

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

OPD Nursing Assessment - Adult

Name: Shabdham Pooja Date of Birth : _____ Age/Sex: 24 UMR No.: 22730

Assessment :

Height: 174 cms Weight: 82 kg. BMI: _____ Respiration: _____ /min Pulse H/R: 84 /min
 BP: 136/78 mmHG Temperature : _____ °F/°C SpO2 98 % BSL _____

Chief Complaints :

Health 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 : NO

Past History: Any Surgeris Explain : NO

Any Other illness: Explain : NO

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
<u>Sushma</u>	<u>020981</u>	<u>Sushma</u>	

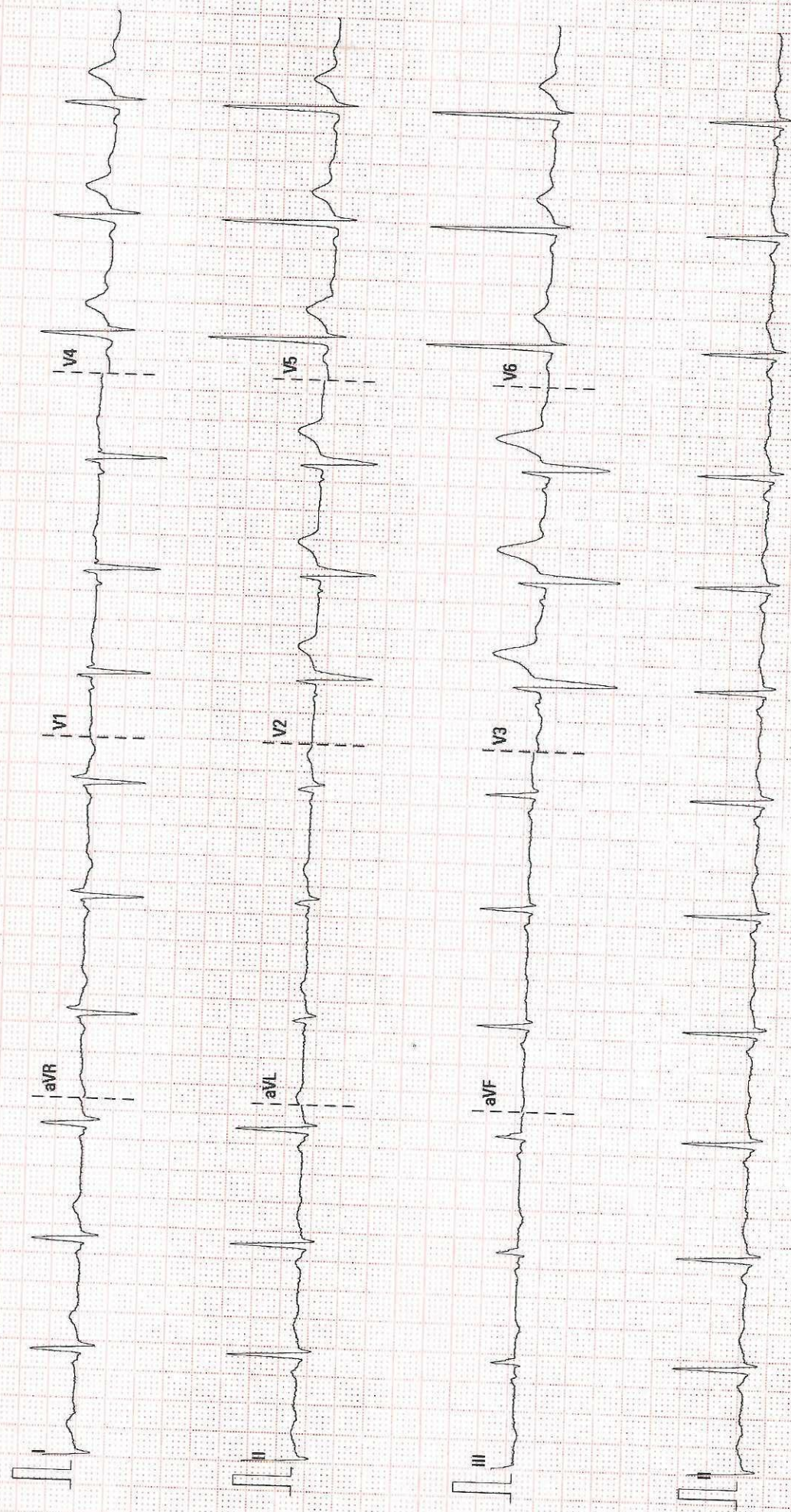
2024-05-13 11:45:59 AM

Name: shabdam pawar
Age: 24 Years
Gender: Male

Vent. Rate 76 bpm
PR Interval 122 ms
QRS Duration 100 ms
QT/QTc Interval 360/388 ms
P/QRS/T Axes 59/58/11 deg
QTc: Hodges

Sinus rhythm
Lead(s) unsuitable for analysis: V1
Normal ECG based on available leads

