

Patient Name : Kristinaben Ambalal Vankar	Sample No. : 24000631
Patient ID : CH-2024-0059138	Visit No. : OPD/2024/11/0000289
Age / Sex : 35y / Female	Coll. Date : 11/11/2024 09:13
Visit Doctor : DR. NAIK BHATIA	S. Coll. Date : 11/11/2024 09:37
Ward : -	Report Date : 11/11/2024 12:03

HEMATOLOGY

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	12.40 gm/dl	12.0 - 16.0 g/dl

WBC

Investigation	Result	Normal Value
WBC Count	7950 /c.mm	4000.0 to 10000.0 /c.mm

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	70.90 %	40.0 - 70.0 %
Lymphocytes	24.90 %	20.0 - 40.0 %
Eosinophils	1.40 %	1.0 - 6.0 %
Monocytes	2.00 %	2.0 - 10.0 %
Basophils	0 %	0.0 - 1.0 %
Total	100.00	

Platelet count

Investigation	Result	Normal Value
Platelets Count:	311000 /cmm	1,50,000 - 4,50,000 /cmm


Blood Group

TEST	RESULT
Blood Group	A
Rh Factor	Positive

ESR

Investigation	Result	Normal Value
ESR After One Hour	22 mm	4.0 - 7.0 mm

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


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

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BIOCHEMISTRY

FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar	93.6 mg/dL	70 to 110 mg/dL

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	21.9 mg/dl	15 - 40 mg/dl

S.Creatinine

Investigation	Result	Normal Value
Creatinine	0.7 mg/dl	F : 0.5 to 1.2

URIC ACID

Investigation	Result	Normal Value
Uric Acid	5.19 mg/dl	1.5 to 6.0 mg/dl

BUN

Investigation	Result	Normal Value
BUN	11.67 mg/dl	8.0 - 23.0 mg/dl

IMMUNOLOGY

TSH

Investigation	Result	Normal Value
TSH	1.87 uIU/ml	0.34 - 4.5 uIU/ml


T3

Investigation	Result	Unit	Reference Range
T3-Triiodothyronine	1.66 ng/ml		0.69 - 2.15 ng/ml

T4

Investigation	Result	Normal Value
T4 Free	72.3 ng/dl	52.0 - 127.0 ng/dl

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BIOCHEMISTRY


LIVER FUNCTION TEST

Parameter	Result	Normal Value
ALT	37 IU/L	0 to 40 IU/L
AST	31.75 U/L	0.0 to 45.0 U/L
Total Bilirubin	0.54 mg/dl	0.2 - 1.3 mg/dl
Direct Bilirubin	0.18 mg/dl	0.0 to 0.3 mg/dl
Indirect Bilirubin	0.36 mg/dl	0.2-0.90 mg/dl
Alkaline Phosphatase	86.62 IU/L	15 - 100 years 37.0 - 147.0 IU/L
Total Protein	7.3 gm/dl	5.0 - 10.0 gm/dl
Albumin	4.2 gm/dl	3.5 to 5.0 gm/dl
Globulin	3.1 gm/dl	2.4 to 3.5 gm/dl
A/G Ratio	1.35	1.1 to 2.5

LIPID PROFILE

Parameter	Result	Normal Value
Total Cholesterol	174.77 mg/dl	Low risk : < 200 Moderate risk : 200 - 239 High risk : > or = 240
Triglyceride	102.39 mg/dl	Normal : < 150.0 Borderline high : 150 - 199 High : 200 - 499 Very High : > or = 500
LDL Cholesterol	36.97 mg/dl [L]	Negative risk : > or = 60 High risk : < 40
HDL Cholesterol	117.32 mg/dL	Up to 0 to 34 mg/dl
LDL/HDL Ratio	20.48 mg/dl	0.5 to 3.0(Low) 3.0 to 6.0(Moderate) > 6.0(High)
Total Chol / HDL Ratio	3.17	Low Risk : 3.3 to 4.4 Average Risk : 4.4 to 7.1 Moderate Risk : 7.1 to 11.0 High Risk : > 11.0
Total Lipids	473.74 mg/dl	400 to 700 mg/dl

