Apollo

Apollo Clinic
VASHI

MEDICAL SUMMARY

NAME:	Sai Bahulikar	UHID:	FVAH5003
AGE:	36 Yrs	DATE OF HEALTHCHECK:	11/2/23
GENDER:	female		

HEIGHT:	154 cm	MARITAL STATUS:	
WEIGHT:	57 kg	NO OF CHILDREN:	

BMI - 24

C/O: No fresh complains

K/C/O: NO

PRESENT MEDICATION: NO

P/M/H:
Lmp - 23/01/2023.

P/S/H:

H/A: SMOKING:
ALCOHOL:
TOBACCO/PAN: } NO.

FAMILY HISTORY FATHER: —
MOTHER: Kdo DM. on Rx

O/E:

LYMPHADENOPATHY: NO

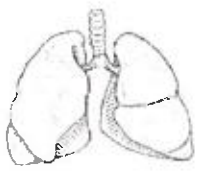
BP: 110/70 mmHg PULSE: 70/min.

PALLOR/ICTERUS/CYNOSIS/CLUBBING:

TEMPERATURE: SCARS:

OEDEMA: NO

S/E:
RS:



AEBE.

P/A:

Soft, NT

CVS: S1S2 (N)

Extremities & Spine: (N)

ENT: (N)

CNS: Conscious, well oriented

Skin:

Vision:

	Without Glass		With Glass	
	Right Eye	Left eye	Right Eye	Left eye
FAR :				
NEAR :				
COLOUR VISION:				
ADVISE :	CBC.			

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

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OPHTHALMIC EVALUATION

UHID No.: 5003 Date : 11/02/2023

Name : Mrs. Sai Bahulikar Age : 36yrs Gender :~~Male/~~Female

Without Correction :

Distance: Right Eye 6/6 P Left Eye 6/6.

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

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

Colour Vision : (BE) WNL.

Anterior Segment Examination : (BE) WNL.

Pupils : (BE) WNL.

Fundus : (BE) WNL.

Intraocular Pressure : _____

Diagnosis : (BE) WNL.

Advice : _____

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

DR. SAGORIKA DEY
MBBS, DOMS
Dr. REGN NO: 2008/04/1182
(Consultant Ophthalmologist)

Adey.

Apollo Clinic, Licensee : **M/s. Indira Health & Lifestyle Pvt. Ltd.**, "The Emerald", Plot No. 195/B, Sector 12, Besides Neel Siddhi Towers, Vashi, Navi Mumbai - 400703. **Tel.:** (91-22) 2788 1322 / 23 / 24 82914 90000 Email: apolloclinicvashi@gmail.com

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DENTAL CHECKUP

Name: Mrs. Sai	**MR NO:**
Age/Gender : 36/F	**Date:** 11/2

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		6	4, 6	
Existing Denture				

TREATMENT ADVICED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling		6	4, 6	
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: NA

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Name : Mrs. Sai Age : 36 yrs Sex : F UHID No. : Date : 11/2/23

36 yrs, F, P2L2

Dyspareunia

Men - LMP - 23/1/2023

O/H - P2L2

Past :- nil

GC - fair
afebrile

CVS / RS NAD
RS

P/A - Soft
non tender

P/S - [illegible]

Dr.

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■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

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TOUCHING LIVES
MC-2364

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Name	: Mrs. Sai Bahulikar	Gender	: Female	Age	: 36 Years
UHID	: FVAH 5003.	Bill No	:	Lab No	: V-284-23
Ref. by	: SELF	Sample Col.Dt	: 11/02/2023 10:05		
Barcode No	: 4980	Reported On	: 11/02/2023 21:01		

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
CBC (Complete Blood Count)-WB (EDTA)			
Haemoglobin(Colorimetric method)	**8.6**	g/dl	11.5 - 15
RBC Count (Impedance)	**3.91**	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	**27.1**	%	35 - 55
MCV:(Calculated parameter)	**69.3**	fl	78 - 98
MCH:(Calculated parameter)	**22.1**	pg	26 - 34
MCHC:(Calculated parameter)	31.8	gm/dl	30 - 36
RDW-CV:	**16.6**	%	10 - 16
Total Leucocyte count(Impedance)	6250	/cumm.	4000 - 10500
Neutrophils:	57	%	40 - 75
Lymphocytes:	40	%	20 - 40
Eosinophils:	01	%	0 - 6
Monocytes:	02	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	3.45	Lakhs/c.mm	1.5 - 4.5
MPV	9.6	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)			
RBCs:	Hypochromasia(++),Microcytosis(++),Anisocytosis(+)		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter.		

