Apollo
TOUCHING LIVES

MEDICAL SUMMARY

Apollo Clinic VASHI

NAME:	Mrs. Swati Agarwal	UHID:	
AGE:	39	DATE OF HEALTHCHECK:	19/2/2024
GENDER:	F		

HEIGHT:	157	MARITAL STATUS:	M
WEIGHT:	64.1	NO OF CHILDREN:	2.
BMI:	26.0		

C/O: Haematuria - 2 days. Pain in A32. Vomiting

K/C/O:

PRESENT MEDICATION: - No.

P/M/H: Renal Calculi

P/S/H: LSCS.
- Renal calculi Removal left Ureter

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:
ALCOHOL:
TOBACCO/PAN: NAD

FAMILY HISTORY FATHER: -
MOTHER: - Renal calculi

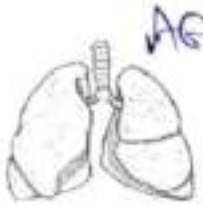
O/E:

BP: 110/80 PULSE:- 84/min

TEMPERATURE: N SCARS:

LYMPHADENOPATHY:
PALLOR/ICTERUS/CYNOSIS/CLUBBING: NAD
OEDEMA:

S/E:
RS: AE&E



P/A: Soft. Tenderness on Rt Flank

CVS: S1S2+

Extremities & Spine: - NAD

ENT: - NAD

CNS: Conscious, oriented

Skin: - NAD

Vision:

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

Vashi : M/S. Indira Health & Lifestyle Pvt. Ltd. The Emerald, 1st Floor, Plot No. 195, Sector - 12, Besides Neel Siddhi Tower, Vashi - Navi Mumbai - 400703.
Tel : (022) - 2788 1322 / 23 / 24 8291490000 • Email: apolloclinicvashi@gmail.com

Name: Swati Agarwal | Age: 39 | Date of Health check-up: 19/04/2024

Findings and Recommendation:

Findings:-

© Calculi

Recommendation:-

Urological opinion

Signature:

Consultant –

DR. ANIRBAN DASGUPTA
MBBS, D.N.B MEDICINE
DIPLOMA CARDIOLOGY
MMC- 2005/02/0920

Apollo

Apollo Clinic VASHI

OPHTHALMIC EVALUATION

UHID No.: ____________ Date 19/12/24.

Name : Miss Swati Age : 39 Gender : Male/Female ✓

Without Correction : Myope

Distance: Right Eye ____________ Left Eye ____________

Near : Right Eye ____________ Left Eye ____________

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye N6 Left Eye N6

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	-1.0					-1.0				
Near										

P. cbrs Reed

Colour Vision : WNL

Anterior Segment Examination : NAD / (BE)

Pupils : ____________

Fundus : ____________

Intraocular Pressure : 14 mm Hg

Diagnosis : ____________

Advice : ____________

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

N. D.

Dr. ____________
(Consultant Ophthalmologist)

DR. RUCHIRA SHARMA
M. S. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON
REG. No. 3262 / 09/02

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Apollo Clinic
VASHI

DENTAL CHECKUP

Name: Mrs. Swati Agrawal.	**MR NO:**
Age/Gender : 39yrs/F	**Date:** 19/2/24

Medical history: ☐ Diabetes ☐ Hypertension ☐ _____

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus& Stains	✓	✓	✓	✓
Mobility				
Caries (Cavities)				
a)Class 1 (Occlusal)			37	
b)Class 2 (Proximal)				
c)Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

TREATMENT ADVICED:

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: _____

DR. NILAM PATIL
B. D. S
Reg. No: A 23226

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Name : Swati Agarwal Age : 30 Sex : F UHID No. : ____________ Date : 19/2/2024

LMP - 29/1/2024

O/H - P2L2 / FTVD

P/H - No medical

O/E - Afebrile

P/A Soft

P/S | Ut AV NS / FM
P/V | B/L FF free

Adv

HP after PAD

DR. ANNVI MASHRU
M.S. Obstetrics and Gynaecology
Reg. No. MMC 2018/03/0581

Dr. ____________________

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Apollo Clinic VASHI

Name	: Mrs. Swati Agarwal	Gender	: Female	Age	: 39 Years
UHID	: FVAH 10688	Bill No	:	Lab No	: V-2345-23
Ref. by	: SELF	Sample Col.Dt	: 19/02/2024 09:55		
Barcode No	: 9023	Reported On	: 19/02/2024 19:22		

