>S. CREATININE</b> <i>Enzymatic - Creatinine amidohydrolase</i>	0.53	mg/dL	0.52 - 1.04
<b>S. URIC ACID</b> <i>Uricase/Peroxidase, Colorimetric</i>	3.7	mg/dL	2.5 - 6.2
<b>Calcium</b> <i>Arsenazo III dye</i>	8.8	mg/dL	8.4 - 10.2
<b>S. PHOSPHORUS *</b> <i>Phosphomolybdate reduction (PMA Phenol)</i>	3.8	mg/dL	2.5 - 4.5
<b>Sodium</b> <i>Direct Ion Selective Electrode</i>	141	mmol/L	137 - 145
<b>S. POTASSIUM</b> <i>Direct Ion Selective Electrode</i>	4.92	mmol/L	3.5 - 5.1
<b>Chloride</b> <i>Direct Ion Selective Electrode</i>	108	mmol/L	98 - 107

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Ref. By : Dr. Health Check Up . Shalby Sample Type : Serum

Parameter	Result	Unit	Biological Ref. Interval
<b>Total T3 *</b> <i>Chemiluminescence immunoassay (CLIA)</i>	118	ng/dL	87 - 178
<b>Total T4 *</b> <i>Chemiluminescence immunoassay (CLIA)</i>	10.61	µg/dL	6.09 - 12.23
<b>TSH *</b> <i>Chemiluminescence immunoassay (CLIA)</i>	2.11	µIU/mL	Non Pregnant Females: 0.38-5.33 µIU/mL Pregnant Females (1st trimester): 0.05-3.70 µIU/mL Pregnant Females (2nd trimester): 0.31-4.35 µIU/mL Pregnant Females (3rd trimester): 0.41-5.18 µIU/mL

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Ref. By : Dr. Health Check Up . Shalby		Sample Type : Urine

## URINE EXAMINATION

Parameter	Result	Unit	Biological Ref. Interval
<b>Physical Examination</b>			
Colour	PALE YELLOW		Pale yellow
Transparency	Clear		Clear
<b>Chemical Examination</b>			
Blood	<i>Peroxidase like activity of hemoglobin</i>	NIL	RBCs/ $\mu$ L
Bilirubin	<i>Azo coupling Reaction with diazonium</i>	NIL	mg/dL
Urobilinogen	<i>Modified Ehrlich reaction</i>	NORMAL	mg/dL
Ketone	<i>Sodium Nitroprusside reation</i>	NIL	mg/dL
Protein	<i>Protein Error of Indicator Principle</i>	NIL	mg/dL
Nitrite	<i>Diazotization reaction of nitrite with an aromatic amine</i>	NEGATIVE	mg/dL
Glucose	<i>Glucose-oxidase/oxidase reaction</i>	NIL	mg/dL
pH	<i>Double Indicator principle</i>	6.5	PH value
Specific Gravity	<i>Refractometric Method - Bromthymol blue</i>	1.005	S.G. value
Leucocyte	<i>Leucocyte Esterase Test</i>	NEGATIVE	WBCs/ $\mu$ L
<b>Microscopic Examination</b>			
Pus cells	0-2/hpf	/hpf	0-5/hpf
Red blood cells	NIL	/hpf	0-2/hpf
Epithelial cells	0-2/hpf	/hpf	NA
Crystals	NIL		Nil
Cast	NIL/LPF		Nil/LPF
Bacteria	NIL		Nil
Amorphous	NIL		Nil
Yeast	NIL		Nil

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Patient's Name: Mrs. Priti Parmar  
UHID: 337781

Age: 37 yrs/ Female  
Date: 16 / 03 / 2023

**ECHOCARDIOGRAPHY REPORT**

**Valves**

Mitral valve :Normal, No MR

Aortic valve :Normal, No AR

Tricuspid valve :Normal, No TR

Pulmonary valve:Normal, No PR

**Chambers**

Left Atrium:Normal

Right Atrium:Normal

Right Ventricle:Normal size cavity,Good RV systolic function With TAPSE:19

Left Ventricle: Normal size cardiac chambers, No Regional wall Motion abnormality.  
Normal LV systolic function  
with Ejection Fraction 60 %.  
Normal Diastolic Flow Pattern.

