CHARUSAT HOSPITAL
Care with compassion

OPHTHALMIC REGISTRATION FORM

Reg. No. : CH-2024-0036264

Date : 20-2-2024

Patient's Name : manisha. m. Pandy Age : 27

Address : _____

Telephone No. : _____ Mobile No. : _____

Referred by / Care of : _____

Profession : _____

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 /

for routine eye checkup.

Eye Involve : RE / LE / BE Duration : _____

Ophthalmic History : Surgery / Laser / FFA / Oct / Glaucoma / RP / Corneal Opacity / Injury / Amblyopia / Treatment

Any Surgery : Cataract / Glaucoma / NAD / RE / LE / BE

Family History : Glaucoma / RP / DM / _____

SYSTEMIC : DM / HT / IHD / COPD / PROSTATE / WROID / ALLERGY / SMOKING / ALCOHOL

NAD

EYE DETAILS :	RE	LE
V/A with PH	6/18	6/18
IOP	11 mmHg	11 mmHg
OWN GLASS :	-1.50 Dsph	-0.50 / -0.50 x 136°
AR :	-1.50 / -0.25 x 3°	-1.00 / -0.50 x 156°

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	-1.50	——	6/6	-1.00	-0.50	150°
Nr. Add	——			——		
Comp						

Bifocal / Distant / Near only / Constant / Progressive / Photocromatic

Remark :

Signature : _____

CHRI/OPTH/5089

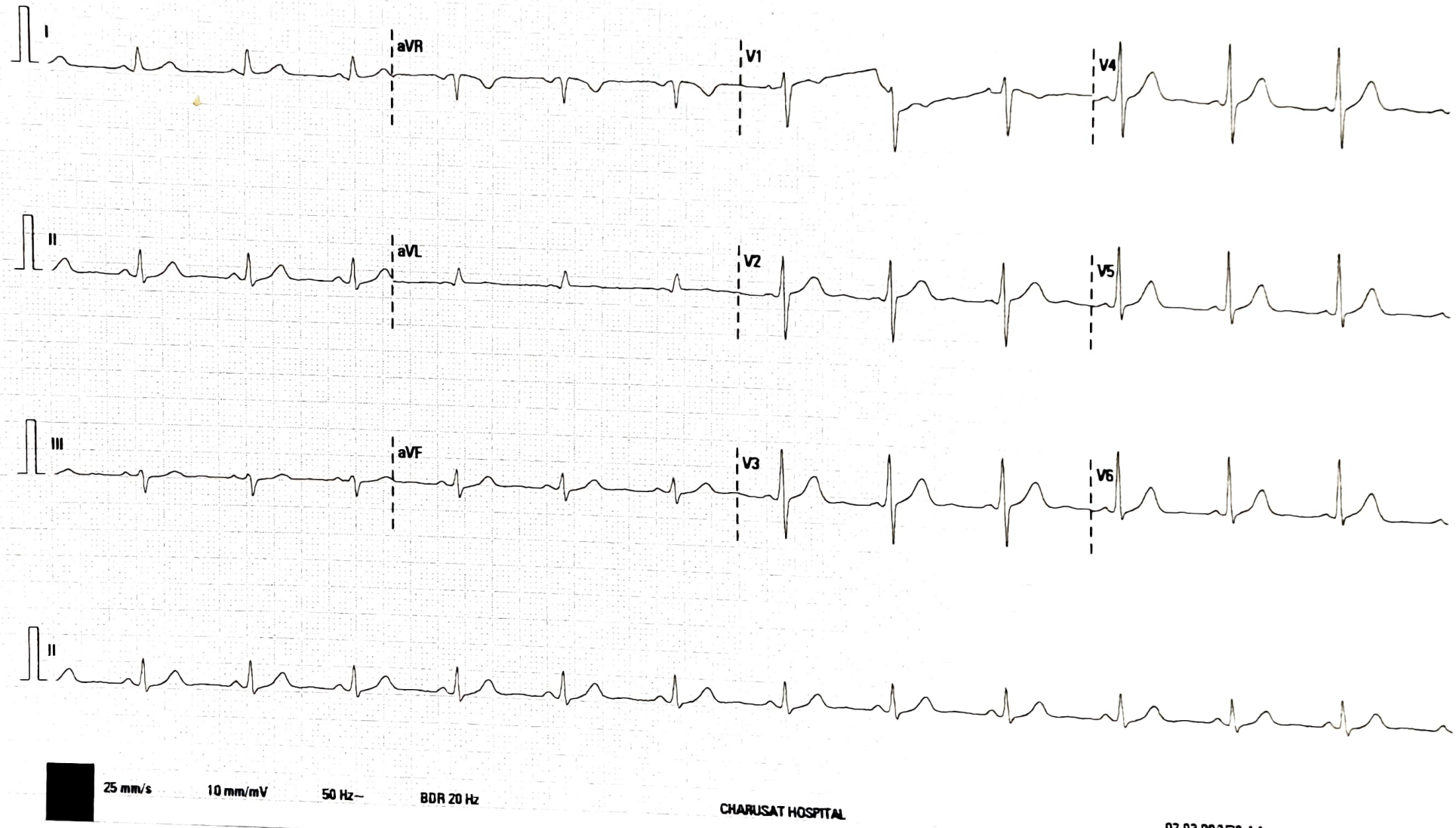
ID: 20240210100608 94
Name:
Age:
Gender: manishcaben