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)	85.9	fl	78 - 98
MCH:(Calculated)	28.4	pg	26 - 34
MCHC:(Calculated)	33.1	gm/dl	30 - 36
RDW-CV:	13.9	%	10 - 16
Total Leucocyte count(Impedance)	6990	/cumm.	4000 - 10500
Neutrophils:	51	%	40 - 75
Lymphocytes:	40	%	20 - 40
Eosinophils:	04	%	0 - 6
Monocytes:	05	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.54	Lakhs/c.mm	1.5 - 4.5
MPV	9.9	fl	6.0 - 11.0
ESR(Westergren Method)	14	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

Dr. Milind Patwardhan
M.D(Path)

Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST	RESULTS
Blood Grouping (ABO & Rh)-WB(EDTA) Serum	
ABO Group:	**:B:**
Rh Type:	**Positive**
Method :	Matrix gel card method (forward and reverse)
------	----------

Sheetal Nakate
Entered By

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin :	4.8	%	Normal <5.7 % Pre Diabetic 5.7 - 6.5 % Diabetic >6.5 % Target for Diabetes on therapy < 7.0 % Re-evalution of therapy > 8.0 %
Mean Blood Glucose :	91.06	mg/dL	

Corelation 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 corelate 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 then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints 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 daibetics .
* 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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Barcode No	: 9023	Reported On	: 19/02/2024 19:22		

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 : >= 126 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)
Post Prandial Plasma Glucose :	89	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : >= 200 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)
Method :	Hexokinase		

Vasanti Gondal
Entered By

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LIPID PROFILE - Serum			
S. Cholesterol(Oxidase)	196	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	129	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	25.8	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	48.5	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	121.7	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4		3.5 - 5
Ratio of LDL/HDL	2.5		2.5 - 3.5

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.38	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.44	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.94	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.51		0.9 - 2
S.Total Bilirubin (DPD):	0.70	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.23	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.47	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	17	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	15	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	81	U/L	35 - 105
S.GGT(IFCC Kinetic):	9	U/L	07 - 32

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	16.2	mg/dl	10.0 - 45.0
BUN (Calculated)	7.56	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	**0.46**	mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	16.43		9:1 - 23:1
S.Uric Acid(Uricase Method)	4.2	mg/dl	2.4 - 5.7

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.71	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	104.2	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	1.07	□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 hypothyrodism.
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

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URINE REPORT

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
PHYSICAL EXAMINATION		
QUANTITY	10 mL	
COLOUR	Pale Yellow	
APPEARANCE	Slightly Hazy	Clear
SEDIMENT	Absent	Absent
CHEMICAL EXAMINATION(Strip Method)		
REACTION(PH)	7.0	4.6 - 8.0
SPECIFIC GRAVITY	1.010	1.005 - 1.030
URINE ALBUMIN	**Trace**	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	**Present (+)**	Absent
Nitrites	Absent	Absent
MICROSCOPIC EXAMINATION		
PUS CELLS	2 - 3 / hpf	0 - 3/hpf
RED BLOOD CELLS	**6 - 8 / hpf**	Absent
EPITHELIAL CELLS	**4 - 5 / hpf**	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Absent	Absent

Anushka Chavan
Entered By

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CYTOPATHOLOGY REPORT - PAP SMEAR

Specimen No: AP-274-24

Specimen Adequacy: ADEQUATE

CELLS

ENDOCERVICAL:	**Present**
ENDOMETRIAL:	Absent
SQUAMOUS:	**SUPERFICIAL(++) AND INTERMEDIATE(++) SQUAMOUS CELLS**
HISTIOCYTES:	Absent
RBCs:	Absent
POLYMORPHS:	**Present(Few)**

FLORA

TRICHOMONAS VAGINALIS:	Absent
FUNGI:	Absent
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
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Chief Pathologist

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Swati, Agarwal
10688

Female

30 Years

19.02.2024 10:34:47
Apollo Clinic
1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703.

