

Dr. Vimmi Goel
 MBBS, MD (Internal Medicine)
 Sr. Consultant Non Invasive Cardiology
 Reg. No: MMC- 2014/01/0113

KIMS-KINGSWAY
HOSPITALS

Name: Mrs. Ganga Mohadikar. Date: 9/12/23
 Age: 34 Sex: MF Weight: 56.7, kg Height: 157.7, inc BMI: 22.72
 BP: 122/84, mmHg Pulse: 99/M bpm RBS: _____ mg/dl
 SPO2: 100% LMP - 26/11/23

34/F

- H/o GDM
- Delinered in Jan' 23
- Compl. Body aches
- NO FH of DM +

O/E

Sup^o
 CW
 L₃
 P/A / N.

Iw

FBS - 123

Rem noted

Adv-

- Diet control
- Daily exercise
- Rpr. HbA_{1c}, FBS
 PMBS after 3 mos
- Cap D-Rise (600) 1 cap
 weekly x 8 wks.

Dr. VIMMI GOEL
 MBBS, MD
 Sr. Consultant-Non Invasive Cardiology
 Reg.No.: 2014/01/0113

DEPARTMENT OF OPHTHALMOLOGY
OUT PATIENT ASSESSMENT RECORD

GANGA MOHADIKAR 34Y(S) 8M(S) 7D(S)/F UMR2324030163 8975849159 MARRIED	CONSULT DATE : 09-12-2023 CONSULT ID : OPC2324090208 CONSULT TYPE : VISIT TYPE : NORMAL TRANSACTION TYPE :	DR. ASHISH PRAKASHCHANDRA KAMBLE MBBS,MS, FVRS,FICO CONSULTANT DEPT OPHTHALMOLOGY
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VITALS

Temp : **Pulse** : **BP (mmHg)** : **spO2** : **Pain Score** : **Height** :
- °F - /min -- %RA -- /10 -- cms
Weight : **BMI** :
- kgs -

CHIEF COMPLAINTS

ROUTINE CHECK UP

MEDICATION PRESCRIBED

#	Medicine	Route	Dose	Frequency	When	Duration
1	REFRESH TEARS 10ML DROPS	Eye	1-1-1-1	Every Day	After Food	2 months
		Instructions : -				
Composition : SODIUM CARBOXYMETHYL CELLULOSE 5MG/ML 10ML						

NOTES

GLASS PRESCRIPTION :-

DISTANCE VISION

EYE	SPH	CYL	AXIS	VISION
RIGHT EYE	-0.50	-1.50	80	6/6
LEFT EYE	-1.50	00	00	6/6

NEAR ADDITION

RIGHT EYE		00	N6
LEFT EYE		00	N6

REMARK- BLUE CUT GLASS

REVIEW

Follow up Date : 09-06-2024

Ashish Kamble

Dr. Ashish Prakashchandra Kamble
MBBS,MS, FVRS,FICO
Consultant

Printed On : 09-12-2023 10:36:49

Name: Mrs. Ganga Mahadikar. Date: 9/12/2023.

Age: 34 yrs. Sex: M/F Weight: _____ kg Height: _____ inc BMI: _____

BP: _____ mmHg Pulse: _____ bpm RBS: _____ mg/dl

Routine Dental check up,

PMH } W.S.
PMH }

O/E: Deep Bite present

Spacing \bar{c} $\frac{2^d}{1} | \frac{1^d}{2}$

Attrition \bar{c} $\frac{\quad}{21 | 12}$

Stain^o +, calculus +

Advice:
• Oral prophylaxis^o
• Orthodontic treatment

Dr. Rahul



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mrs. GANGA MOHADIKAR	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 08:45 am	Report Date : 09-Dec-23 11:46 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	12.8	12.0 - 15.0 gm%	Photometric
Haematocrit(PCV)		38.6	36.0 - 46.0 %	Calculated
RBC Count		4.54	3.8 - 4.8 Millions/cumm	Photometric
Mean Cell Volume (MCV)		85	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		28.2	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		33.2	31.5 - 35.0 g/l	Calculated
RDW		15.0	11.5 - 14.0 %	Calculated
Platelet count		360	150 - 450 10 ³ /cumm	Impedance
WBC Count		10500	4000 - 11000 cells/cumm	Impedance

DIFFERENTIAL COUNT

Neutrophils	76.0	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes	17.0	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils	2.1	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes	4.9	2 - 10 %	Flow Cytometry/Light microscopy
Basophils	0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count	7980	2000 - 7000 /cumm	Calculated



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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Lymphocyte Count		1785	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		220.5	20 - 500 /cumm	Calculated
Absolute Monocyte Count		514.5	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
<u>PERIPHERAL SMEAR</u>				
RBC		Normochromic Normocytic, Anisocytosis +(Few)		Light microscopy
WBC		As Above		
Platelets		Adequate		
ESR		37	0 - 20 mm/hr	Automated Westergren's Method
*** End Of Report ***				

Suggested Clinical Correlation * If neccessary, Please discuss

Verified By : : 11100245

Test results related only to the item tested.