Unconfirmed Diagnosis



25 mm/s 10 mm/mV 50 Hz BOR 35 Hz

02.10.00/V28.4.1 SN-FM-26036610



DEPARTMENT OF LABORATORY

Patient Name : Mr. SHABDAM ANIL PAWAR **Age / Gender** : 24 Y(s)/Male
Bill No/ UMR No : PUBC22785/PUU22730 **Referred By** : Dr. GENERAL MEDICINE CONSULTANT
Received Dt : 13-May-24 11:39 am **Report Date** : 13-May-24 01:20 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
CUE (COMPLETE URINE EXAMINATION)			
GENERAL EXAMINATION			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.020	1.010 - 1.030
PH		6.0	4.5 - 8.0
CHEMICAL EXAMINATION			
PROTEIN	Urine	ABSENT	ABSENT
GLUCOSE		ABSENT	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



DEPARTMENT OF LABORATORY

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Received Dt : 13-May-24 11:39 am	Report Date : 13-May-24 01:20 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA Blood	14.8	13.2 - 17.3 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		7,150	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		303000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.70	4.5 - 6 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		42.3	40 - 50 %	Analogical integration
MCV		90.1	82 - 95 fl	Calculated
MCH		31.5	27 - 32 pg	Calculated
MCHC		35.0	32 - 36 g/dL	Calculated
RDW(cv)		11.7	11.5 - 14.0 %	Calculated
MPV		7.5	6 - 9.5 fl	Calculated
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	57.6	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		29.3	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		1.7	00 - 06 %	DHSS/Microscopy
MONOCYTES		10.2	00 - 10 %	DHSS/Microscopy
BASOPHILS		1.2	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA Blood	Normocytic Normochromic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate On Smear		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" O "		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		8	0 - 15 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

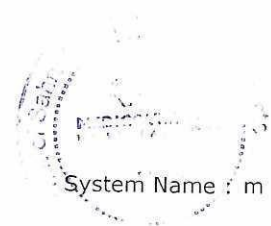




DEPARTMENT OF LABORATORY

Patient Name : Mr. SHABDAM ANIL PAWAR	Age / Gender : 24 Y(s)/Male
Bill No/ UMR No : PUBC22785/PUU22730	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 12:03 pm	Report Date : 13-May-24 03:08 pm

Parameters **Specimen** **Result** **Biological Reference In Method**





DEPARTMENT OF LABORATORY

Patient Name : Mr. SHABDAM ANIL PAWAR	Age /Gender : 24 Y(s)/Male
Bill No/ UMR No : PUBC22785/PUU22730	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 12:04 pm	Report Date : 13-May-24 03:46 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
SERUM CREATININE		0.87	0.8 - 1.3 mg/dL	Jaffe
SGPT (ALT)		15.8	<= 41 U/L	Enzymatic
SERUM BILIRUBIN TOTAL		0.45	0.1 - 1.2 mg/dL	Colorimetric Diazo Method
DIRECT BILIRUBIN		0.17	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.28	<= 1.0 mg/dL	
FBS (FASTING BLOOD SUGAR)				
FASTING BLOOD GLUCOSE		86.6	Normal Range : 70 - 99 mg/dL Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		9.5	7.0 - 21.0 mg/dL	Calculatead
PPBS (POST PRANDIAL BLOOD SUGAR)				
PPBS (POST PRANDIAL BLOOD SUGAR)		87.4	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase

*** End Of Report ***

Lab Incharge


Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PATHOLOGIST

Test results related only to the item tested.
No part of the report can be reproduced without written permission of the laboratory.





Patient ID:	PUU22730	Patient Name:	SHABDAM PAWAR
Age:	24 Years	Sex:	M
Accession Number:	PUBC22785-PK	Modality:	DX
Referring Physician:	HC	Study:	CHEST
Study Date:	13-May-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. Sunita Shewale (MBBS, DMRE)
Consulting Radiologist**

Dr. Sunita Shewale
Consulting Radiologist
MBBS, DMRE

Date: 13-May-2024 12:54:06





Mr. Shabdham Pawar

24/M

PEME

No H/O DM / BA / HERNIA

No DOE chest pain

No addiction



13/5/24

REBC - ves

CH - GA(N)

CMS - NAD

[Handwritten signature]

Dr. Aditya Vinod Sondankar
MBBS, DNB (Medicine)
Masterclass in Diabetes (PGDCED)
Consultant General Medicine
Reg No. 2009083017



Date:- 13/05/24.

Name:- Mr. Shabdham A. Pawar.

Age/Sex:- 24 / M.

S/O, Ophthalmologist: Dr. K. Mane

Eye	UCVA	PCGVA	Pinhole	NEAR	COLOR VISION
Right	6/15	6/6 (1.00 x 90°)	6/6	NG	> 20/20 (16/16)
Left	6/12	6/6 (1.00 x 100°)		cont. glasses.	

Other findings:-

Squint

Nystagmus

Night blindness:-

} no

Impression:-

Eye exam is within normal limits

for desired fitness for work.

Dr. Kirti Mane
MBBS, DOMS, MMC
Reg. No. : 2005/05/2708



MEDICAL CERTIFICATE

I, Dr. Ravindra Kulkarni, do hereby certify that I have carefully examined
Sri./Smt. (Whose signature is given below), son / daughter
of Shabdram Pawar physically fit / unfit to join school / organization / undergo
professional education.

Signature of Candidate / Guardian: Shabdram Pawar

Signature of Doctor: Registration No:

R Kulkarni

Place: Medicover Hospital KLE
Pune

Date: 15/05/2014

Dr. Ravindra L Kulkarni
MD, DNB, FSCAI
Cardiology Sr Consultant
Physician & Cardiologist
Reg No: 88810

Seal:

