

ECHOCARDIOGRAPHY REPORT

Name : Himanshu .V. Parekh
 Regn.No. : CH-2024-0054214
 Age/Sex : 38 Years/Male Date: 08/03/2024

Study :

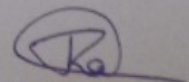
Structure	Patient Value	Normal Value
Aortic Valve annulus	28mm	<40 mm
Aortic valve Cusp separation	16mm	<18 mm
Left atrium	30mm	<40 mm
EPSS	05mm	<6 mm
Inter Ventricular Septum (diastole)	11mm	09 mm - 12 mm
Posterior Wall (diastole)	11mm	10 mm - 12 mm
LVID (diastole)	48mm	35 mm - 50 mm
LVID (systole)	32mm	24 mm - 35 mm
Ejection Fraction	60%	55 - 60 %

Doppler Study :

Structure	Patient Value	Structure	Patient value
Mitral Valve E Wave	0.5m/s	Aortic Valve Velocity	1.0m/s
A Wave	0.8m/s	Peak aortic valve Grad	
Peak/Mean MVG		Pulmonary valve velocity	0.7m/s
MVA		Tricuspid Valve Gradient	

Impression:

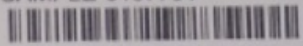
Normal Left Ventricle
 Normal LV systolic function, LVEF ~ 60 % (no RWMA at rest)
 Normal Diastolic function
 No evidence of visual Clot or vegetation
 Normal Pericardium





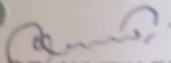
CHARUSAT HOSPITAL




Patient Name :	HIMANSHU VISHNUBHAI PAREKH	Sample No. :	SAMPLE-0107731 
Patient ID :	CH-2024-0054214	Visit No. :	OPD/2024/03/0000414
Age/Sex :	38y/Male	Call. Date :	08-Mar-2024 10:55
Referred By :	KRUNAL VYAS	S. Coll. Date :	08-Mar-2024 15:07
Ward :	-	Report Date :	08-Mar-2024 15:09

PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	111.0 mg/dl [NORMAL]	100 - 140


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Patient Name :	HIMANSHU VISHNUBHAI PAREKH	Sample No. :	SAMPLE-0107721 
Patient ID :	CH-2024-0054214	Visit No. :	OPD/2024/03/0000414
Age/Sex :	38y/Male	Call. Date :	08-Mar-2024 10:55
Referred By :	KRUNAL VYAS	S. Coll. Date :	08-Mar-2024 11:29
Ward :	-	Report Date :	08-Mar-2024 13:38

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	13.3 gm/dl [LOW]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	5.01 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	8480 /c.mm [NORMAL]	4000 - 10000

Platelet count

Investigation	Result	Normal Value
Platelets	3.69 Lakh/cmm [NORMAL]	1.5 - 4.5

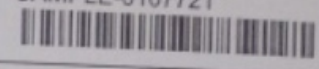
WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	65 % [NORMAL]	40 - 70
Lymphocytes	27 % [NORMAL]	20 - 40
Eosinophils	02 % [NORMAL]	1 - 6
Monocytes	06 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	22.7 mg/dl [NORMAL]	15 - 40

S.Creatinine

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Investigation	Result	Normal Value
Serum Creatinine	0.75 mg/dl [LOW]	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	4.76 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

ESR

Investigation	Result	Normal Value
ESR - After One Hour	10 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

Blood Group

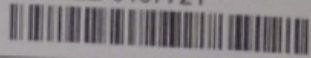
Investigation	Result	Normal Value
ABO :	B	
Rh :	Positive	

FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar :	98.3 mg/dl [NORMAL]	70 - 110

HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	148.4 mg/dl	

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Hb A 1c

6.8 %

> 8 : Action Suggested
 7-8 : Good Control
 < 7 : Goal
 6-7 : Near Normal Glycemia
 < 6 : Non-diabetic Level

Comments

Hb A1C also known as Glycosylated 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 6-8 week and provides a much better indication of longterm glycemic control than blood glucose determination.
 This Reaction is irreversible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications), nephropathy(Kidney-complications) & neuropathy(nerve 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 :	3.11 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3


Investigation	Result	Normal Value
T3-Triiodothyronine :	1.59 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

T4

Investigation	Result	Normal Value
T4-thyroxine :	85.6 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

LIPID PROFILE


Investigation	Result	Normal Value
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Serum Cholesterol (Chol) :	98.4 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	94.2 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	28.6 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	50.12 mg/dl	
VLDL :	19.68 mg/dl [NORMAL]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	1.75 - [NORMAL]	< 3.5
TC / HDL Ratio :	3.44 - [LOW]	4.0 to 6.0
LDL (DIRECT) :	54.9 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)

