CHARUSAT HOSPITAL

Patient Name :	DIPTIKUMARI . .	**Sample No. :**	SAMPLE-0111337
Patient ID :	CH-2024-0057606	**Visit No. :**	OPD/2024/08/0001220
Age/Sex :	30y/Female	**Call. Date :**	24-Aug-2024 10:04
Referred By :	KRUNAL VYAS	**S. Coll. Date :**	24-Aug-2024 14:47
Ward :	-	**Report Date :**	24-Aug-2024 15:00

PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	99.1 mg/dl [LOW]	100 - 140

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

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

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
24-08-2024	DIPTIKUMAR	F	BODY PROFILE	UF-TOTAL ABDOMEN USG

USG OF THE ABDOMEN/ PELVIS WAS PERFORMED

The liver is normal in size and echotexture. No focal solid or cystic lesions are seen.
The intra hepatic biliary radicles are normal. The portal vein and CBD are normal.
The gall bladder is contracted with no calculi or polyp. The wall is not thickened.

The pancreas reveals a normal echopattern, with no focal calcification or a neoplasm. The spleen reveals a normal sonographic features.

Both kidneys are normal in size and echotexture. Evidence of good cortico medullary differentiation is noted. No evidence of any calculi or hydronephrosis.

No free fluid or lymphadenopathy is seen.
The urinary bladder is well distended with no calculi or polyps.

The uterus is anterverted, normal size.
The endometrium is in the midline. No focal myoma is seen.
Both the ovaries are nomal in size and shape. No focal solid or cystic lesion is seen.

No adnexal abnormality is seen.
No free fluid is seen in the pouch of douglas.

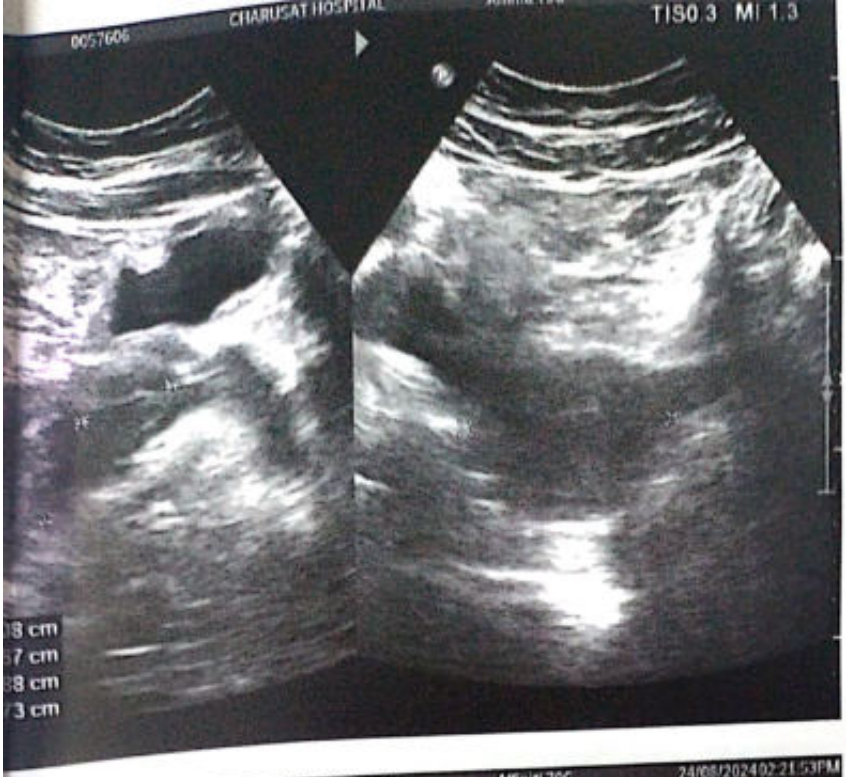
Size in CM.

