

**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: Kalyani Kshatirya Date of Birth : \_\_\_\_\_ Age/Sex: 36/F UMR No.: 19936

**Assessment :**

Height: 160 cms Weight: 38.9 kg. BMI: \_\_\_\_\_ Respiration: 20/min Pulse H/R: 68/min

BP: 97/61 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>Nedhi</u>	<u>028002</u>	<u>N.</u>	<u>08/03/24</u>



**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mrs. KALYANI KSHATRIYA	<b>Age / Gender</b> : 36 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC20037/PUU19936	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 12-Mar-24 04:04 pm	<b>Report Date</b> : 12-Mar-24 05:26 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	20	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.020	1.010 - 1.030
PH		5.0	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**

<b>Patient Name</b> : Mrs. KALYANI KSHATRIYA	<b>Age / Gender</b> : 36 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC20037/PUU19936	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 12-Mar-24 04:03 pm	<b>Report Date</b> : 12-Mar-24 05:26 pm

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>COMPLETE BLOOD COUNT</b>				
<b>COMPLETE BLOOD COUNT</b>				
HAEMOGLOBIN	EDTA	13.3	11.7 - 15.5 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		7320	4000 - 11000 Cells/cumm	Impedance
PLATELET COUNT		307000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.61	3.9 - 5.0 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		38.3	36 - 46 %	Analogical integration
MCV		83.2	82 - 95 fl	Calculated
MCH		28.9	27 - 32 pg	Calculated
MCHC		34.8	32 - 36 g/dL	Calculated
RDW(cv)		12.2	11.5 - 14.0 %	Calculated
MPV		8.2	6 - 9.5 fl	Calculated
<b>DIFFERENTIAL COUNT</b>				
NEUTROPHILS	EDTA	64.1	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		23.7	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		2.9	00 - 06 %	DHSS/Microscopy
MONOCYTES		8.9	00 - 10 %	DHSS/Microscopy
BASOPHILS		0.4	00 - 01 %	DHSS/Microscopy
<b>PERIPHERAL SMEAR EXAMINATION</b>				
RBC morphology	EDTA	Normocytic Normochromic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate On Smear		
<b>BLOOD GROUPING AND RH</b>				
BLOOD GROUP	Blood	" O "		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		8	0 - 20 mm/1st hour	WESTERGREN'S METHOD

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







**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mrs. KALYANI KSHATRIYA	<b>Age / Gender</b> : 36 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC20037/PUU19936	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
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<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
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System Name : M



**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mrs. KALYANI KSHATRIYA	<b>Age / Gender</b> : 36 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC20037/PUU19936	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSULTANT
<b>Received Dt</b> : 12-Mar-24 04:03 pm	<b>Report Date</b> : 12-Mar-24 05:26 pm

**FINAL REPORT**

Specimen

<b>BUN(BLOOD UREA NITROGEN)</b>			
BUN (Blood Urea Nitrogen.)	10.9	7.0 - 21.0 mg/dL	Calculatead
<b>HBA1C (GLYCOSYLATED HAEMOGLOBIN)</b>			
HBA1C	4.9	Normal < 5.7 Pre diabetic 5.7 - 6.5 Diabetic > 6.5 : 5.7 - 6.5	TINIA
<b>PPBS (POST PRANDIAL BLOOD SUGAR)</b>			
PPBS (POST PRANDIAL BLOOD SUGAR )	64.5	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase
<b>LIPID PROFILE</b>			
TOTAL CHOLESTEROL	142.6	Borderline High : 200 - 240 mg/dL High risk : > 240 mg/dL Desirable: : < 200 mg/dL	Enzymatic
HDL CHOLESTEROL	46.0	Major risk factor for heart disease : : < 40 mg/dL Negative risk factor for heart disease : : > 60 mg/dL	Homogeneous enzymatic colorimetric assay
LDL CHOLESTEROL	82.6	Optimal - < 100 mg/dL	Homogeneous enzymatic colorimetric assay
VLDL SERUM TRYGLYCERIDES	14 70.0	6 - 38 mg/dl	Calculation
CHO/HDL RATIO	3.1	Borderline High 150 - 199 mg/dL	Enzymatic colorimetric test
LDL/HDL RATIO	1.8	Normal - < 3.5	Calculation
COMMENT		2.5 - 3.5	Calculation
		10-12 hours fasting is mandatory for Lipid profile parameters. If not ,Values may not be accurate.	
<b>FBS (FASTING BLOOD SUGAR)</b>			
FASTING BLOOD GLUCOSE	82.7	Normal Range 70 - 99 mg/dL	Hexokinase
SERUM CREATININE	0.69	0.6 - 1.2 mg/dL	Jaffe
<b>T3,T4 AND TSH</b>			
T3	1.08	0.8 - 2.0 ng/mL	Method : ECLIA
T4	9.02	5.1 - 14.1 ug/dL	Method : ECLIA





**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mrs. KALYANI KSHATRIYA	<b>Age /Gender</b> : 36 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC20037/PUU19936	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 12-Mar-24 04:04 pm	<b>Report Date</b> : 12-Mar-24 05:26 pm

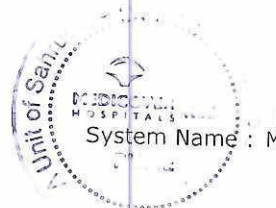
<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
TSH (THYROID STIMULATING HORMONE)		3.25	0.27 - 4.2 uIU/mL Method : ECLIA
<b>LFT(LIVER FUNCTION TEST)</b>			
TOTAL BILIRUBIN		0.37	0.1 - 1.2 mg/dL Colorimetric diazo method
DIRECT BILIRUBIN		0.18	<= 0.20 mg/dL Method: Diazo Method
INDIRECT BILIRUBIN		0.19	<= 1.0 mg/dL Calculated
SGPT (ALT)		30.1	<= 33 U/L Enzymatic
SGOT (AST)		23.3	<= 32 U/L Enzymatic
ALKALINE PHOSPHATASE (ALP)		128	35 - 104 U/L PNPP
TOTAL PROTEINS		7.45	6.4 - 8.3 g/dL Method : Biuret method
SERUM ALBUMIN		4.83	3.5 - 5.2 g/dL Method : Bromcresol Green (BCG)
GLOBULINS		2.62	1.8 - 3.6 g/dL Calculation
A/G RATIO		1.84	1.1 - 2.2 Calculation
GAMMA GLUTAMYL TRANSFERASE (GGT)		54	6 - 42 U/L Enzymatic colorimetric assay (IFCC)
SERUM URIC ACID		3.9	2.4 - 5.7 mg/dL Enzymatic colorimetric test

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

Lab Incharge

*[Signature]*  
**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.





**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mrs. KALYANI KSHATRIYA	<b>Age / Gender</b> : 36 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC20086/PUU19936	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 12-Mar-24 04:46 pm	<b>Report Date</b> : 12-Mar-24 05:53 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
<b>SERUM ELECTROLYTES</b>				
SERUM SODIUM	SERUM	140.4	136 - 145 mmol/L	ISE
SERUM POTASSIUM		4.05	3.5 - 5.1 mmol/L	ISE
SERUM CHLORIDES		99.7	98 - 107 mmol/L	ISE
BLOOD UREA		23.5	16.6 - 48.5 mg/dL	Urease kinetic

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

**Lab Incharge**

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



System Name : M

Test results related only to the item tested.  
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8/2/2023

Mrs. Kalyani. Keshariya  
361A

P.

Oil ear wax

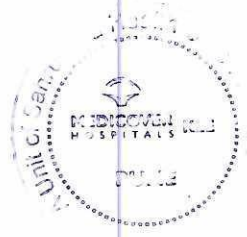
- Waxonit lid  
olive oil ear  
drop.

Solinax - 0 ear drop

5-6 drop 2 times/day  
x 5 days

Surecal D<sub>3</sub> 60K10.

1 — 0  
Morning. after BP &  
milk.  
x 8 days.



L





Date:- 08/03/24

Name:- Mrs. Kalyani Kshatriya.

Age/Sex:- 36/F

S/B: Ophthalmologist: Dr Kish Mane

Eye	UCVA	PGVA	Pinhole	NEAR	COLOR VISION
Right	6/60	6/6 (6.50D sph)			
Left	6/60	6/6 (6.50D sph)	6/6	> N <sub>6</sub> c & cont glasses	> CNAL

Other findings:-

Squint

Nystagmus

Night blindness:-

} no.

Impression:-

Eye exam is within normal limits

for desired fitness for work.

Ro  
(BU) Eld. Soha  
o — o — o x 1mth

Hot fomentation 10 min  
daily x 1mth.

*Dr Kish*  
Dr K. Mane  
2005/05/2708





**DEPARTMENT OF RADIOLOGY**

<b>Patient Name : Mrs. Kalyani Kshatriya</b>	<b>Age : 36 yrs / F</b>
<b>Ref. By : Health check up</b>	<b>OPD/IPD No: PUU:19936</b>
<b>Date of USG: 08/03/2024</b>	<b>Date of Reporting: 08/03/2024</b>

**ULTRA SOUND SCAN OF BOTH BREASTS**

**CLINICAL DETAILS:** Routine screening. Post LSCS status 7 month. Lactational amenorrhea since then.

**FINDINGS:**

Both breasts show normal fibro glandular pattern.

No obvious mass lesion / collection / cyst / abnormal vascularity / probe tenderness in either breast.

No abnormal calcification seen.