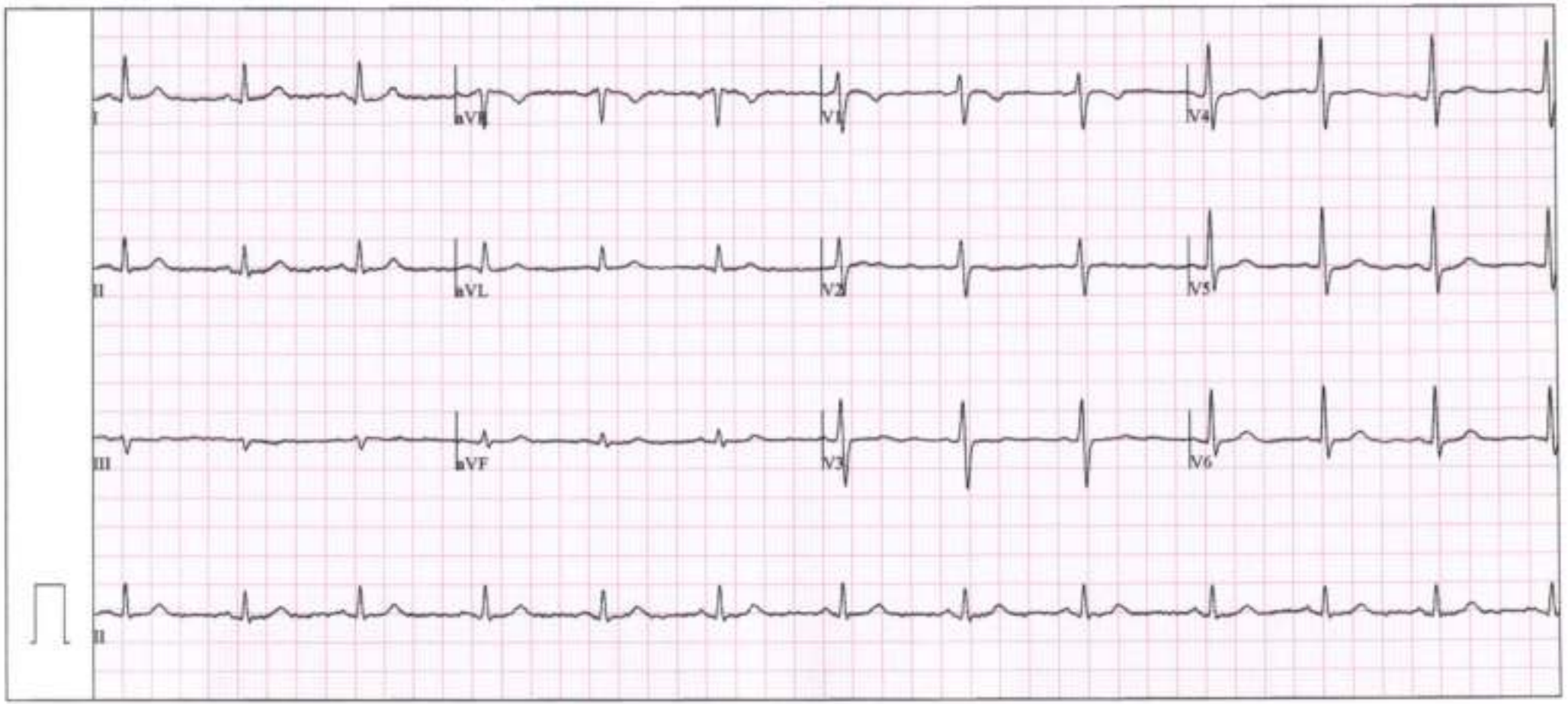
74 bpm
-- / -- mmHg

NORMAL ECG

QRS :	84 ms
QT / QTcBaz :	376 / 417 ms
PR :	108 ms
P :	62 ms
RR / PP :	814 / 810 ms
P / QRS / T :	21 / 15 / 29 degrees