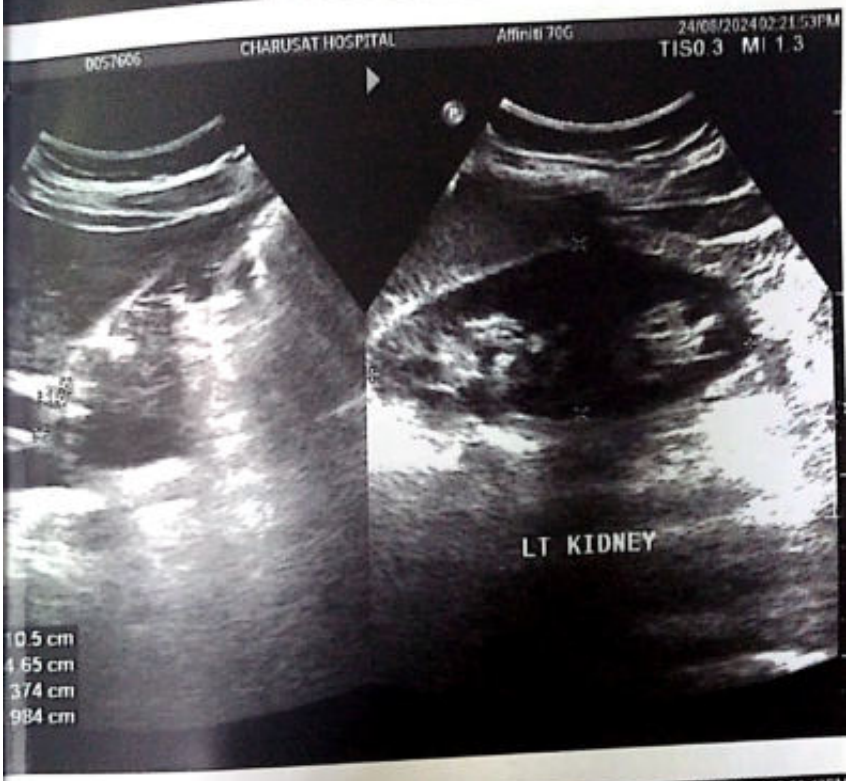
Right Kidney	Left Kidney
10.1X3.7	10.5X4.6

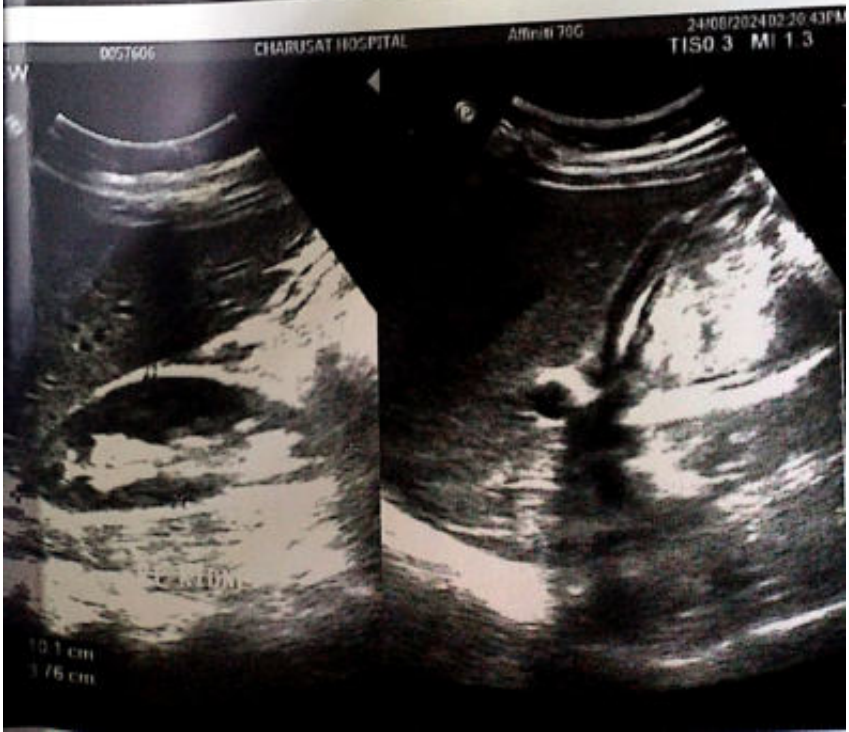
IMPRESSION :

NO ABNORMALITY DETECTED.

Thanks for reference
DR KIRTI C THAKKAR
M.B.B.S,D.M.R.D


0057606
CHARUSAT HOSPITAL
TIS0.3 MI 1.3
8 cm
7 cm
8 cm
3 cm


0057606
CHARUSAT HOSPITAL
Affiniti 70G
24/08/2024 02:21:53PM
TIS0.3 MI 1.3
LT KIDNEY
10.5 cm
4.65 cm
374 cm
984 cm


0057606
CHARUSAT HOSPITAL
Affiniti 70G
24/08/2024 02:20:43PM
TIS0.3 MI 1.3

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
24-08-2024	DIPTIKUMARI	F	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.

X-ray of LUMBO-SACRAL Spine AP & lateral view.

Mineralisation of bones is normal.
No evidence of compression or displacement of vertebrae detected.
Intervertebral disc space show evidence of mild narrowing..
Pedicles & transverse processes are normal.
Psoas shadows are normal on both sides.
No evidence of erosion or sclerosis of bones seen.

COMMENTS:

Intervertebral disc space show evidence of mild narrowing..

NO OTHER OBVIOUS ABNORMALITY DETECTED.

Thanks for reference
DR.VIRAL C.THAKKAR
M.B.B.S,D.M.R.D

CHARUSAT HOSPITAL

Patient Name :	DIPTIKUMARI . .	Sample No. :	SAMPLE-0111330
Patient ID :	CH-2024-0057606	Visit No. :	OPD/2024/08/0001220
Age/Sex :	30y/Female	Call. Date :	24-Aug-2024 10:04
Referred By :	KRUNAL VYAS	S. Coll. Date :	24-Aug-2024 10:26
Ward :	-	Report Date :	24-Aug-2024 11:46

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	11.5 gm/dl [LOW]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	3.92 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	6470 /c.mm [NORMAL]	4000 - 10000

Platelet count

Investigation	Result	Normal Value
Platelets	2.41 Lakh/cmm [NORMAL]	1.5 - 4.5

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	73 % [HIGH]	40 - 70
Lymphocytes	23 % [NORMAL]	20 - 40
Eosinophils	01 % [NORMAL]	1 - 6
Monocytes	03 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	19.6 mg/dl [NORMAL]	15 - 40

S.Creatinine

CHARUSAT HOSPITAL

Patient Name :	DIPTIKUMARI . .	Sample No. :	SAMPLE-0111330
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Age/Sex :	30y/Female	Call. Date :	24-Aug-2024 10:04
Referred By :	KRUNAL VYAS	S. Coll. Date :	24-Aug-2024 10:26
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Investigation	Result	Normal Value
Serum Creatinine :	0.77 mg/dl [NORMAL]	Male : 0.7 to 1.5 mg/dl Female : 0.5 to 1.2 mg/dl

BUN

Investigation	Result	Normal Value
BUN :	09 [NORMAL]	8.0 to 23.0 (mg/dl)

URIC ACID

Investigation	Result	Normal Value
Serum Uric Acid	4.41 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

ESR

Investigation	Result	Normal Value
ESR - After One Hour	12 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

Blood Group

Investigation	Result	Normal Value
ABO :	A	
Rh :	Positive	

FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar :	89.3 mg/dl [NORMAL]	70 - 110

HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	114.0 mg/dl	

CHARUSAT HOSPITAL

Patient Name :	DIPTIKUMARI . .	Sample No. :	SAMPLE-0111330
Patient ID :	CH-2024-0057606	Visit No. :	OPD/2024/08/0001220
Age/Sex :	30y/Female	Call. Date :	24-Aug-2024 10:04
Referred By :	KRUNAL VYAS	S. Coll. Date :	24-Aug-2024 10:26
Ward :	-	Report Date :	24-Aug-2024 11:46

Hb A 1c	5.6 %	> 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.	

TSH

Investigation	Result	Normal Value
TSH :	2.56 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3

Investigation	Result	Normal Value
T3-Triodothyronine :	1.77 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

T4

Investigation	Result	Normal Value
T4-thyroxine :	66.0 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

LIPID PROFILE

Investigation	Result	Normal Value

CHARUSAT HOSPITAL

atient Name :	DIPTIKUMARI . .	Sample No. :	SAMPLE-0111330
atient ID :	CH-2024-0057606	Visit No. :	OPD/2024/08/0001220
ge/Sex :	30y/Female	Call. Date :	24-Aug-2024 10:04
eferred By :	KRUNAL VYAS	S. Coll. Date :	24-Aug-2024 10:26
ard :	-	Report Date :	24-Aug-2024 11:46

Serum Cholesterol (Chol) :	160.1	mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	71.2	mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	53.7	mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	74.38	mg/dl	
/LDL :	32.02	mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
DL/HDL Ratio :	1.39	- [NORMAL]	< 3.5
C / HDL Ratio :	2.98	- [LOW]	4.0 to 6.0
DL (DIRECT) :	97.4	mg/dl [Optimal]	< 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)

