



**MEDICAL CERTIFICATE**

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

Signature of Candidate / Guardian: omkar kandekar

Signature of Doctor: R.M. Registration No: 2011/05/1654

Place: pune

Date: 06/06/2014

Dr. Rizwan Malik  
MBBS, MD (Medicine)  
Consultant Physician  
MMC Reg. No: 2011/05/1654  
Seal:

**Place Label Here**  
 Pt. Name: \_\_\_\_\_  
 UMR: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 IP: \_\_\_\_\_  
 If label not available, write Pt. Name, IP No., Sex, Date, Name of Treating Physician

**OPD Nursing Assessment - Adult**

Name: Omkar Kamekar Date of Birth: \_\_\_\_\_ Age/Sex: 23/m UMR No.: 23703

**Assessment :**

Height: 168 cms Weight: 72.5 kg. BMI: \_\_\_\_\_ Respiration: 20/min Pulse H/R: 88/min  
 BP: 133/79 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 / Gain-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 Surgeries 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>Shweta</u>	<u>024523</u>	<u>SK</u>	<u>4/6/24</u>



04-06-2024 11:30:43 AM

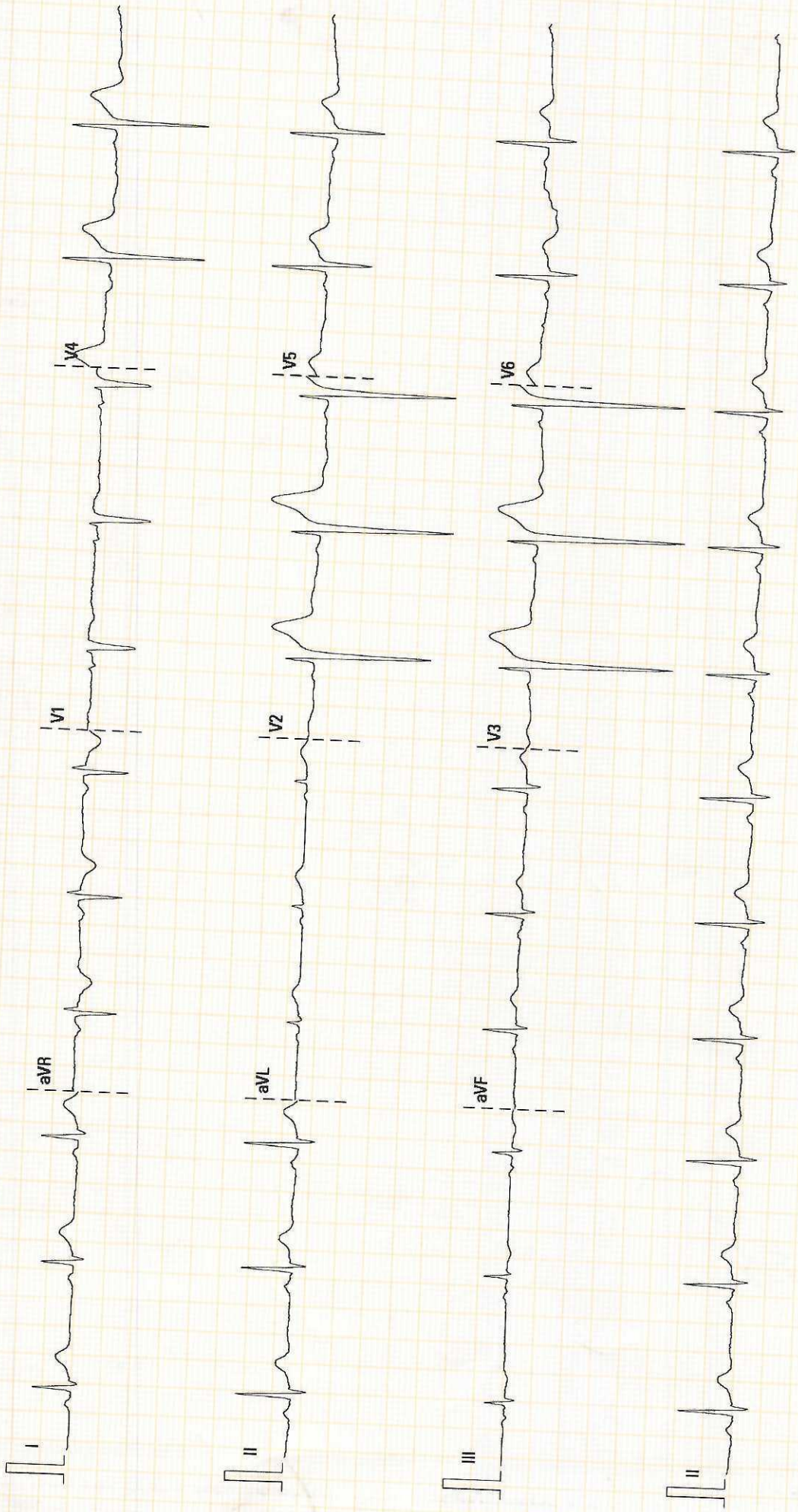
ID: 2024060411305351  
Name: Ankar Kandeekar  
Age: 23 Years  
Gender: Male