10-02-2024 10:05:58 AM

Vent. Rate	77 bpm
PR Interval	112 ms
QRS Duration	88 ms
QT/QTc Interval	358/388 ms
P/QRS/T Axes	58/29/53 deg
QTc:Hodges	

Sinus rhythm
— Interpretation made without knowing patient's gender/age —

Unconfirmed Diagnosis.



25 mm/s 10 mm/mV 50 Hz— BDR 20 Hz

CHARUSAT HOSPITAL

02.03.00/V28.4.1

SN:FN-52001657

CHARUSAT HOSPITAL

Patient Name :	MANISHA . KUMARI	**Sample No. :**	SAMPLE-0106928
Patient ID :	CH-2021-0036204	**Visit No. :**	OPD/2024/02/0000524
Age/Sex :	27y 4m/Female	**Call. Date :**	10-Feb-2024 09:14
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 16:01
Ward :	-	**Report Date :**	10-Feb-2024 16:01

PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	96.0 mg/dl [LOW]	100 - 140
Post Prandial Urine Sugar (2Hrs) :	Absent	

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

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

DENTAL REGISTRATION FORM

CHARUSAT HOSPITAL

Date & Time : 20-2-2024

Registration No. : CH-2024-003620

Name : Mrs. M. Pandey

Age : 27

Sex : F

Contact No. :

Emergency Contact No. :

Address :

OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine checkups

Family History :

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

- ☐ Hypertension
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Bleeding Disorder
- ☐ Smoking

Habits : ☐ Tobacco

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 આપુ છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ફાયદા-ગેરફાયદા, દવાની કે ઇંજેક્શનની 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 ચારૂસેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની ડિપોઝીટ પેટે અપાયેલ રકમ મેળવવા માટે હકદાર 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 : Calculus + +

Treatment Plan : Scaling.

Date : 10/2/24

Time : _____

Name of Doctor : Dr. Shashwati

Signature : _____

CHRF/DENTAL/5016

CHARUSAT HOSPITAL

Patient Name :	MANISHA . KUMARI	**Sample No. :**	SAMPLE-0106906
Patient ID :	CH-2021-0036204	**Visit No. :**	OPD/2024/02/0000524
Age/Sex :	27y 4m/Female	**Call. Date :**	10-Feb-2024 09:14
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 15:37

HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	111.0 mg/dl	
Hb A 1c	5.5 %	> 8 : Action Suggested 7-8 : Good Control < 7 : Goal 6-7 : Near Normal Glycemia < 6 : Non-diabetic Level

Comments

Hb A1C also know asGlycosylated 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 69-8 week and provides a much better indicationn of longterm glycemic contril than blood glucose determination.