Ms Kaveri Gaonkar
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		BIOLOGICAL REFERENCE INTERVAL
ESR(Westergren Method)			
Erythrocyte Sedimentation Rate:-	05	mm/1st hr	0 - 20

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TEST	RESULTS
Blood Grouping (ABO & Rh)-WB(EDTA) Serum	
ABO Group:	**:A:**
Rh Type:	**Positive**
Method :	Tube Agglutination (forward and reverse)
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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin :	5.1	%	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 :	99.67	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% final HbA1c levels

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL

PLASMA GLUCOSE

Fasting Plasma Glucose :	91	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 :	123	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		

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Lipid Profile- Serum			
S. Cholesterol(Oxidase)	122	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	106	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	21.2	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	41.2	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	59.6	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	3		3.5 - 5
Ratio of LDL/HDL	1.4		2.5 - 3.5

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.03	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.73	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.3	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	**2.06**		0.9 - 2
S.Total Bilirubin (DPD):	**2.05**	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	**0.65**	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	**1.4**	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	13	U/L	5 - 36
S.ALT (SGPT) (IFCC Kinetic with P5P):	9	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	51	U/L	35 - 105
S.GGT(IFCC Kinetic):	18	U/L	07 - 32

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	12.4	mg/dl	10.0 - 45.0
BUN (Calculated)	5.78	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.57	mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	10.14		9:1 - 23:1
S.Uric Acid(Uricase Method)	4.4	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)	1.57	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	92.28	nmol/L	66 - 181 nmol/L
TSH (Thyroid-stimulating hormone) (ECLIA)	2.46	□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	40	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent
CHEMICAL EXAMINATION(Strip Method)			
REACTION(PH)	6.0		4.6 - 8.0
SPECIFIC GRAVITY	1.005		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	1 - 2 /hpf		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	2 - 3 /hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

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CYTOPATHOLOGY REPORT

Specimen No: AP-213-23

Specimen Adequacy: ADEQUATE

CELLS

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

FLORA

TRICHOMONAS VAGINALIS:	Absent
MONILIA:	Absent
BACTERIA:	Absent
DODERLEIN BACILLI:	Absent
LEPTOTHRIX:	Absent

CELLULAR CHANGES

METAPLASIA:	Absent
DYSPLASIA:	Absent
MALIGNANT CELL:	Absent
ATROPHIC CHANGES:	Absent
IMPRESSION:	**NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY**

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
STOOL EXAMINATION		
PHYSICAL EXAMINATION		
COLOUR	Brown	
CONSISTENCY	Semi Solid	
MUCUS	Absent	Absent
FRANK BLOOD	Absent	Absent
CHEMICAL EXAMINATION		
OCCULT BLOOD (Guaiac method)	Absent	Absent
PH(Litmus paper)	Acidic	Acidic/Alkaline
MICROSCOPIC EXAMINATION		
PUS CELLS	Absent	0 - 1
EPITHELIAL CELLS	Absent	Absent
RED BLOOD CELLS	Nil /HPF	Absent
FAT GLOBULES	Absent	Absent
VEGETABLE FIBRES	Present	Present
YEASTS	Absent	Absent
CYST	Absent	Absent
VEGETATIVE FORMS	Absent	Absent
OVA	Absent	Absent
LARVAE	Absent	Absent

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Sai, Bhahulikar
5003

Female

36 Years

11.02.2023 10:47:11
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1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703.