**Septae**

IVS: Intact. No residual VSD.

IAS :Intact.


Pericardium:Normal.

IVC:14 mm with more than 50% collapsibility.

**OTHER FINDINGS : Bilateral lung angle clear**

**CONCLUSION:**

- Normal LV Systolic function
- No RWMA
- EF 60 %



**DR.SUSHIL YADAV**  
Consultant Clinical cardiologist

**Note : Normal echo study does not rule out underlying Coronary artery disease**

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Sex: **F**  
 ID: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Birth date: \_\_\_\_\_ years  
 cm kg mmHg

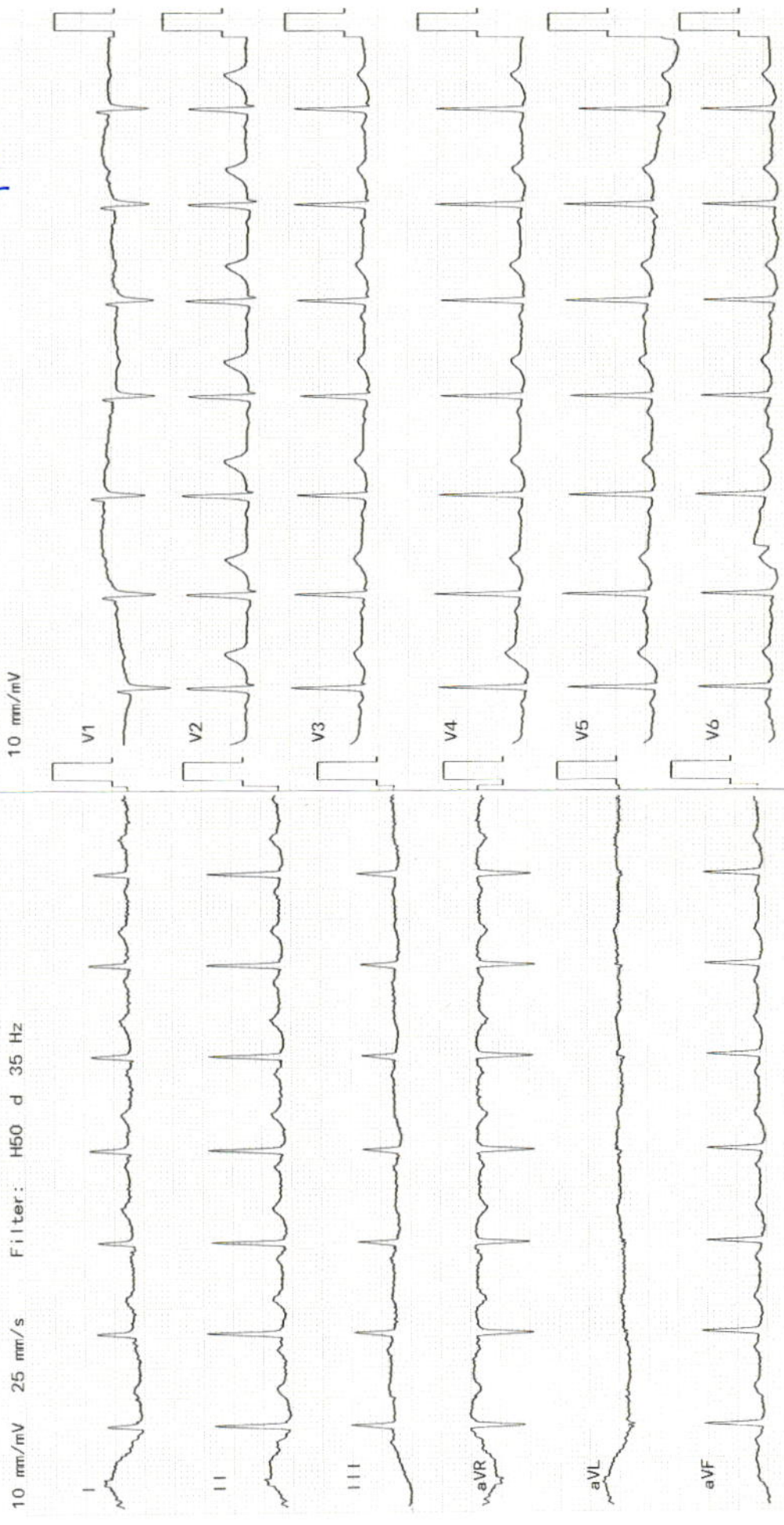
1100 Sinus rhythm  
 9110 \*\* normal ECG \*\*