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Jaiswal

Dr. PURVA JAISWAL, MBBS,MD,DNB
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. GANGA MOHADIKAR	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 08:44 am	Report Date : 09-Dec-23 10:48 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	123	< 100 mg/dl	GOD/POD,Colorimetric
GLYCOSYLATED HAEMOGLOBIN (HBA1C)				
HbA1c		5.6	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

*** End Of Report ***

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Dr. PURVA JAISWAL, MBBS,MD,DNB

SPAN CONSULTANT PATHOLOGIST Private Limited

44, Parwana Bhawan, Kingsway, Nagpur - 440 001, Maharashtra, India

Phone: +91 0712 6789100

CIN: U74999MH2018PTC303511



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. GANGA MOHADIKAR	Age / Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 11:15 am	Report Date : 09-Dec-23 12:54 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Post Prandial Plasma Glucose	Plasma	90	< 140 mg/dl	GOD/POD, Colorimetric

Interpretation:

Clinical Decision Value as per ADA Guidelines 2021

Diabetes Mellites If,

Fasting \geq 126 mg/dl

Random/2Hrs. OGTT \geq 200 mg/dl

Impaired Fasting = 100-125 mg/dl

Impaired Glucose Tolerance = 140-199 mg/dl

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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Dr. Anuradha Deshmukh, MBBS,MD
CONSULTANT MICROBIOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. GANGA MOHADIKAR	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 08:45 am	Report Date : 09-Dec-23 11:06 am

LIPID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	154 < 200 mg/dl	Enzymatic(CHE/CHO/POD)
Triglycerides		69 < 150 mg/dl	Enzymatic
HDL Cholesterol Direct		51 > 50 mg/dl	(Lipase/GK/GPO/POD)
LDL Cholesterol Direct		80.41 < 100 mg/dl	Phosphotungstic acid/mgcl-Enzymatic (microslide)
VLDL Cholesterol		14 < 30 mg/dl	Enzymatic
Tot Chol/HDL Ratio		3 3 - 5	Calculated
			Calculation

<u>Intiate therapeutic</u>	<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	>130, optional at 100-129
Multiple major risk factors conferring 10 yrs CHD risk >20%	>130	10 yrs risk 10-20 % >130
Two or more additional major risk factors, 10 yrs CHD risk <20%	>160	10 yrs risk <10% >160
No additional major risk or one additional major risk factor	>190, optional at 160-189	<160

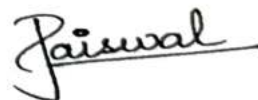
*** End Of Report ***

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Dr. PURVA JAISWAL, MBBS,MD,DNB
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. GANGA MOHADIKAR **Age / Gender** : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163 **Referred By** : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 08:45 am **Report Date** : 09-Dec-23 11:06 am

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
RFT				
Blood Urea	Serum	13	15.0 - 36.0 mg/dl	Urease with indicator dye
Creatinine		0.40	0.52 - 1.04 mg/dl	Enzymatic (creatinine amidohydrolase)
GFR		133.1		Calculation by CKD-EPI 2021
Sodium		138	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.04	3.5 - 5.1 mmol/L	Direct ion selective electrode
THYROID PROFILE				
T3		1.66	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.22	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.13	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

*** End Of Report ***

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SPANV CONSULTANT PATHOLOGIST Private Limited
44, Parwana Bhawan, Kingsway, Nagpur - 440 001, Maharashtra, India.
Phone: +91 0712 6709100
CIN: U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mrs. GANGA MOHADIKAR	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 08:45 am	Report Date : 09-Dec-23 11:06 am

LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.49	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.25	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.24	0.1 - 1.1 mg/dl	Dual wavelength spectrophotometric
Alkaline Phosphatase		140	38 - 126 U/L	pNPP/AMP buffer
SGPT/ALT		23	13 - 45 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		20	13 - 35 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		7.46	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.10	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.37	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.22		

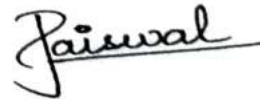
*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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**Dr. PURVA JAISWAL, MBBS,MD,DNB
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF PATHOLOGY