Vent. Rate 68 bpm  
PR Interval 134 ms  
QRS Duration 88 ms  
QT/QTc Interval 354/368 ms  
P/QRS/T Axes 36/52/25 deg  
QTc:Hodges

Sinus rhythm

Normal ECG

Unconfirmed Diagnosis



25 mm/s 10 mm/mV 50 Hz-- BDR 35 Hz

MEDICOVER KLE PUNE

02.10.00/V28.4.1

SN:FN-26035806



Mr. Omkar Kandekar

231M

No H/O DM/HITn/BAIDA

No DOE / chest pain

No addiction



416124

RS - BC - vesi

AM - SIC (N)

CNS - NAD

1  
Dr. Sondankar

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





**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mr. OMKAR KANDEKAR	<b>Age /Gender</b> : 23 Y(s)/Male
<b>Bill No/ UMR No</b> : PUBC23848/PUU23703	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 04-Jun-24 11:04 am	<b>Report Date</b> : 04-Jun-24 12:53 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
<b>CUE (COMPLETE URINE EXAMINATION)</b>			
<b><u>GENERAL EXAMINATION</u></b>			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.025	1.010 - 1.030
PH		6.0	4.5 - 8.0
<b><u>CHEMICAL EXAMINATION</u></b>			
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
<b><u>MICROSCOPIC EXAMINATION</u></b>			
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

Patient Name : Mr. OMKAR KANDEKAR
Age /Gender : 23 Y(s)/Male
Bill No/ UMR No : PUBC23848/PUU23703
Received Dt : 04-Jun-24 11:04 am
Referred By : Dr. GENERAL MEDICINE CONSUL
Report Date : 04-Jun-24 12:53 pm

FINAL REPORT

Table with columns: Parameter, Specimen, Result Values, Biological Reference, Method. Includes sections for Complete Blood Count, Differential Count, Peripheral Smear Examination, and Blood Grouping and Rh.

\*\*\* End Of Report \*\*\*

System Name : M



**DEPARTMENT OF LABORATORY**

**Patient Name** : Mr. OMKAR KANDEKAR  
**Age / Gender** : 23 Y(s)/Male  
**Bill No/ UMR No** : PUBC23848/PUU23703  
**Referred By** : Dr. GENERAL MEDICINE CONSUL  
**Received Dt** : 04-Jun-24 11:07 am  
**Report Date** : 05-Jun-24 11:29 am

Parameters                      Specimen    Result                      Biological Reference In Method

System Name : M



**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mr. OMKAR KANDEKAR	<b>Age / Gender</b> : 23 Y(s)/Male
<b>Bill No/ UMR No</b> : PUBC23848/PUU23703	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 04-Jun-24 11:18 am	<b>Report Date</b> : 04-Jun-24 01:09 pm

**FINAL REPORT**

Specimen

**BUN(BLOOD UREA NITROGEN)**

BUN (Blood Urea Nitrogen.)	5.7	7.0 - 21.0 mg/dL	Calculated
<b>SERUM CREATININE</b>	0.88	0.8 - 1.3 mg/dL	Jaffe
SGPT (ALT)	21.9	<= 41 U/L	Enzymatic
<b>SERUM BILIRUBIN TOTAL</b>	0.79	0.1 - 1.2 mg/dL	Colorimetric Diazo Method
DIRECT BILIRUBIN	0.30	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN	0.49	<= 1.0 mg/dL	

**FBS (FASTING BLOOD SUGAR)**

<b>FASTING BLOOD GLUCOSE</b>	92.6	Normal Range : 70 - 99 mg/dL	Hexokinase
		Impaired Glucose tolerance : 100 - 125 mg/dL	
		Diabetes Mellitus : - > 126 mg/dL	

**PPBS (POST PRANDIAL BLOOD SUGAR)**

<b>PPBS (POST PRANDIAL BLOOD SUGAR )</b>	125.6	Normal range : < 140 mg/dL	Hexokinase
		Impaired glucose tolerance : <= 199 mg/dL	
		Diabetes Mellitus : >= 200 mg/dL	

\*\*\* End Of Report \*\*\*

**Lab Incharge**

**Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB**  
**CONSULTANT RHEUMATOLOGIST**

Test results related only to the item tested.

No part of the report can be reproduced without written permission of the laboratory.

System Name : M





<b>Patient ID:</b>	PUU23703	<b>Patient Name:</b>	OMKAR KANDEKAR
<b>Age:</b>	23 Years	<b>Sex:</b>	M
<b>Accession Number:</b>	PUBC23848-PK	<b>Modality:</b>	DX
<b>Referring Physician:</b>	HC	<b>Study:</b>	CHEST
<b>Study Date:</b>	04-Jun-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**  
(typed & printed by sk)

 <b>Dr. Sunita Shewale</b> Consulting Radiologist MBBS, DMRE Date: 04-Jun-2024 12:09:56
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Date:- 04/06/24

Name:- Mr. Omkar Kandekar.

Age/Sex:- 23/M.

S/B: Ophthalmologist: Dr Kirti Mane.

Eye	UCVA	PGVA	Pinhole	NEAR	COLOR VISION
Right	6/6	no glasses	>6/6	No cout glasses	WNL (16/16)
Left	6/6				

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