LIVER FUNCTION TEST

Investigation	Result	Normal Value
Total Bilirubin :	0.77 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.22 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	30.6 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	15.9 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	136.2 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0

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Total Protein (TP) :	7.5 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) :	0.55 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.2 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 :	20 ml	
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Acidic -	
Specific Gravity :	1.015 -	
Chemical Examination :		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	
Acetone :	Absent -	
Urobilinogen :	Absent -	
Microscopic Examination :		
Pus Cells :	1-2 -	
RBCs :	Absent -	
Epithelial cells :	2-3 -	



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


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Casts : Absent -

Crystals : Absent -

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DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR	INVESTIGATION
08-03-2024	HIMANSHU V PAREKH	38Y	M	BODY PROFILE	UM-TOTAL ABDOMEN USG

USG ABDOMEN report.

Liver: show evidence of normal size, parenchymel echotexture & no evidence of focal solid or cystic mass lesion seen. Normal hepatic vasculature seen with no evidence of intrahepatic biliary dilatation seen.

Gall bladder: is physiologically distended with no evidence of calculus or sludge. Thickness of gall bladder wall is normal with no evidence of pericholecystic fluid collection. CBD, portal vein & splenic vein size are normal.

Spleen: size & parenchymel echotexture is normal with no focal mass lesion seen.

Pancreas: show evidence of normal size & parenchymel echotexture with no evidence of focal mass lesion.

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

Right kidney: show evidence of normal size, position, corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen. No evidence of focal solid or cystic mass lesion seen.

Left kidney: show evidence of normal size, position, corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen. No evidence of focal solid or cystic mass lesion seen.

Bladder: walls are normal & no evidence of stone or mass seen.

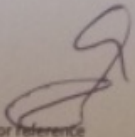
Prostate: show evidence of normal size & parenchymel echotexture. No evidence of ascitis or abnormal bowel loops seen.

Size cm app

Right	Left
Kidney	Kidney
8.33X3.66	9.78X5.0

COMMENTS:

No abnormality detected.

Thanks for Reference

 DR KIRTI C THAKKAR
 M.B.B.S.D.M.R.D

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
08-03-2024	HIMANSHU V PAREKH	M	BODY PROFILE	X-RAY

X-ray CHEST PA view.

No evidence of consolidation or infiltration seen involving both lungs.

Costophrenic sinuses are clear.

Vascular shadows are normal on both sides.

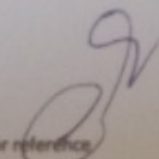
Hilar shadows show evidence of normal size, position & opacity.

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.


