

NAME:	Ms. Suman Y.	UHID:	
AGE:	27	DATE OF HEALTHCHECK:	25-1-2024
GENDER:	F		

HEIGHT:	157	MARITAL STATUS:	M
WEIGHT:	65.2	NO OF CHILDREN:	2
BMI:	26.5		

C/O: Pain in small joints →
hands, fingers.

K/C/O:
PRESENT MEDICATION: - No.

P/M/H: - No

P/S/H: - No

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ ~~Sedentary~~

H/A: SMOKING:

FAMILY HISTORY FATHER: - DM.

ALCOHOL:

MOTHER: -

TOBACCO/PAN:

O/E:

LYMPHADENOPATHY:

BP: 100/80 PULSE: - 78/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING: - NAD

TEMPERATURE: M SCARS:

OEDEMA:

S/E:

RS:



P/A:



CVS: - Normal

Extremities & Spine: - NAD

CNS: Convulsion, subacute

ENT: - NAD

Skin: - NAD

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

Name:	Age:	Date of Health check-up:
-------	------	--------------------------

Findings and Recommendation:

Findings:-

exine shows yeast cells
EKG Sinus Arrhythmia.
USG - gr. Fatty liver.
Bulky Uterus
Reft reports same
Consult Ayurveda

Recommendation:-

DR. PRADNYA P. DAI
(M.B.)
Reg. No. 8754

Pradnyai

Signature:

Consultant -

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 23/1/24

Name: Swetha Y.

Age: 37

Gender: Male/Female

Without Correction :

Distance: Right Eye FCCF.

Left Eye C/C

Near : Right Eye —

Left Eye N/G

With Correction :

Distance: Right Eye —

Left Eye C/C

Near : Right Eye —

Left Eye N/G.

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance		<u>Plano</u>		<u>—</u>					<u>—</u>	
Near	<u>—</u>					<u>—</u>				

Colour Vision: (Normal)

Anterior Segment Examination: (RE)

(LE)

Pupils: _____

Fundus: _____

Intraocular Pressure: _____

Diagnosis: _____

Advice: _____

Re-Check on _____ (This Prescription needs verification every year)

Dr. **SHETH NIKET PRASHANT**
 (Consultant Ophthalmologist)
 M.B.B.S. D.O.M.S.
 Regn. No 2008/10/3646

DENTAL CHECKUP

Name: Shwetha Y.	MR NO:
Age/Gender : 31/F.	Date: 28/1/24.

Medical history: Diabetes Hypertension _____

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains			✓	✓
Mobility				
Caries (Cavities)				
a) Class 1 (Occlusal)			✓	
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling			✓	
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: Scaling & polishing
 Orthodontic Advice for Braces: Yes / No
 Prosthetic Advice to Replace Missing Teeth: Denture Bridge Implant
 Oral Habits: Tobacco Cigarette Others since ___ years
 Advice to quit any form of tobacco as it can cause cancer.
 Other Findings: _____

- Scaling & polishing - 900
 - Filling 2 ts - 1200

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Name: Mrs Swarna Y. Age: 32 Sex: F UHID No.: _____ Date: 25/01/2024

37 year (married) P₂L₂ (LSCS) ^{5th}

NO complaints; willing for PAP smear

Comp. 15/01/2024

O/S

GC Fair

Afibril

P- 72/min.

PA - soft


Pls. Cx } Healthy
Ny }

(PAP smear taken)

Plw reports

- Physician Reference also

swellings of distal phalanges
* 6 months

Dr. 
TRUPTI SHINDE
DR. TRUPTI VIJAY SHINDE
MBBS, M.S. (OBS & GYNA)
REG. NO.: 2014/07/3301



Apollo Clinic
VASHI

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

Name : Ms. Swetha Y Gender : Female Age : 37 Years
 UHID : FVAH 10375. Bill No : Lab No : V-3330-23
 Ref. by : SELF Sample Col.Dt : 25/01/2024 09:10
 Barcode No : 5600 Reported On : 25/01/2024 18:36