VER FUNCTION TEST

vestigation	Result		Normal Value
otal Bilirubin :	0.43	mg/dl [NORMAL]	0.0 to 1.2
irect Bilirubin (DBIL) :	0.19	mg/dl [NORMAL]	0.0 to 0.30
LT (SGPT) :	22.6	IU/L [NORMAL]	[0.0 - 40]
ST (SGOT) :	12.6	IU/L [NORMAL]	<= 45.0
lkaline Phosphatase (ALP) :	61.6	IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0

CHARUSAT HOSPITAL

Patient Name :	DIPTIKUMARI . .	Sample No. :	SAMPLE-0111330
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Age/Sex :	30y/Female	Call. Date :	24-Aug-2024 10:04
Referred By :	KRUNAL VYAS	S. Coll. Date :	24-Aug-2024 10:26
Ward :	-	Report Date :	24-Aug-2024 11:46

Total Protein (TP) :	7.2 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	4.1 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.24 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.1 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.3	

URINE R & M

Investigation	Result	Normal Value
Physical Examination :		
Quantity :	15 ml	
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Acidic -	
Specific Gravity :	1.025 -	
Chemical Examination :		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	
Acetone :	Absent -	
Urobilinogen :	Absent -	
Microscopie Examination :		
Pus Cells :	3-4 -	
RBCs :	Absent -	
Epithelial cells :	2-3 -	

CHARUSAT HOSPITAL

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Casts :	Absent	-
Crystals :	Absent	-

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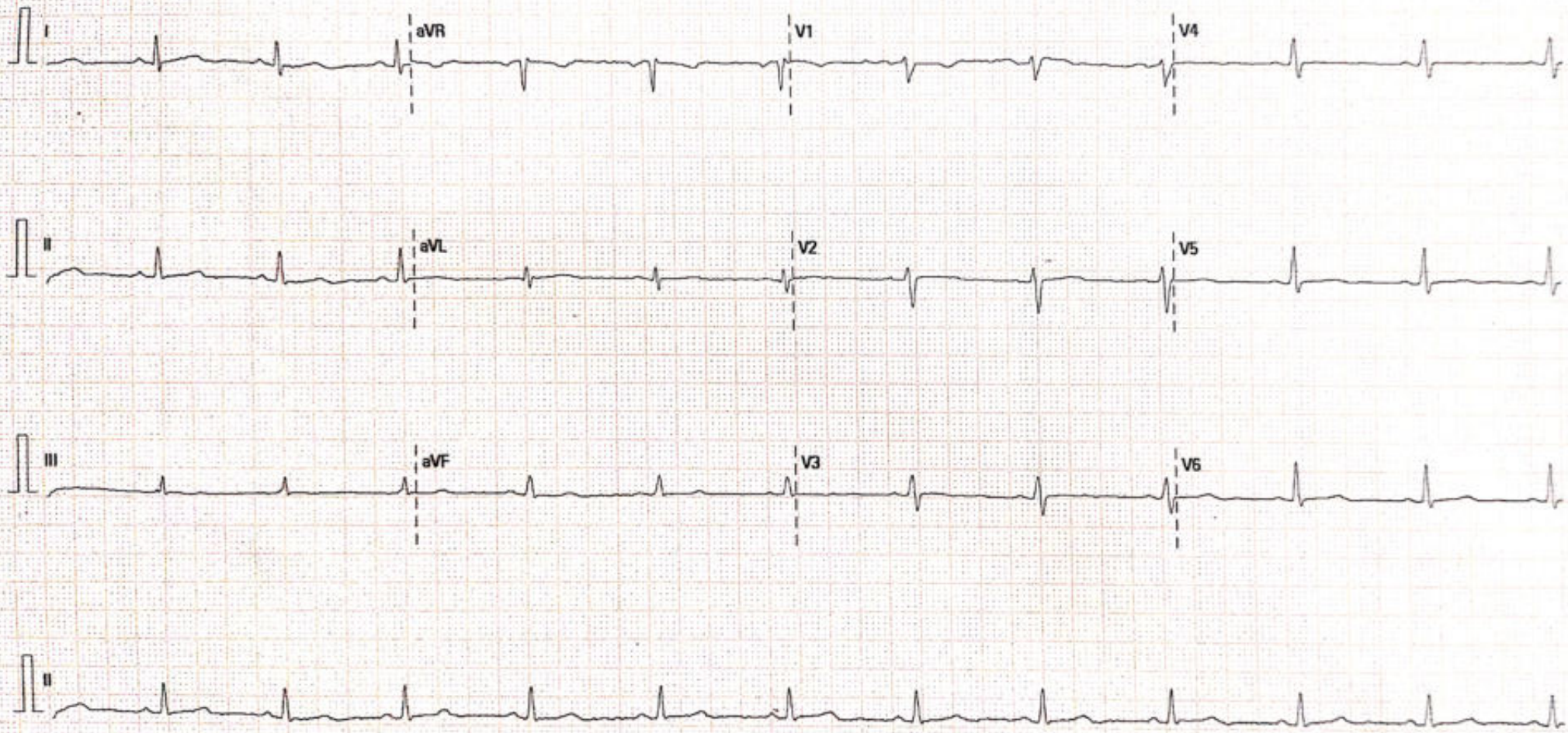
(M.B.B.S,M.D)