Skin and subcutaneous fat pad appear normal.

Nipple, Sub periareolar regions appear normal. No dilated ducts.

Few small axillary lymph nodes measuring 5-6 mm in short axis with intact echogenic hila and symmetrical cortex noted on both sides.

**IMPRESSION:**

**No significant abnormality in sonomammography study at present.**

**ACR BIRADS CATEGORY I - (Negative)**

**Advised clinical correlation and follow up Sonomammography.**

**Dr. Sunita Shewale**  
**Consultant Radiologist**





**DEPARTMENT OF RADIOLOGY**

<b>Patient Name : Mrs. Kalyani Kshatriya</b>	<b>Age : 36 yrs / F</b>
<b>Ref. By : Health check up</b>	<b>OPD/IPD No: PUU:19936</b>
<b>Date of USG: 08/03/2024</b>	<b>Date of Reporting: 08/03/2024</b>

**USG ABDOMEN AND PELVIS**

**CLINICAL DETAILS:** Routine screening. Post LSCS status 7 month.lactational amenorrhea since then.

**FINDINGS:**

**Liver :** It is normal in size. It measures 132 mm along maximum craniocaudal axis. It shows normal surface regularity. It shows normal parenchymal echotexture in both the lobes. No obvious focal lesion is seen. No evidence of intrahepatic biliary radicle dilatation. Common bile duct appears undilated. The hepatic veins and inferior vena cava appears unremarkable. The portal vein appears unremarkable.

**Gall Bladder :** It is partially distended. No evidence of obvious intraluminal calculus/ mass seen. No evidence of obvious wall thickening or pericholic collection.

**Pancreas :** It is well visualised. The head, body and tail appears normal in size and shows homogenous echotexture. The pancreatic duct appears undilated.

**Spleen :** It is normal in size. It measures 89 mm along its maximum length. It shows normal shape and parenchymal echotexture. No obvious focal lesion is noted.

**Kidneys :** Right kidney measures 98 x 29 mm in size & Left kidney measures 92 x 38 mm in size. They appear normal in size, shape, location and axis. They show normal parenchymal echotexture with well maintained corticomedullary differentiation. No evidence of hydronephrosis on either side.No focal lesion or calculus is noted on either side.

**Urinary Bladder:** It is partially distended. No obvious intraluminal calculus/focal lesion is seen.

**Uterus :**It is anteverted in position. It is normal in size and shape. It grossly appears normal. The endometrial echo is central and measures 7 mm in maximum thickness.

**Ovaries :** Both the ovaries are not well visualised. No obvious adnexal mass lesion is seen.

Retro peritoneum isobscured by bowel gases. No obvious enlarged retro peritoneal or mesenteric lymph nodes noted. The visualised bowel loops appear unremarkable. No evidence of obvious bowel wall thickening. No ascites seen.

**IMPRESSION:**

**No sonographically evident intra-abdominal pathology.**

**Clinical correlation recommended.**

**Dr. Sunita Shewale**  
**Consultant Radiologist**

*(Because of technical and technological limitation complete diagnosis cannot be assured on imaging sonography. Sonography has its limitation for evaluation of GIT lesion. Clinical correlation, consultation if required repeat imaging required in the event of controversies.)*







NAME OF PATIENT: MRS. KALYANI NAIR	AGE/SEX: 36YRS/F
REF BY: Dr.PRASHANT SHINDE	DATE: 8/03/2024
PRN NO: PUU19936	WARD : HC

**2D ECHOCARDIOGRAPHY & COLOR DOPPLER STUDY**

All chambers normal sized.  
No regional wall motion anomaly at rest.  
Good LV and RV systolic function, LVEF= 60 %  
IAS/IVS intact.  
All valves normal.  
Great artery origins normal.  
No clot/vegetation/effusion.  
No coarctation of aorta.  
IVC collapsible.

**MEASUREMENTS: -**

Aortic annulus	LA	IVS	PW(D)	LVIDd	LVIDs	LVEF
18	28	9	9	36	23	60%

**COLOR DOPPLER STUDY: -**

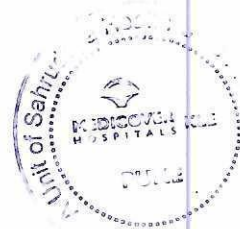
Normal flow velocity patterns across all valves.  
No pulmonary hypertension.

**CONCLUSION:-**

Normal chamber dimensions.  
Good biventricular function. (LVEF = 60%).  
Normal flow velocity patterns across all valves.  
No pulmonary hypertension.  
IVC collapsible.