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

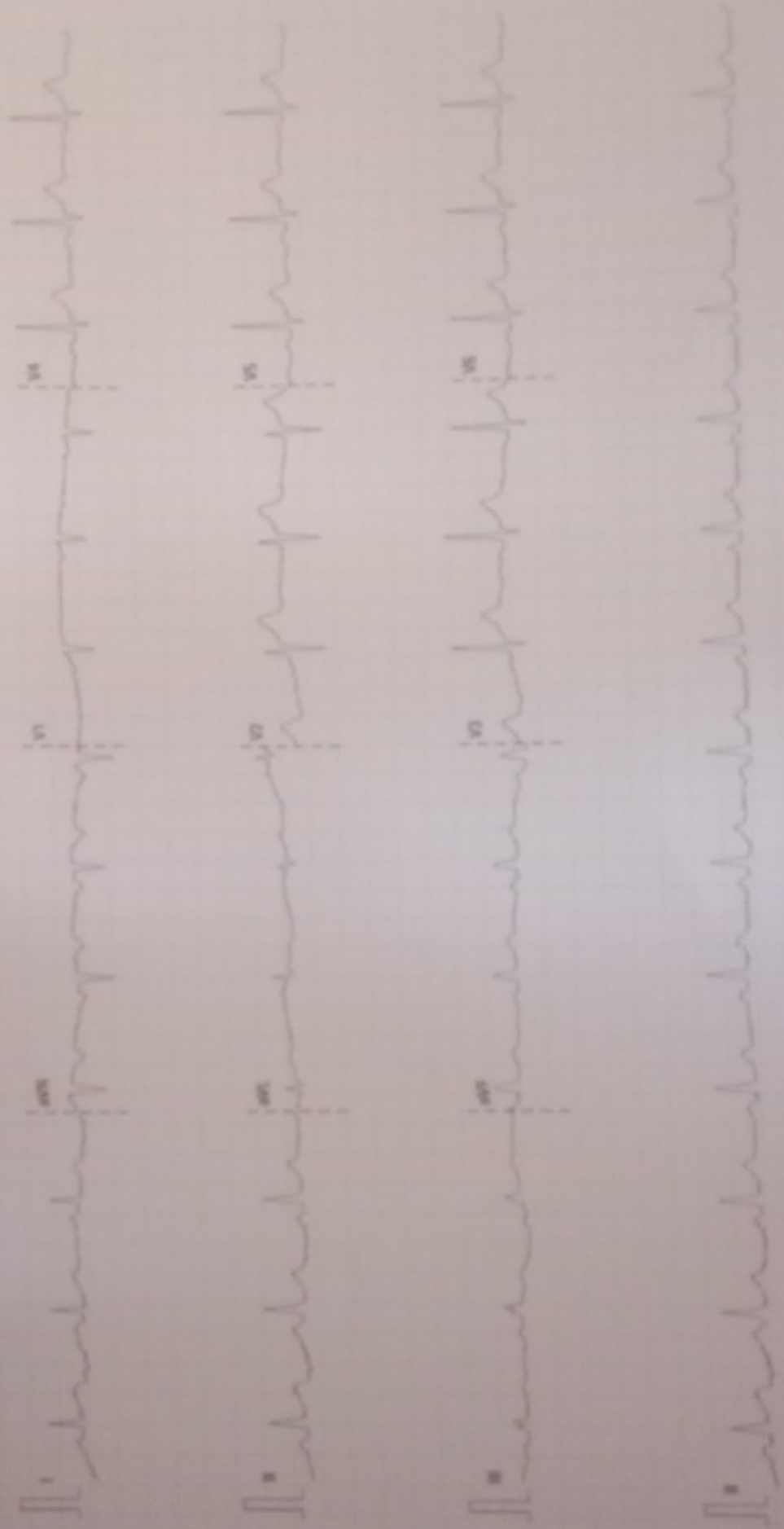
ID: 00542114
Name: Parvath, Hemachand V
Age: 28 Years
Gender: Male

08-03-2024 11:25:08 AM

Heart Rate: 80 bpm
PR Interval: 150 ms
QRS Duration: 76 ms
QT/QTc Interval: 342/377 ms
P/QRS/T Axis: 43/53/49 deg
STc Analysis

Sinus rhythm

Unconfirmed Diagnosis



02-03-2024 11:25:08 AM

CHARLES M. HOSPITAL

808 25 14

52 14

18 mmHg

25 mmHg



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



M.O.
Dr. Pavan Sir

Date & Time : 08-07-24

Registration No. : CH-2024-0054219

Name : Himansh V. Parakh Contact No. : (M) _____

Age : 38 Sex : M (O) _____

Address : _____

B.P. : 130/80mm Pulse : 90/min SpO₂ : 98% on R2

BMI : _____ Height : _____ Weight : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : Health down

no any reason

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

HABBITTS :

- Smoking
- Alcohol
- Tobacco
- Others (Specify) : _____

CHRS/OPD/5083



DENTAL REGISTRATION FORM



Date & Time : 08-03-24

Registration No. : CH-2024-0054214

Name : Himanshu V. Parekh

Contact No. : _____

Age : 38

Emergency Contact No. : _____

Sex : M

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

સંમતિ પત્રક

હું ડાક્ટરને મારી સારવાર કરવાની મંજૂરી આપું છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ફાયદા-ગેરફાયદા, દવાની કે ઇન્જેક્શનની આડ અસર અને સારવારની સફળતા, નિષ્ફળતા વિશે મને તથા મારા સંબંધીઓને સમજૂતી આપેલ છે. મેં ડાક્ટરને 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 ડાક્ટર કે આરસેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની કિંમતો પેટે અપાયેલ રકમ મેળવવા માટે હકકદાર રહીશ નહીં. આ સંમતિ હું સ્વેચ્છાએ કોઈપણ દબાણ વગર આપું છું.

તારીખ : _____

સમય : _____

દર્દી / સગાની સહી

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 : _____

Treatment Plan : No treatment needed.

Date : 8/3/24

Name of Doctor : Dr. Shashwath

Time : _____

Signature : _____

CHB/DENTAL/0016



OPHTHALMIC REGISTRATION FORM



Reg. No. : CH-2024-0057212

Date : 08-03-24

Patient's Name : Himanshu V. Parekh Age : 38/M

Address : _____

Telephone No. : _____ Mobile No. : _____

Referred by / Care of : _____

Profession : no night driving problem since 5 months

Type or 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 / Nil / RE / LE / BE

Family History : Glaucoma / RP / DM / _____

SYSTEMIC : DM / HT / IHD / COPD / PROSTATE / WROID / ALLERGY / SMOKING / ALCOHOL Nil!
NO glasses since 20 yrs. glasses 1 yr old.