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)		
Haemoglobin(Colorimetric method)	12.9 g/dl	11.5 - 15
RBC Count (Impedance)	4.52 Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	38.9 %	35 - 55
MCV:(Calculated)	86 fl	78 - 98
MCH:(Calculated)	28.6 pg	26 - 34
MCHC:(Calculated)	33.3 gm/dl	30 - 36
RDW-CV:	13 %	10 - 16
Total Leucocyte count(Impedance)	7480 /cumm.	4000 - 10500
Neutrophils:	57 %	40 - 75
Lymphocytes:	35 %	20 - 40
Eosinophils:	05 %	0 - 6
Monocytes:	03 %	2 - 10
Basophils:	00 %	0 - 2
Platelets Count(Impedance method)	2.44 Lakhs/c.mm	1.5 - 4.5
MPV	8.7 fl	6.0 - 11.0
ESR(Westergren Method)	15 mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)		
RBCs:	Normochromic, Normocytic	
WBCs:	Normal	
Platelets	Adequate	
Note:	Test Run on 5 part cell counter. Manual diff performed.	

Neha More
Entered By

Ms Kaveri Gaonkar
Verified By


Page 4 of 00 **Milind Patwardhan**
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

Name : Ms. Swetha Y Gender : Female Age : 37 Years
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.0 %
 Normal < 5.7 %
 Pre Diabetic 5.7 - 6.5 %
 Diabetic > 6.5 %
 Target for Diabetes on therapy < 7.0 %
 Re-evaluation of therapy > 8.0 %

Mean Blood Glucose : 96.8 mg/dL

Correlation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298


Method High Performance Liquid Chromatography (HPLC).

INTERPRETATION

- The HbA1c levels correlate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
- This Methodology is better than the routine chromatographic methods & also for the diabetic pts having HEMOGLBINOPATHIES OR UREMIA as Hb variants and uremia does not INTERFERE with the results in this methodology.
- It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts & every 3 - 4 months in well controlled diabetics .
- Mean blood glucose (MBG) in first 30 days (0-30)before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

Neha More
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Dr. M. D. Patwardhan
Page 5 of 10
M.D(Path)
Chief Pathologist

End of Report
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

PLASMA GLUCOSE


Fasting Plasma Glucose : 96 mg/dL Normal < 100 mg/dL
Impaired Fasting glucose : 101 to 125 mg/dL
Diabetes Mellitus : \geq 126 mg/dL
(on more than one occasion)
(American diabetes association guidelines 2016)

Post Prandial Plasma Glucose : 101 mg/dL Normal < 140 mg/dL
Impaired Post Prandial glucose : 140 to 199 mg/dL
Diabetes Mellitus : \geq 200 mg/dL
(on more than one occasion)
(American diabetes association guidelines 2016)

Method : Hexokinase

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Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LIPID PROFILE - Serum

S. Cholesterol(Oxidase)	155	mg/dL	Desirable < 200 Borderline: >200-<240 Undesirable: >240
S. Triglyceride(GPO-POD)	65	mg/dL	Desirable < 150 Borderline: >150-<499 Undesirable: >500
S. VLDL:(Calculated)	13	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	56.0	mg/dL	Desirable > 60 Borderline: >40-<59 Undesirable: <40
S. LDL:(calculated)	86	mg/dL	Desirable < 130 Borderline: >130-<159 Undesirable: >160
Ratio Cholesterol/HDL	2.8		3.5 - 5
Ratio of LDL/HDL	1.5		2.5 - 3.5

Alsaba Shaikh
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Ms Kaveri Gaonkar
Verified By



Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

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Name : Ms. Swetha Y Gender : Female Age : 37 Years
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Thyroid (T3,T4,TSH)- Serum

Total T3 (Tri-iodo Thyronine) (ECLIA)	1.56	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	85.43	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	1.56	IU/ml	Euthyroid : 0.35 - 5.50 IU/ml Hyperthyroid : < 0.35 IU/ml Hypothyroid : > 5.50 IU/ml

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure, Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

Alsaba Shaikh
Entered By

Ms Kaveri Gaonkar
Verified By



Dr. Milind Patwardhan
M.D(Path)

Page 8 of 8 Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Slightly Hazy		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	5.0	4.6 - 8.0
SPECIFIC GRAVITY	1.010	1.005 - 1.030
URINE ALBUMIN	Absent	Absent
URINE SUGAR(Qualitative)	Absent	Absent
KETONES	Absent	Absent
BILE SALTS	Absent	Absent
BILE PIGMENTS	Absent	Absent
UROBILINOGEN	Normal(<1 mg/dl)	Normal
OCCULT BLOOD	Absent	Absent
Nitrites	Absent	Absent

MICROSCOPIC EXAMINATION

PUS CELLS	2 - 3 / hpf	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	6 - 8 / hpf	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Absent	Absent
OTHER	Yeast Cells Present	Absent

Anushka Chavan
 Entered By

Ms Kaveri Gaonkar
 Verified By


 Dr. Milind Patwardhan
 Page 9 of 10 (MD(Path))
 Chief Pathologist

End of Report
 Results are to be correlated clinically

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CYTOPATHOLOGY REPORT

Specimen No: AP-112-24

Specimen Adequacy: ADEQUATE

CELLS

ENDOCERVICAL: **Present**

ENDOMETRIAL: Absent

SQUAMOUS: **SUPERFICIAL(+), INTERMEDIATE(+++) & PARABASAL(+) CELLS**

HISTIOCYTES: Absent

RBCs: Absent

POLYMORPHS: **Present(+)**

FLORA

TRICHOMONAS VAGINALIS: Absent

FUNGI: **Fungal organisms morphologically consistent with Candida Spp.**

LACTOBACILLI: Absent

CELLULAR CHANGES

METAPLASIA: Absent

DYSPLASIA: Absent

MALIGNANT CELL: Absent

ATROPHIC CHANGES: Absent

BARE NUCLEI: Absent

IMPRESSION: **NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY**

Anushka Chavan
Entered By

Ms Kaveri Gaonkar
Verified By



Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

Sreelha Y
10375

37 Years

Female

25 JUL 2024 9:12:10
Apollo Clinic
1st Flr, The Eastern Section-12,
Vaidh, Marudai-600703

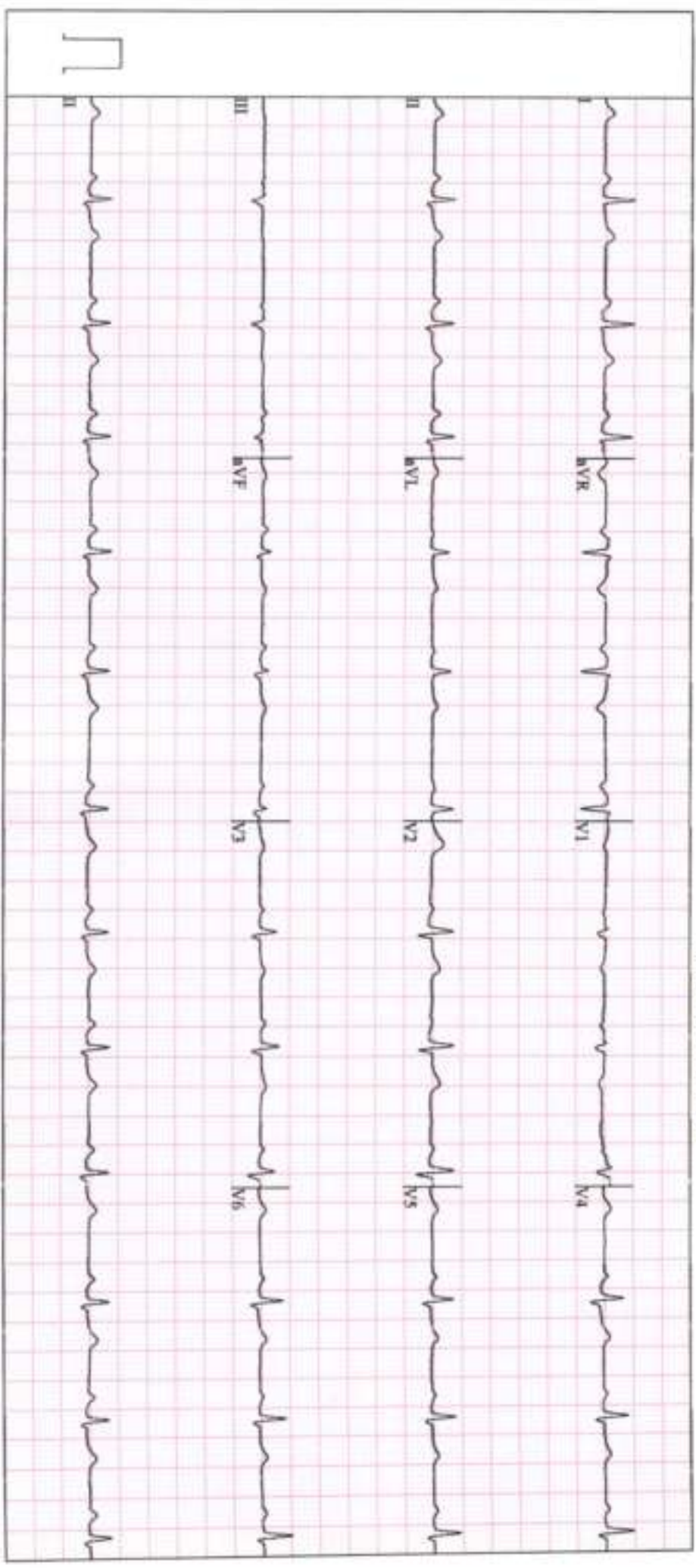
72 bpm
-- mmHg

QRS : 82 ms
QT / QTc Baz : 374 / 409 ms
PR : 156 ms
P : 106 ms
RR / PP : 830 / 833 ms
P / QRS / T : 33 / 8 / 21 degrees

Normal sinus rhythm with sinus arrhythmia
Low voltage QRS
Borderline ECC

Sina Anirban

DR. ANIRBAN DASGUPTA
M.B.B.S., D.N.B. Medicine
Diploma Cardiology
MMC-2005/02/0920



GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz Unconfirmed 4x3.5x3.25_R1 1/1

PATIENT'S NAME	SWETHA Y	AGE :- 37Y/F
UHID	10375	DATE :- 25-01-24

2D Echo and Colour Doppler Report

All cardiac chambers are normal in dimension

No obvious resting regional wall motion abnormalities (RWMA)

Interatrial and Interventricular septum – Appears Normal

Valves – Structurally normal

Good biventricular function.

IVC is normal.