*Patibon*

② *16/3/23*

Medication:  
 Symptoms:  
 History:  
 vent. rate 95 bpm  
 PR int 120 ms  
 PRS dur 68 ms  
 JT/QTc(E) int 338/ 391 ms  
 P/QRS/T axis 44/ 58/ 34 °  
 RV5/SV1 amp 1.58/ 0.73 mV  
 RV5+SV1 amp 2.31 mV

Unconfirmed Report  
 Reviewed by:





For OPD & Billing Use

**SHALBY**  
MULTI-SPECIALTY  
HOSPITAL

**DR. HIMANI THAKER (VYAS)**  
M.S (Gynec)  
Consultant Obstetrician & Gynecologist  
Laparoscopic Surgeon  
Infertility Specialist  
Email-ID:- thaker.himani@gmail.com  
Register No. G-31062

**Shalby Women's Health Clinic**

Name:- *Pratibha*  
Chief Complaints:-

Date: *16/3/23*  
Weight:-  
Height:-  
OPR NO:-

- Nutritional Assessment:-
- Obese
  - Well Nourished
  - Mild-Moderate Nourished
  - Severely Mal-Nourished

*Monit -*

M/H:- *Peri - 34 days P.M.*  
*30*

LMP:- *9/3/23*

O/H :-  
*O/H - B L3*

P/H:-  
F/H  
Examination:-  
*3 mscs | 2♀ | 14yr | L3  
15 | 12yr |  
7yr*

*DBL done for Amenorrhoea  
then restored bleeding*

Provisional Diagnosis:-

*P/A - soft  
P/S - Cp healthy.*

**SHALBY HOSPITAL, SURAT**  
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Vapi - Indore - Jabalpur - Mohali - Naroda (Ahmedabad) - Surat - Jaipur **Upcoming Hospitals : Mumbai - Nasik**

*PAP smear  
taken*

Patient Name: PRITI PARMAR		
Age / Sex: 37Yrs. / Female	Study: USG Abdomen + Pelvis	
Referred By: Dr. at shalby hospital	Date: 16/03/2023	

**ULTRASOUND OF ABDOMEN AND PELVIS (TAS)**

**Liver** is normal in size and appearance. It shows normal parenchymal reflectivity. No focal lesion seen. The Hepatic veins appear normal. No evidence of dilated I.H.B.R.  
**Portal vein** appears normal.

**Gall bladder** is well distended and appears normal. No evidence of calculi seen. Wall appears normal. No pericholecystic fluid seen. **CBD** appears normal.

**Pancreas** appears normal in size and echotexture.

**Spleen** appears normal in size and appearance. No focal lesion seen.

**Right kidney** shows normal echotexture and corticomedullary differentiation. There is no evidence of scarring, hydronephrosis or calculi.

**Left kidney** shows normal echotexture and corticomedullary differentiation. There is no evidence of scarring, hydronephrosis or calculi.

**Urinary bladder** well distended and appears normal. No evidence of any intraluminal mass or calculi.

**Uterus** appears normal in size. The uterine myometrial echotexture is homogenous. No focal lesion is seen.

There is no evidence of any ovarian or adnexal mass lesion.

No ascites is seen. No abnormal bowel wall thickening and dilatation seen.

**IMPRESSION:**

- **No significant abnormality detected.**

*Thanks for referrals.*

**Dr. Nimit R Desai**  
**Consultant Radiologist**

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Vapi - Indore - Jabalpur - Mohali - Naroda (Ahmedabad) - Surat - Jaipur - Mumbai