30/F

QT/QTc Interval	386/407 ms
P/QRS/T Axes	26/62/31 deg
QTc:Hodges	

Anterior T wave abnormality is nonspecific

Unconfirmed Diagnosis.



25 mm/s 10 mm/mV 50 Hz— BDR 20 Hz CHARUSAT HOSPITAL 02.03.00/V28.4.1 SN:FN-52001657

LALITABEN P. D. PATEL OPD SERVICES
REGISTRATION FORM (OPD)

Dr. Jainish sir

Date & Time : 24-8-24

Registration No. : CH-24-0037606

Name : Diptikumari Contact No. : (M)

Age : 30 Sex : F (O)

Address :

B.P. : 130/80 mm Hg Pulse : 106/min SpO, : 99% RA

BMI : Height : Weight :

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : Come for Health check up

CASE ANALYSIS

Past History : NAD

Present History :

O/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) : _____

CHRF/OPD/5083

Investigation/s Advised :

Provisional Diagnosis :

Allergy :

Nutritional Advice :

TREATMENT ADVISED

DATE	DOCTOR'S NOTE	REM
	Adv → All Reports (N) S/B. Gynecologist C/o-Nil Adv Cmp-9/8/24 No Rx required M/H 2-3/28-30 Regular. mod. painless	

Signature with Stamp

LALITABEN P. D. PATEL OPD SERVICES
REGISTRATION FORM (OPD)

CHRF CHARUSAT HOSPITAL

Dr. Sanjay

Date & Time : 24-8-24

Registration No. : C4-24-0057606

Name : Diptikumari

Contact No. : (M)

Age : 30 Sex : F

(O)

Address :

B.P. :

Pulse :

SpO_2 :

BMI :

Height :

Weight :

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : - C/o Chronic ... - off ... - ...

- ... H/o ...

CASE ANALYSIS

Past History :

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) :

CHRF/OPD/S083

Investigation/s Advised : _____

_____

Provisional Diagnosis : _____

Allergy : _____

Nutritional Advice : _____

TREATMENT ADVISED

DATE	DOCTOR'S NOTE	REM
X-ray L5	Spine AP Lat	
	Adv	
	- Spinal exercise (extension)	
X-X-1 (7-8 pm)	- Tab FOJOV-MP FORTE 1 HS x 30	
	- O_3 60k i/v/im x 4	
	Sign	

DENTAL REGISTRATION FORM

CHARUSAT HOSPITAL

Date & Time : 24-8-24

Registration No. : CM-24-0037602

Name : Dipti Kumari

Age : 30

Sex : F

Contact No. :

Emergency Contact No. :

Address :

OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine Check up.

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

..... ડૉક્ટરને મારી સારવાર રવાની મંજૂરી આપુ છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ફાયદા-ગેરફાયદા, દવાની કે ઇંજેક્શનની આડ અસર અને સારવારની સફળતા, નિષ્ફળતા વિશે મને તથા મારા સંબંધીઓને સમજૂતી આપેલ છે. મેં ડૉક્ટરને મારી શારીરિક સ્થિતિ તથા તેને લગતી દવા વિશે સંપૂર્ણ માહિતી આપેલ છે. જો કોઈપણ સંજોગોમાં સારવાર અધૂરી છોડીશ કે અનિયમિત રહીશ તો તેની નિષ્ફળતા માટે ડૉક્ટર કે ચારુસેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની ડિપોઝીટ પેટે અપાયેલ રકમ મેળવવા માટે હકદાર રહીશ નહીં. આ સંમતિ હું સ્વેચ્છાએ કોઈપણ દબાણ વગર આપું છું.

તારીખ : _____

સમય : _____

_____

દર્દી / સગાની સહી

CONSENT

..... 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 : NAD

Final Diagnosis : _____

Treatment Plan : _____

Date : _____

Time : _____

Name of Doctor Palgu

Signature : _____

CHRF/DENTAL/5016