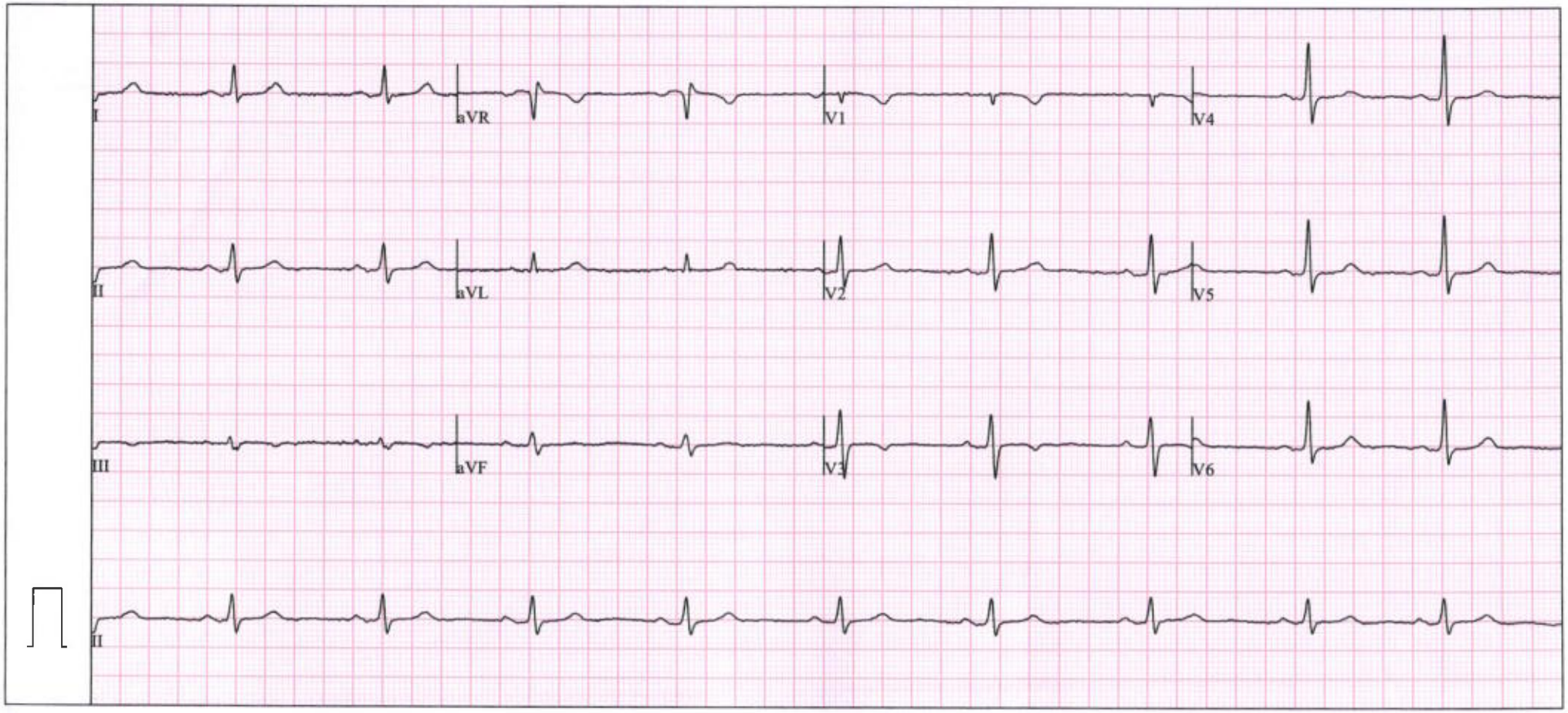
58 bpm
-- / -- mmHg

NORMAL ECG

QRS :	82 ms
QT / QTcBaz :	412 / 404 ms
PR :	170 ms
P :	60 ms
RR / PP :	1030 / 1034 ms
P / QRS / T :	34 / 9 / -4 degrees

Sinus bradycardia
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 VASHI

PATIENT'S NAME	SAI BAHULIKAR	AGE :- 36Y/F
UHID	5003	DATE :- 11-02-23

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.

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

Measurements

Aorta annulus	18 mm
Left Atrium	34 mm
LVID(Systole)	23 mm
LVID(Diastole)	40 mm
IVS(Diastole)	08 mm
PW(Diastole)	10 mm
LV ejection fraction.	55-60%

Conclusion

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

Dasgupta

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

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VASHI

PATIENT'S NAME	SAI BAHULIKAR	AGE :- 36 y/F
UHID NO	5003	11 Feb 2023

X-RAY CHEST PA VEIW

OBSERVATION:

Bilateral lung fields are clear.
Both hila are normal.
Bilateral cardiophrenic and costophrenic angles are normal.
The trachea is central.
Aorta appears normal.
The mediastinal and cardiac silhouette are normal.
Soft tissues of the chest wall are normal.
Bony thorax is normal.

IMPRESSION:

- **No significant abnormality seen.**

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

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PATIENT'S NAME	SAI BAHULIKAR	AGE :- 36Y/F
UHID	5003	11 Feb 2023

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal 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. CBD appears normal.

Visualised parts of head & body of **PANCREAS** appear normal.

SPLEEN is normal in size, and echotexture. No focal lesion seen. Splenic vein 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 10.8 x 3.6 cm. **LEFT KIDNEY** measures 10.8 x 3.3 cm.

URINARY BLADDER is well distended; no e/o wall thickening or mass or calculi seen.

UTERUS is anteverted and is enlarged in size, normal shape and echotexture;
It measures 8.9 x 5.6 x 4.1 cm; ET measures 10.6 mm. shows 2.0 x 1.7 cm anterior wall subserosal fibroid.

Both ovaries are enlarged in size, shows small multiple peripheral follicles.
RIGHT OVARY Vol: 4.3 x 3.8 x 2.2 cm (Vol: 20.0ml),
LEFT OVARY Vol: 4.8 x 2.4 x 3.5 cm (Vol: 20.6ml).

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

IMPRESSION –

- **Bulky uterus with anterior wall subserosal fibroid.**
- **Bilateral polycystic ovaries.**
- **No other significant abnormality detected.**

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

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

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Name: Mrs. Sai Bahulikar	Age: 36 Y	Date of Health check-up: 11/2/23

Findings and Recommendation:

Findings:-

- Hb ↓
- LFT deranged
- PCOD.
- Fibroid

Recommendation:-

- Glycomet cap
- Repeat LFT after 15 days
- Iron supplement

Signature:

Consultant –

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