Patient Name : Mrs. GANGA MOHADIKAR	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 09:10 am	Report Date : 09-Dec-23 11:44 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
URINE MICROSCOPY			
PHYSICAL EXAMINATION			
Volume	Urine	30 ml	
Colour.		Pale yellow	
Appearance		Clear	
CHEMICAL EXAMINATION			
Reaction (pH)	Urine	6.0	4.6 - 8.0
Specific gravity		1.010	1.005 - 1.025
Urine Protein		Negative	Indicators ion concentration protein error of pH indicator
Sugar		Negative	GOD/POD
Bilirubin		Negative	Diazonium
Ketone Bodies		Negative	Legal's est Principle
Nitrate		Negative	
Urobilinogen		Normal	Ehrlich's Reaction
MICROSCOPIC EXAMINATION			
Epithelial Cells	Urine	0-1	0 - 4 /hpf
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		0-1	0 - 4 /hpf
Casts		Absent	
Crystals		Absent	
USF(URINE SUGAR FASTING)			
Urine Glucose	Urine	Negative	GOD/POD

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100400

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Jaiswal

Dr. PURVA JAISWAL, MBBS,MD,DNB

SPANV CONSULTANT PATHOLOGIST Private Limited

44, Parwana Bhawan, Kingsway, Nagpur - 440 001, Maharashtra, India.

Phone: +91 0712 0709100

CIN: U74999MH2018PTC303510



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY

Patient Name : Mrs. GANGA MOHADIKAR	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324061301/UMR2324030163	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 09-Dec-23 08:45 am	Report Date : 09-Dec-23 11:42 am

BLOOD GROUPING AND RH

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
BLOOD GROUP.	EDTA Whole Blood & Plasma/ Serum	"AB"	Gel Card Method
Rh (D) Typing.		" Positive "(+Ve)	
		*** End Of Report ***	

Suggested Clinical Correlation * If neccessary, Please discuss

Verified By : : 11100245

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Dr. PURVA JAISWAL, MBBS,MD,DNB
CONSULTANT PATHOLOGIST

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	GANGA MOHADIKAR	STUDY DATE	09-12-2023 10:18:17
AGE/ SEX	34Y8M7D / F	HOSPITAL NO.	UMR2324030163
ACCESSION NO.	BIL2324061301-10	MODALITY	DX
REPORTED ON	09-12-2023 13:00	REFERRED BY	Dr. Vimmi Goel

X-RAY CHEST PA VIEW

Both the lung fields are clear.

Heart and Aorta are normal.

Both hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

IMPRESSION -

No pleuro-parenchymal abnormality seen.



DR NAVEEN PUGALIA
MBBS, MD [076125]
SENIOR CONSULTANT RADIOLOGIST.

N.B : This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations.
Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

PATIENT NAME:	MRS. GANGA MOHADIKAR	AGE /SEX:	34 YRS/F
UMR NO	2324030163	BILL NO	2324061301
REFERRED BY	DR. VIMMI GOEL	DATE	09/12/2023

USG WHOLE ABDOMEN

LIVER is normal in size, shape and shows normal echotexture.
No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated.
PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No sludge or calculus seen.
Wall thickness is within normal limits.

PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in shape, size and echotexture. No focal lesion seen.

Both KIDNEYS are normal in shape, size and echotexture.
No evidence of calculus or hydronephrosis seen.
URETERS are not dilated.

BLADDER is partially distended. No calculus or mass lesion seen.

No mass lesion seen in pelvis region.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

No significant abnormality seen.

Suggest clinical correlation / further evaluation.



DR. R.R. KHANDELWAL
SENIOR CONSULTANT
MD RADIO DIAGNOSIS [MMC-55870]

Kingsway Hospitals
44 Kingsway, Mohan Nagar,
Near Kasturchand Park, Nagpur

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Mrs. Ganga, Mohadikar
Patient ID: 030163
Height:
Weight:
Study Date: 09.12.2023
Test Type: Treadmill Stress Test
Protocol: BRUCE

DOB: 02.04.1989
Age: 34yrs
Gender: Female
Race: Indian
Referring Physician: Mediwheel HCU
Attending Physician: Dr. Vimmi Goel
Technician: --

Medications:

Medical History:

NIL

Reason for Exercise Test:

Screening for CAD

Exercise Test Summary:

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	03:05	0.00	0.00	111	120/80	
	WARM-UP	00:25	1.00	0.00	126		
EXERCISE	STAGE 1	03:00	1.70	10.00	144	120/80	
	STAGE 2	03:00	2.50	12.00	157	130/80	
	STAGE 3	01:02	3.40	14.00	173		
RECOVERY		01:00	0.00	0.00	139	140/80	
		02:00	0.00	0.00	121	130/80	
		00:14	0.00	0.00			

The patient exercised according to the BRUCE for 7:02 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 111 bpm rose to a maximal heart rate of 176 bpm. This value represents 94 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 140/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation:

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: appropriate.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: Insignificant ST-T changes seen..