This Reaction is irreverdible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications). nephropathy(Kidney-complications) & neuropathy(never complications) are potentially serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.

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(M.B.B.S,M.D)

Gynec

DOCTORS' NOTES

DATE & TIME	DOCTOR'S NOTES	SIGNATURE
10/02/24 Age:- 28	Dr. Janki Amin	AV
	Nullipara. Anal :- swollen. — Tls lingu[illegible]	
	M/ls:- [illegible]. — Tls [illegible]	
	No [illegible] fun [illegible]. [illegible]	

CHARUSAT HOSPITAL

DOCTORS' NOTES

DATE & TIME	DOCTOR'S NOTES	SIGNATURE
10/2/24	S/B Dr Jaiyam Come for Health check up ↓ No Acute c/o All Reports (N) P – 96/min BP – 110/70 mm Hg SpO2 → 99% on RA	OPD → No active complaints Received

CHRI/MRD/5048

CHARUSAT HOSPITAL

Patient Name :	MANISHA . KUMARI	**Sample No. :**	SAMPLE-0106906
Patient ID :	CH-2021-0036204	**Visit No. :**	OPD/2024/02/0000524
Age/Sex :	27y 4m/Female	**Call. Date :**	10-Feb-2024 09:14
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 12:02

Investigation	Result	Normal Value
Serum Creatinine	0.48 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 :	06 [LOW]	8.0 to 23.0 (mg/dl)

URIC ACID

Investigation	Result	Normal Value
Serum Uric Acid	4.15 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

ESR

Investigation	Result	Normal Value
ESR - After One Hour	20 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

Blood Group

Investigation	Result	Normal Value
ABO :	A	
Rh :	Positive	

FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar :	95.0 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

TSH

Investigation	Result	Normal Value
TSH :	2.22 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3

Investigation	Result	Normal Value

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
10-02-2024	MANISHABEN KUMARI	F	BODY PROFILE	UF-TOTAL ABDOMEN USG

USG OF THE ABDOMEN/ PELVIS WAS PERFORMED

The liver is normal in size and echotexture. No focal solid or cystic lesions are seen. The intra hepatic billiary radicles are normal. The portal vein and CBD are normal. The gall bladder is contracted 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 anterverted, normal size.
The endometrium is in the midline. No focal myoma is seen.
Both the ovaries are nomal 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 Kidney	Left Kidney
9.26X3.93	10.3X4.74

IMPRESSION :

NO ABNORMALITY DETECTED.

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

CHARUSAT HOSPITAL

Patient Name :	MANISHA . KUMARI	**Sample No. :**	SAMPLE-0106906
Patient ID :	CH-2021-0036204	**Visit No. :**	OPD/2024/02/0000524
Age/Sex :	27y 4m/Female	**Call. Date :**	10-Feb-2024 09:14
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 12:02

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	12.4 gm/dl [NORMAL]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	4.00 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	9720 /c.mm [NORMAL]	4000 - 10000

Platelet count

Investigation	Result	Normal Value
Platelets	1.50 Lakh/cmm [NORMAL]	1.5 - 4.5

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	64 % [NORMAL]	40 - 70
Lymphocytes	29 % [NORMAL]	20 - 40
Eosinophils	02 % [NORMAL]	1 - 6
Monocytes	05 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	13.6 mg/dl [LOW]	15 - 40

S.Creatinine

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

CHARUSAT HOSPITAL

Dr. Pavan

Date & Time : 20-2-2024

Registration No. : CH-2027-0036704

Name : Manisha. Maiy. Pandey Contact No. : (M) _____

Age : 27 Sex : F (O) _____

Address : _____

B.P. : 110/70 mmHg Pulse : 96 bpm SpO_2 : 99 %

BMI : _____ Height : 150 cm Weight : 54.6 kg

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : _____

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

HABBITS : ☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Others (Specify) : _____

CHRF/OPD/5083

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY D
10-02-2024	MANISHABEN KUMARI	F	BODY PROFILE

USG OF THE ABDOMEN/ PELVIS WAS

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The gall bladder is contracted with no cal

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Size in CM.