Dr. PRASHANT SHINDE  
MD.DM. (Cardiology)

Consultant and interventional Cardiologist





Mrs. Kalyani Kshetraya

08/03/24

Came for Routine checkup

Ecg - 0

Euv - 0

Adv

Collect Gluc report



f



ID: 2024030810551856  
Name: kalyani kshatriya  
Age: 36 Years  
Gender: Female

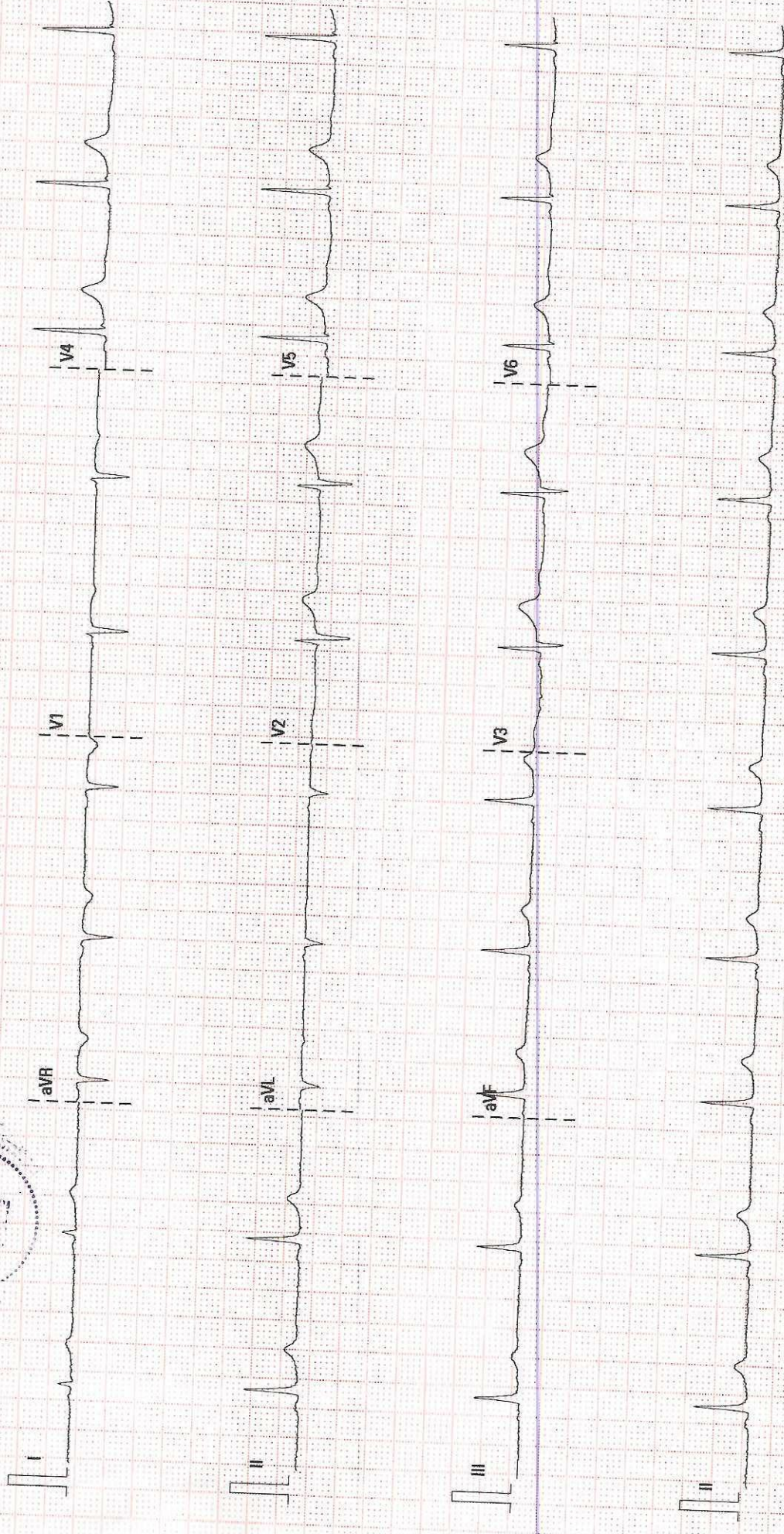
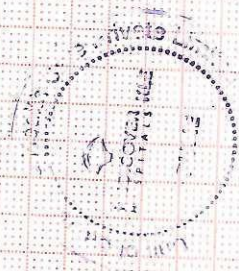
08-03-2024 10:55:08 AM

Vent. Rate  
PR Interval  
QRS Duration  
QT/QTc Interval  
P/QRS/T Axes  
QTc-Hodges

58 bpm  
112 ms  
84 ms  
408/405 ms  
24/80/63 deg

Sinus rhythm  
Normal ECG

Unconfirmed Diagnosis



25 mm/s

10 mm/mV

50 Hz

BDF 38 Hz

MEDICO KLE PUNE

02.10.00/V28.4.1

SIN-FN-26035806