EYE DETAILS :

	RE	LE
V/A with PH	<u>6/18</u>	<u>6/12</u>
IOP	<u>14 mmHg</u>	<u>12 mmHg</u>
OWN GLASS :	<u>-2.00 / -0.50 x 180</u>	<u>-4.75 / -1.00 x 68</u>
AR :	<u>-6.00 / -0.75 x 30</u>	<u>-6.50 / -0.25 x 155</u>

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	-6.00	-	6/9	-6.00	-	6/9
Nr.						
Comp						

Remark : _____ Bifocal / Distant / Near only / Constant / Progressive / Photocromatic

Signature : _____

CHRF/OPHTH/0085

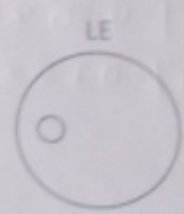
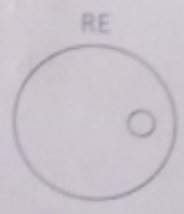
- | | | |
|---------------|--|--|
| Lid | (N) Swelling / Style / Chalazion / Entropion / Ectropion
Blepharitis / Meibomianitis | (N) Swelling / Style / Chalazion / Entropion / Ectropion
Blepharitis / Meibomianitis |
| Lacrimal : | (N) Swelling / Patent / Partially Patent / Block
Punctual Stenosis | (N) Swelling / Patent / Partially Patent / Block
Punctual Stenosis |
| Conjunctiva : | Chemosis / Congestion / Pterygium / Pingecula | Chemosis / Congestion / Pterygium / Pingecula |
| Cornea : | (N) Clear / Vasculin / Arcus Opacity / Adh Leucoma
Epi Defect / Ulcer / Keratitis / Spk | (N) Clear / Vasculin / Arcus Opacity / Adh Leucoma
Epi Defect / Ulcer / Keratitis / Spk |
| A/C : | (N) Shallow / Deep / Hypopyon / Hyphema | (N) Shallow / Deep / Hypopyon / Hyphema |
| Pupil : | (N) Non / Semi Full / Dilated / Synechia / Exfo
Pbi / Bi / Irregular / Synechia / Atrophy / Membrane | (N) Non / Semi Full / Dilated / Synechia / Exfo
Pbi / Bi / Irregular / Synechia / Atrophy / Membrane |
| Cataract : | (N) Cortical / Post Polar / Post subcapsular
Nuclear : Grey / Yellow / Brown / Black / Mature
Pseudophakia / Aphakia | (N) Cortical / Post Polar / Post subcapsular
Nuclear : Grey / Yellow / Brown / Black / Mature
Pseudophakia / Aphakia |
| Ant Vit : | (N) Cells Tobacco Dusting / | (N) Cells Tobacco Dusting / |
| Glow : | (N) Normal / White / Yellow / | (N) Normal / White / Yellow / |



SPECIAL NOTE

FUNDS

- | | | |
|------------|---|---|
| Media | Clear / VH / Vitritis / Asteroid / Synchisis | Clear / VH / Vitritis / Asteroid / Synchisis |
| Disc | (N) Wni / Pallor / Edema / Cupping _____ / NVD | (N) Wni / Pallor / Edema / Cupping _____ / NVD |
| B/V | (N) NAD / BRVO / BRAD / CRVO / CRAG
(N) Hemi CRVO / CSCR / ERM / CME / CSME | (N) NAD / BRVO / BRAD / CRVO / CRAG
(N) Hemi CRVO / CSCR / ERM / CME / CSME |
| Macula : | FR N / DULL / CSCR / ERM / CME / CSME
(N) MH / LMH / CNVM / DRUSEN / GA / HMD
HGE / ATROPHY / PIGMENT / IIT / ESUDATES | FR N / DULL / CSCR / ERM / CME / CSME
(N) MH / LMH / CNVM / DRUSEN / GA / HMD
HGE / ATROPHY / PIGMENT / IIT / ESUDATES |
| Cataract : | N / MYOPIA / TEES / PIGMENT / HGE / CWS /
(N) EXUDATES / HGE / -VH / SUBHYALOID / TERA / RD /
CD / COLOBOMA / BUCKLE / LASER / CRYO / MARKS | N / MYOPIA / TEES / PIGMENT / HGE / CWS /
(N) EXUDATES / HGE / -VH / SUBHYALOID / TERA / RD /
CD / COLOBOMA / BUCKLE / LASER / CRYO / MARKS |



REMARK / INVESTIGATION : Dilatation follows up.