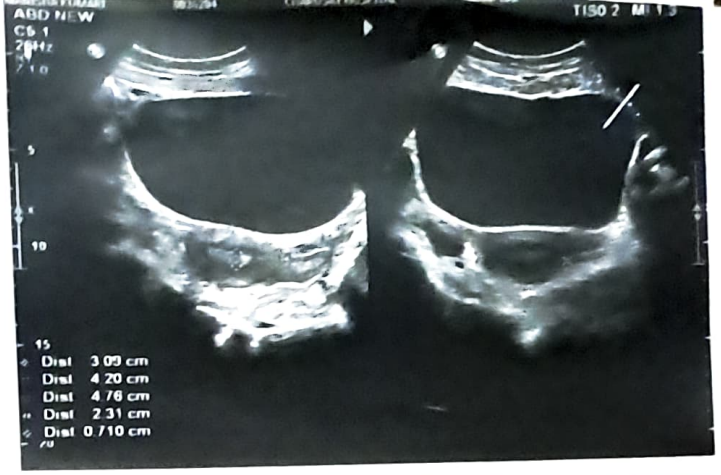
Right Kidney	Left Kidney
9.26X3.93	10.3X4.74

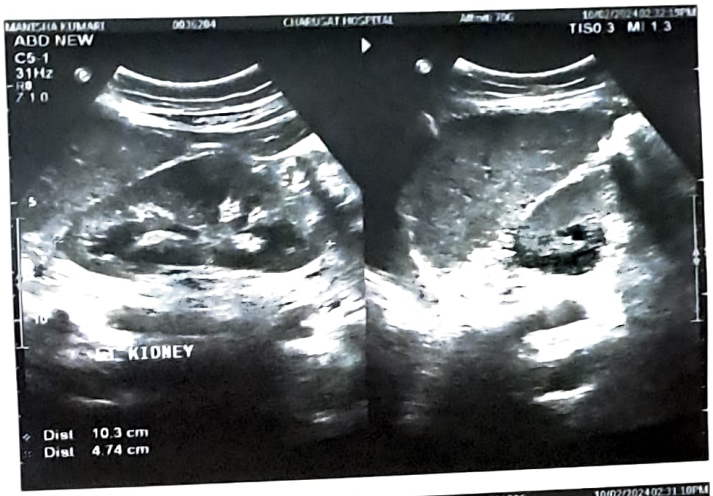
IMPRESSION :

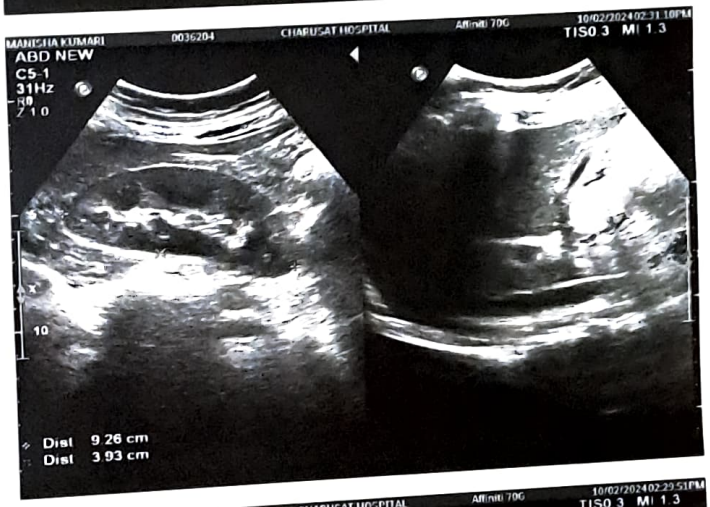
NO ABNORMALITY DETECTED.