Sinus rhythm with short PR
Otherwise normal ECG

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 4x2.5x3_25_R1 1/1

Apollo Clinic
The Emerald, Plot No-195/B, Sector-12,
Neel Siddhi Towers, Vashi-400703

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: SWATI , AGARWAL
Patient ID: 10688
Height:
Weight:

DOB: 18.07.1984
Age: 39yrs
Gender: Female
Race: Asian

Study Date: 19.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR.ANIRBAN DASGUPTA
Technician: SWAPNALI LAKHIMALE

Medications:
NIL

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	00:42	0.00	0.00	115	110/80	
	STANDING	00:12	0.00	0.00	106		
	HYPERV.	00:16	0.00	0.00	96		
	WARM-UP	00:35	0.90	0.00	121	110/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	164	130/90	
	STAGE 2	01:02	2.50	12.00	173	140/90	
RECOVERY		01:04	0.00	0.00	121	170/90	

The patient exercised according to the BRUCE for 4:02 min:s, achieving a work level of Max. METS: 7.00. The resting heart rate of 102 bpm rose to a maximal heart rate of 176 bpm. This value represents 97 % of the maximal, age-predicted heart rate. The resting blood pressure of 110/80 mmHg , rose to a maximum blood pressure of 170/90 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: none.
Overall impression: Normal stress test.

Conclusions
TMT IS NEGATIVE FOR INDUCIBLE MYOCARDIAL ISCHAEMIA AT THE WORKLOAD ACHIEVED.

Physician-DR.ANIRBAN DASGUPTA

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PATIENT'S NAME	SWATI AGARWAL	AGE :- 39 Y/F
UHID NO	10688	19 Feb 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 IN CURRENT RADIOGRAPH.

Clinico-haematological correlation is recommended.

Thanking you for the referral,
With regards,

DR. SIDDHI PATIL
Cons. Radiologist

Vashi : **M/S. Indira Health & Lifestyle Pvt. Ltd.** The Emerald, 1st Floor, Plot No. 195, Sector - 12, Besides Neel Siddhi Tower, Vashi - Navi Mumbai - 400703.
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PATIENT'S NAME	SWATI AGARWAL	AGE :- 39Y/F
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USG ABDOMEN AND PELVIS (TAS)

Liver is normal in size, shape and echotexture. There is no focal lesion seen. The portal vein and common bile duct are normal in course and caliber. There is no evidence of intra-hepatic biliary duct dilatation seen.

Gall Bladder is partially distended. No calculus, abnormal wall thickening or pericholecystic fluid collection is seen.

The visualized **Pancreas** is normal in size, shape and echotexture. There is no focal lesion seen.

Spleen is normal in size, shape and echotexture. There is no focal lesion seen.

Right Kidney measures 11.4 x 4.2 cm. **Left Kidney** measures 11.9 x 5.1 cm.
A calculus measuring about 7 mm is seen at right upper ureter causing back pressure changes in the form of mild hydronephrosis and hydroureter. Both kidneys are normal in size, shape and echotexture. No evidence of any focal lesion is noted. No hydronephrosis, hydroureter or calculus is noted in left kidney. Cortico medullary differentiation is well maintained.

Urinary Bladder is well distended. There is no evidence of focal lesion. No evidence of any calculus is seen.

Uterus is normal in size and echotexture. No evidence of any focal lesion. It measures about 8.9 x 3.8 x3.1 cm in size. The endometrium measures 13.3 mm. Both ovaries are not well appreciated at present scan, however adnexa appears clear.

There is no free fluid or abdominal lymphadenopathy.

IMPRESSION: **FINDINGS REVEAL OBSTRUCTIVE RIGHT MID URETERIC CALCULUS CAUSING BACK PRESSURE CHANGES IN THE FORM OF MILD HYDRONEPHROSIS AND HYDROURETER. NO OTHER SIGNIFICANT ABNORMALITY IS DETECTED AT PRESENT STUDY.**

Clinico-haematological correlation and imaging follow-up is recommended.

Thanking you for the referral,
With regards,

DR. SIDDHI PATIL
Con. Radiologist

• ANDHERI • COLABA • NASHIK • VASHI

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