Overall impression: Normal stress test.

Conclusions:

TMT is negative for inducible ischemia.

Insignificant ST-T changes seen.

Dr. Vimmi GOEL
MBBS, MD
Sr. Consultant Non Invasive Cardiology
Reg. No.: 2014/01/0113

PBC DEPT.

Rate 106 . Sinus tachycardia.....rate> 99
Consider right atrial enlargement.....P >0.24mV limb lead

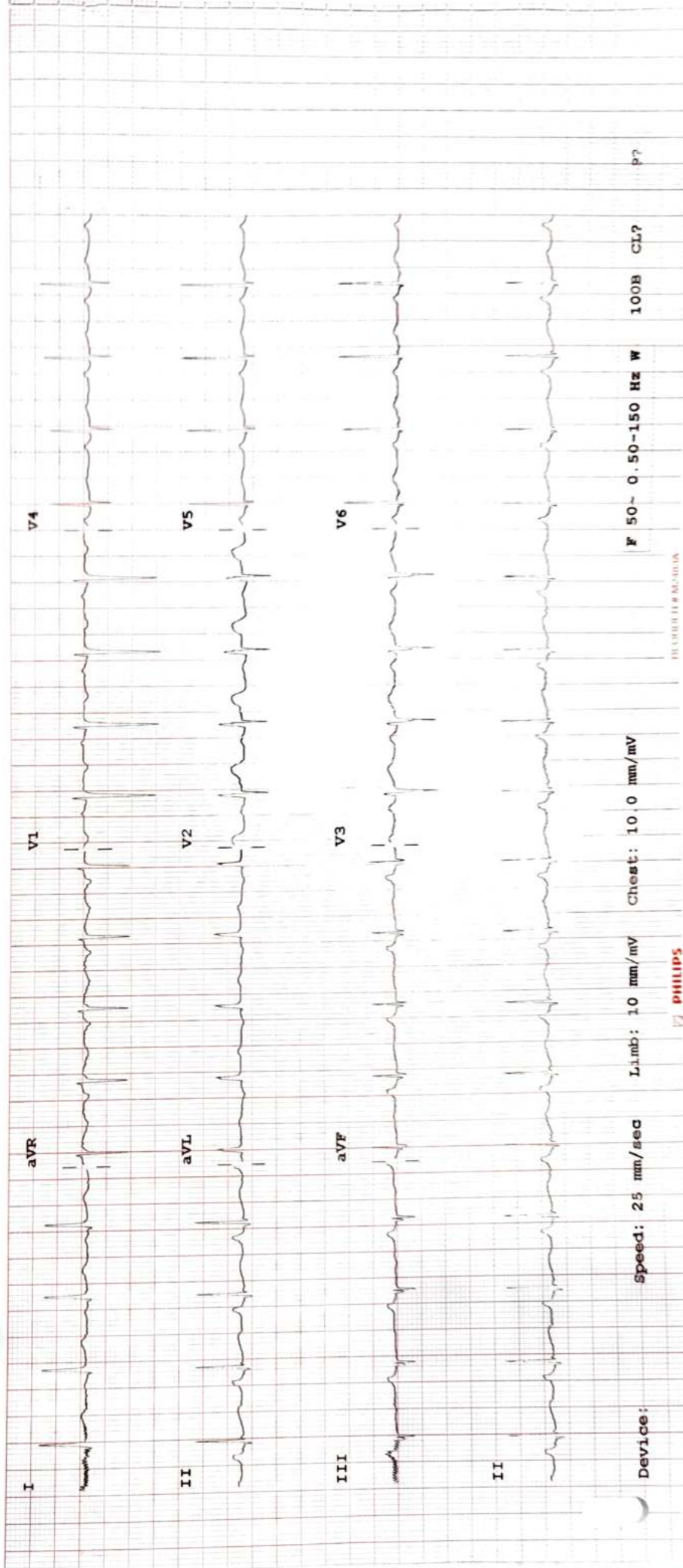
FR 151
QRSD 72
QT 317
QTc 421

--AXIS--
P 77
QRS 8
T 32

12 Lead; Standard Placement

- OTHERWISE NORMAL ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-150 Hz W 100B CL? P?