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CONSULTANT PATHOLOGIST


DR. KETAN KAPADIA
CONSULTANT PATHOLOGIST



LALITABEN P. D. PATEL OPD SERVICES

REGISTRATION FORM (OPD)



Dr. Alpash

Date & Time : 11-11-24

Registration No. : 11-24-0959132

Name : Kristinaben A. Vankar Contact No. : (M) _____

Age : 35 Sex : F (O) _____

Address : _____

B.P. : 110/70 Pulse : 79 SpO₂ : 99

BMI : _____ Height : _____ Weight : 72

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : for routine checkup

UMP - 11/11/24, no fresh complaints.

MIH - 5-6 days, 28-20

CASE ANALYSIS

Past History : MIH - C₂ P₂ A₂ L₂

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) : _____

C:\BET\OPD\0283

BMI : _____

Height : _____

SpO₂ : _____

Weight : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : _____
 - for routine checkup
 - No fresh complains.
 CMP - 11/11/24.
 MIM - 5-6 days,
 2820

CASE ANALYSIS

Past History : _____
 OIH - C₂ P₂ A₂ L₂ -

Present History : _____

G/E Vitals : _____

Systemic Examination : _____

FAMILY HISTORY :

- Diabetes
- IHD
- Hypertension
- Others (Specify) : _____

PATIENT'S MEDICAL/OTHER HISTORY :

- | | | |
|---------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> IHD | <input type="checkbox"/> T.B. |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Food Allergy | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Drug Allergy | <input type="checkbox"/> Pregnancy | |

HABBITTS :

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

DENTAL REGISTRATION FORM



Date & Time : 11-11-24

Registration No. : CH-24-0059138

Name : Kristinaben A. Van Kerk Contact No. : _____

Age : 35 Emergency Contact No. : _____

Sex : F 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 ડૉક્ટરને મારી સારવાર કરવાની મંજૂરી આપું છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ફાયદા-ગેરફાયદા, દવાની કે ઈન્જેક્શનની 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 ચાર્જેડ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની કિંમતો પેટે અપાયેલ રકમ મેળવવા માટે હક્કદાર 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 : Cl-I caries 76/7

Treatment Plan : filling 76/7, Scaling

Date : 10:50 AM 11/11/24 Name of Doctor Dr. Hinal

Time : _____ Signature : [Signature]

CHARUSAT/20216

DENTAL DEPARTMENT

Follow up

DATE	DOCTOR'S NAME	ESTIMATE	AMOUNT PAID	AMOUNT DUE
11/11/24	Adv: ct-I filling #6/7 Scaling			

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
11-11-2024	KRISTINADEN S VANKAR	F	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 JITENDRA THAKKAR
M.S.B.S, D.M.R.D

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
11-11-2024	KRISTINABEN A VANKAR	F	BODY PROFILE	UF-TOTAL ABDOMEN USG

USG OF THE ABDOMEN/ PELVIS WAS PERFORMED

The liver is normal in size and mild fatty 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 well distended 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 antverted, normal size. IUCD SEEN IN UTERUS.
The endometrium is in the midline. No focal myoma is seen.
Both the ovaries are normal 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	Left
Kidney	Kidney
10.5X3.3	10.6X5.0

IMPRESSION :

POSSIBILITY OF MILD FATTY LIVER PARENCHYMEL CHANGES

NO OTHER OBVIOUS ABNORMALITY DETECTED.

Thanks for reference
DR. KIMLAKHANKAR
M.B.B.S, D.M.R.D

CHARUSAT

PATIENT NAME	SEX	REFERRED BY
KIRTIJEE A VANKAR	F	BODY PROFILE

DOMEN/ PELVIS WAS

il in size and mild fatty
a hepatic biliary radicle
all bladder is well diste

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verted, normal size.IL
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in the pouch of doug

MILD FATTY LIVER I

IS ABNORMALITY I