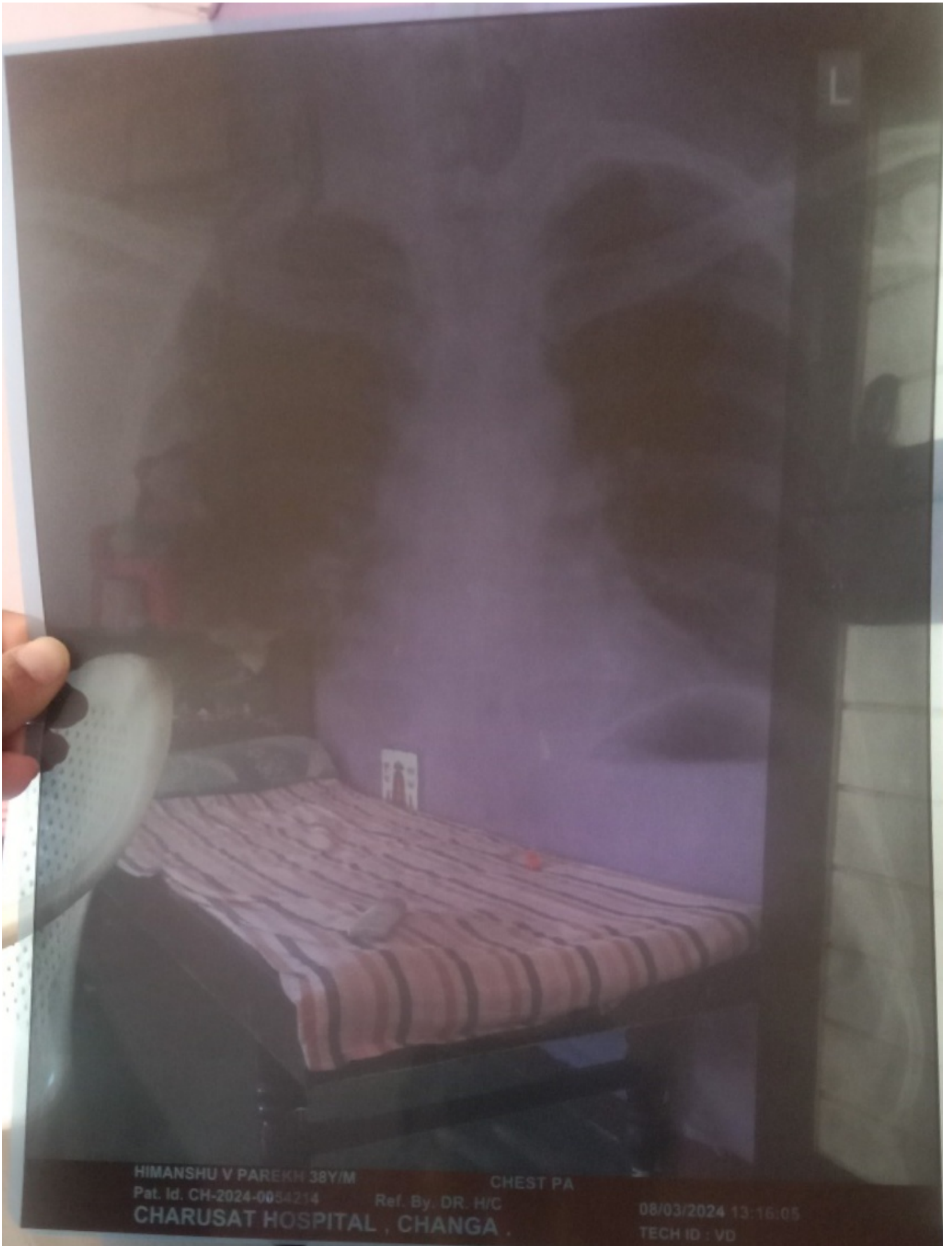
GONIO / OM X X

- COLOR VISION
FIELD OF VISION
FFA / OCT
BSCAN / ASCAN

K READING K1 u4.00 @ 15
 K2 u5.25 @ 15

 K1 u4.75 @ 120
 K2 u5.75 @ 170

IOL POWER _____



HIMANSHU V PAREKH 38Y/M

CHEST PA

Pat. Id. CH-2024-0054214

Ref. By. DR. H/C

08/03/2024 13:16:05

CHARUSAT HOSPITAL, CHANGA.

TECH ID : VD