Pericardium is normal.

Great vessels - Origin and visualized proximal part are normal.

No coarctation of aorta.

Doppler study

Normal flow across all the valves.

No pulmonary hypertension.

No diastolic dysfunction.

• ANDHERI • COLABA • NASHIK • VASHI

Measurements

Aorta annulus	18 mm
Left Atrium	32 mm
LVID(Systole)	23 mm
LVID(Diastole)	40 mm
IVS(Diastole)	09 mm
PW(Diastole)	09 mm
LV ejection fraction.	55-60%

Conclusion

- Good biventricular function
- No RWMA
- Valves – Structurally normal
- No diastolic dysfunction
- No PAH



Performed by: Dr. Anirban Dasgupta
D.N.B. Internal Medicine, Diploma Cardiology (PGDCC-IGNOU).

PATIENT'S NAME	SWETHA Y	AGE :- 37 y/F
UHID NO	10375	25 Jan 2024

DIGITAL RADIOGRAPH OF CHEST (PA VIEW)

The lung fields are clear.

Heart and aorta appears normal.

Both hila appear normal.

Both costo-phrenic angles are clear.

Visualized bony thorax appears normal.

IMPRESSION: NO SIGNIFICANT ABNORMALITY IS DETECTED.

Clinico-haematological correlation is recommended.

Thanking you for the referral,
With regards,



DR. SIDDHI PATIL
Cons. Radiologist

• ANDHERI • COLABA • NASHIK • VASHI

PATIENT'S NAME	SWETHA Y	AGE : 37 y/F
UHID	10375	25 Jan 2024

USG WHOLE ABDOMEN

LIVER is normal in size, shape and shows bright echotexture .No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

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

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

RIGHT KIDNEY measures 9.7 x 4.0 cm. **LEFT KIDNEY** measures 10.8 x 4.2 cm.

Urinary Bladder is adequately distended; no e/o any obvious wall thickening or mass or calculi seen.

UTERUS is anteverted and measures 9.2 x 4.2 x 2.0 No focal lesion seen.

Right ovary 2.1 x 1.7, left ovary 2.3 x 1.7

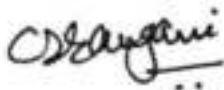
Both ovaries are normal in size, shape and position.

Visualised BOWEL LOOPS appear normal. There is no free fluid seen.

IMPRESSION –

- **Grade I fatty liver.**
- **Bulky uterus.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



DR.CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg: No. 073826