Pre - op

Post- op

Health Check-up

Date : 16/3/23

Patient Reg. No. : \_\_\_\_\_

Patient Name : Poojita Parmar

Age / Sex : 37/P

Address : Surat

**Complaints :**

Pain : \_\_\_\_\_

Bleeding gums : \_\_\_\_\_

Swelling : \_\_\_\_\_

Sensitivity : \_\_\_\_\_

Pus Discharge : \_\_\_\_\_

**Medical History :**

Hypertension : DM

Acidity

Pregnancy : \_\_\_\_\_

Bleeding Disorders : \_\_\_\_\_

Asthma : \_\_\_\_\_

Allergy : \_\_\_\_\_

Past Surgical Intervention : \_\_\_\_\_

Any Medication : Stevion +

**On Examination :**

Abscess : \_\_\_\_\_

Food lodgement : \_\_\_\_\_

Periodontitis : \_\_\_\_\_

Gingivitis : \_\_\_\_\_

Missing Teeth : \_\_\_\_\_

Mobility : \_\_\_\_\_

**Treatment Advised :**

Scaling : Sitzings 1  2  3  Deep

Perio Surgery : \_\_\_\_\_

Restoration : \_\_\_\_\_

Class V Fillings : \_\_\_\_\_

RCT : 17

Extraction : 27 (R.S.)

Dentures : \_\_\_\_\_

Partial Denture : \_\_\_\_\_

Implants : \_\_\_\_\_

Crown & Bridge

Present : \_\_\_\_\_



Crown / Bridge Replacement :

Advised Crown / Bridge :

Advised X - Ray / O.P.G. :


**Some Golden Rules :**

1. Brush your teeth twice a day.
2. Floss your teeth daily.
3. Gargle forcefully after each meal.
4. Visit your dentist twice a year.
5. Any dental treatment should be performed in an well maintained.

hygienic setup using "autoclaved" instruments & "sterilized pouch" facility.

After knee replacement any treatment should be done under "Antibiotic Coverage"

Adv.

- Scaling
- RCT of 17
- Extraction of 27 (R.S.)

**Dr. Darshini V. Shetty**  
(Consultant Dental Surgeon)



**DR. RUJUTA SHELAT**  
Consultant Ophthalmologist  
Reg. No.:- G-48712

Name :- *Priti Parmar*

Date:- *16/3/23*

Chief Complaints:-

*N/C*

H/O: Trauma in RE

Pain Assessment:-

Past History:-

Family History:-

Allergy:-

Personal History:- **Habits:-** Alcohol:- Y/N Tobacco: Y/N Smoking: Y/N Regular Exercise: Y/N

General Examination:-

BP:- Pulse:- Temp:-

Visual Acuity:- *FC @ 2 m*  
*6/6*

Systemic Examination:-

HT:- WT:-

PH Vision:- *NZ*

NCT *76 mm of hg*

ON Examination Ant. Segmenet

Both Eye

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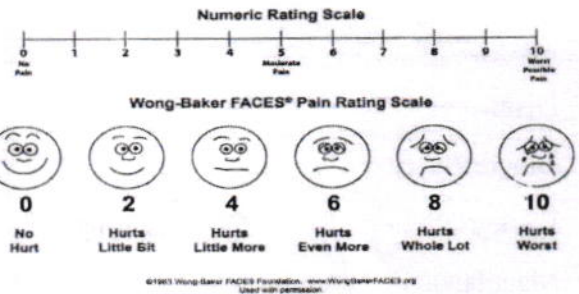
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Cornea

Anterior Chamber

Lens

Fundus

Rt. EYE

Lt. EYE

Media:-

Disc:-

Blood Vessel:-

Background:-

Macula:-

Diagnosis:-

} LE  
WNL

Investigation:-

Treatment:-

Nutritional Assessment:-

Preventive Care & Counsellings:-

Follow Up ON:- After 6 month

RNS

Signature of the Consultant

**DR. NIKITA PATEL**  
M.B.B.S, M.S (ENT SURGEON)  
EMAIL : nikitapatel93@quclock.com  
Mo. No.:- +919712993275  
Regi. No. G-57620

**Shalby ENT Clinic**

Name:- *Rabiben*

Age :-

Date:- *16/03/23*

Chief Complaints:-

Weight:-

Height:-

OPR NO:-

*Chronic Dry cough*

Past History :-

Family History:-

Systemic Examination:-

*Examined*

Provisional Diagnosis:-

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Treatment and further advices:-  
(Write in Capital Letters)

Investigation Advised:-

Rx

Sp.   
Enilindus 1+3f BP

Q

Follow Up:

Date:- \_\_\_\_\_

બધી દવાઓ ડોક્ટરને બતાવીને લેવી.