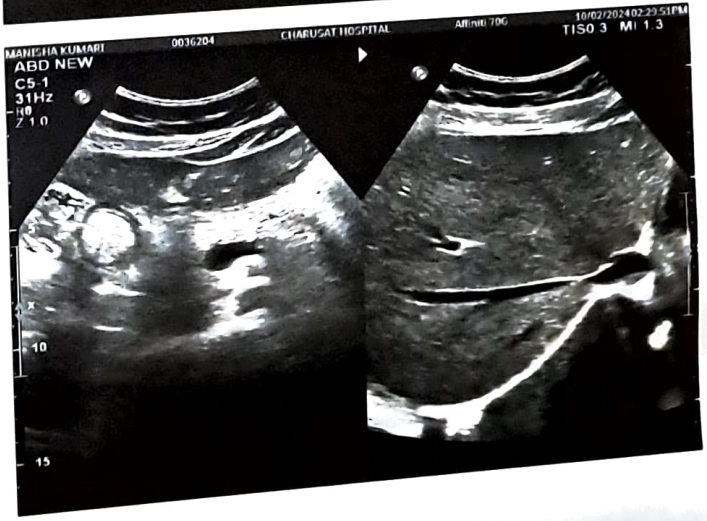
Thanks for reference
DR KIRTI C THAKKAR
M.B.B.S,D.M.R.D

CHARUSAT Campus, Changa, District Anand 388 421 (Guj) India
Web : www.ch-rf.org / www.charusat









tient Name :	MANISHA . KUMARI	Sample No. :	SAMPLE-0106906
tient ID :	CH-2021-0036204	Visit No. :	OPD/2024/02/0000524
e/Sex :	27y 4m/Female	Call. Date :	10-Feb-2024 09:14
ferred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 09:56
rd :	-	Report Date :	10-Feb-2024 12:02

otal Bilirubin :	0.47	mg/dl [NORMAL]	0.0 to 1.2
irect Bilirubin (DBIL) :	0.15	mg/dl [NORMAL]	0.0 to 0.30
LT (SGPT) :	34.1	IU/L [NORMAL]	[0.0 - 40]
ST (SGOT) :	20.8	IU/L [NORMAL]	<= 45.0
kaline Phosphatase (ALP) :	94.0	IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
otal Protein (TP) :	7.68	gm/dl [NORMAL]	[Adult 6.0 to 7.8]
bumin (ALB) :	4.41	gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
direct Bilirubin (IBIL) :	0.32	[NORMAL]	0.0 to 0.75 (mg/dl)
obulins :	3.27	gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
G Ratio	1.3		

INE R & M estigation	Result	Normal Value
ysical Examination :		
antity :	15 ml	
our :	Pale Yellow -	
earance :	Clear -	
ur :	URINIOD -	
ction :	Acidic -	
cific Gravity :	1.020 -	
nical Examination :		
min :	Absent -	
r :	Absent -	
alls :	Absent -	
igments :	Absent -	

CHARUSAT HOSPITAL

Patient Name :	MANISHA KUMARI	**Sample No. :**	SAMPLE-0106906
Patient ID :	CH-2021-0036204	**Visit No. :**	OPD/2024/02/0000524
Age/Sex :	27y 4m/Female	**Call. Date :**	10-Feb-2024 09:14
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 12:02

Total Bilirubin	0.47	mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL)	0.15	mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT)	34.1	IU/L [NORMAL]	[0.0 - 40]
AST (SGOT)	20.8	IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP)	94.0	IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP)	7.68	gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB)	4.41	gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL)	0.32	[NORMAL]	0.0 to 0.75 (mg/dl)
Globulins	3.27	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	15 ml	
Colour	Pale Yellow -	
Appearance	Clear -	
Odour	URINIOD -	
Reaction	Acidic -	
Specific Gravity	1.020 -	
Chemical Examination :		
Albumin	Absent -	
Sugar	Absent -	
Bile Salts	Absent -	
Bile Pigments		