

NAME:	Mrs. Madhuri Kulkarni	UHID:	
AGE:	40	DATE OF HEALTHCHECK:	10-01-2024
GENDER:	F		

HEIGHT:	148	MARITAL STATUS:	M
WEIGHT:	52	NO OF CHILDREN:	2
BMI:	23.7		

C/O: RA - mild pain, cervical pain  
Arteriovc.

K/C/O:  
PRESENT MEDICATION: - No

P/M/H: - No

P/S/H: WLS

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER: - (MAD)  
MOTHER: - (MAD)

ALCOHOL: No  
TOBACCO/PAN: No

O/E:

LYMPHADENOPATHY: (MAD)  
PALLOR/ICTERUS/CYNOSIS/CLUBBING: (MAD)

BP: 90/70 PULSE: 86/min

TEMPERATURE: NSCARS:

OEDEMA:

S/E:  
RS:



P/A: (MAD)

CVS: S2A

Extremities & Spine: - (MAD)

ENT: - (MAD)

CNS: normal, oriented

Skin: - (MAD)

Vision:

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

Name:	Age:	Date of Health check-up:
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### Findings and Recommendation:

#### Findings:-

HB - 9.2 gm<sup>l</sup>.  
CBC - Sugg of iron def anaemia -  
urine - shows pus cells  
& calcium oxalate crystals  
ECG - Abnormal.

#### Recommendation:-

Consult Physician

DR. PRADNYA P. DANI  
(M.B.B.S.)  
Reg. No. 47941

  
Signature:  
Consultant -

## OPHTHALMIC EVALUATION

UHID No.: \_\_\_\_\_

Date: 10/1/24

Name: MADHURI KUMARI Age: 40y Gender: Male/Female

Without Correction :

Distance: Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

Near : Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

With Correction :

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

Near : Right Eye N-6 Left Eye N-6

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

Colour Vision : (PDE) - WNL

Anterior Segment Examination : (PDE) - WNL

Pupils : (PDE) - WNL

Fundus : (PDE) - WNL

Intraocular Pressure : \_\_\_\_\_

Diagnosis : (PDE) - WNL

Advice : \_\_\_\_\_

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

Dr. Sagorika Dey  
**DR. SAGORIKA DEY**  
 MBBS DOMS  
 REGN NO: 2008/04/1182

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

## DENTAL CHECKUP

<b>Name:</b> Mrs. Madhuri Kanari	<b>MR NO:</b>
<b>Age/Gender :</b> 40yrs/F	<b>Date:</b> 10/11/24

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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Ali*



Name: Madhuri Kurari Age: 40 Sex: F UHID No.: \_\_\_\_\_ Date: 10/1/24

CMP - 1/1/24

OIU - P2L2 { FTND  
FTUSG

PIH - No Medical or Gyn

OIE - Gyn join

PIA - Soft

PIV - wt AN INSIFAY  
BILFA heel NT.

Adv

- fup 505

- 7. Fluone (50mg)

(4)

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

Dr. \_\_\_\_\_



**Apollo Clinic**  
VASHI

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

Name : Mrs. Madhuri Kumari Gender : Female Age : 40 Years  
 UHID : FVAH 10183. Bill No : Lab No : V-1295-23  
 Ref. by : SELF Sample Col.Dt : 10/01/2024 09:05  
 Barcode No : 3565 Reported On : 10/01/2024 17:26


**TEST RESULTS BIOLOGICAL REFERENCE INTERVAL**

**HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)**

Haemoglobin(Colorimetric method)	<b>9.2</b>	g/dl	11.5 - 15
RBC Count (Impedance)	4.88	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	<b>31.3</b>	%	35 - 55
MCV:(Calculated)	<b>64.2</b>	fl	78 - 98
MCH:(Calculated)	<b>19</b>	pg	26 - 34
MCHC:(Calculated)	<b>29.5</b>	gm/dl	30 - 36
RDW-CV:	<b>19.2</b>	%	10 - 16
Total Leucocyte count(Impedance)	6590	/cumm.	4000 - 10500
Neutrophils:	62	%	40 - 75
Lymphocytes:	29	%	20 - 40
Eosinophils:	04	%	0 - 6
Monocytes:	05	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.23	Lakhs/c.mm	1.5 - 4.5
MPV	9.1	fl	6.0 - 11.0
ESR(Westergren Method)	18	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Hypochromasia(++),Microcytosis(++),Anisocytosis(++),Poikilocytosis (Mild)		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

Pooja Surve  
Entered By

Ms Kaveri Gaonkar  
Verified By

Page 7 of 10  
  
 Dr. Milind Patwardhan  
 M.D(Path)  
 Chief Pathologist

End of Report  
 Results are to be correlated clinically








Name : Mrs. Madhuri Kumari      Gender : Female      Age : 40 Years  
UHID : FVAH 10183.      Bill No :      Lab No : V-1295-23  
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
<b>PLASMA GLUCOSE</b>			
Fasting Plasma Glucose :	86	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 :	96	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)	171	mg/dL	Desirable < 200 Borderline: >200-<240 Undesirable: >240
S. Triglyceride(GPO-POD)	69	mg/dL	Desirable < 150 Borderline: >150-<499 Undesirable: >500
S. VLDL:(Calculated)	13.8	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	53.4	mg/dL	Desirable > 60 Borderline: >40-<59 Undesirable: <40
S. LDL:(calculated)	103.8	mg/dL	Desirable < 130 Borderline: >130-<159 Undesirable: >160
Ratio Cholesterol/HDL	<b>3.2</b>		3.5 - 5
Ratio of LDL/HDL	<b>1.9</b>		2.5 - 3.5

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TEST      RESULTS      UNITS      BIOLOGICAL REFERENCE INTERVAL

**LFT(Liver Function Tests)-Serum**

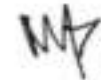
S.Total Protein (Biuret method)	7.02	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.42	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.6	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.7		0.9 - 2
S.Total Bilirubin (DPD):	0.39	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.16	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.23	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	24	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	17	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	88	U/L	35 - 105
S.GGT(IFCC Kinetic):	9	U/L	07 - 32

Name : Mrs. Madhuri Kumari      Gender : Female      Age : 40 Years  
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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	<b>BIOCHEMISTRY</b>	
S.Urea(Urease Method)	16.9      mg/dl	10.0 - 45.0
BUN (Calculated)	7.88      mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	<b>0.42</b> mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	18.76	9:1 - 23:1
S.Uric Acid(Uricase Method)	3.0      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)	2.54	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	140.4	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	3.45	□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 :**

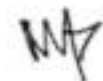
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**TSH :**

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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End of Report  
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TEST      RESULTS      BIOLOGICAL REFERENCE INTERVAL

**URINE REPORT**

**PHYSICAL EXAMINATION**

QUANTITY	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Slightly Hazy		Clear
SEDIMENT	Absent		Absent

**CHEMICAL EXAMINATION(Strip Method)**

REACTION(PH)	6.5	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	<b>18 - 20 / hpf</b>	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	<b>10 - 12 / hpf</b>	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	<b>Calcium Oxalate (Few)</b>	Absent
BACTERIA	<b>Present(Few)</b>	Absent

Vasanti Gondal  
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Ms Kaveri Gaonkar  
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Dr. Milind Patwardhan  
M.D(Path)

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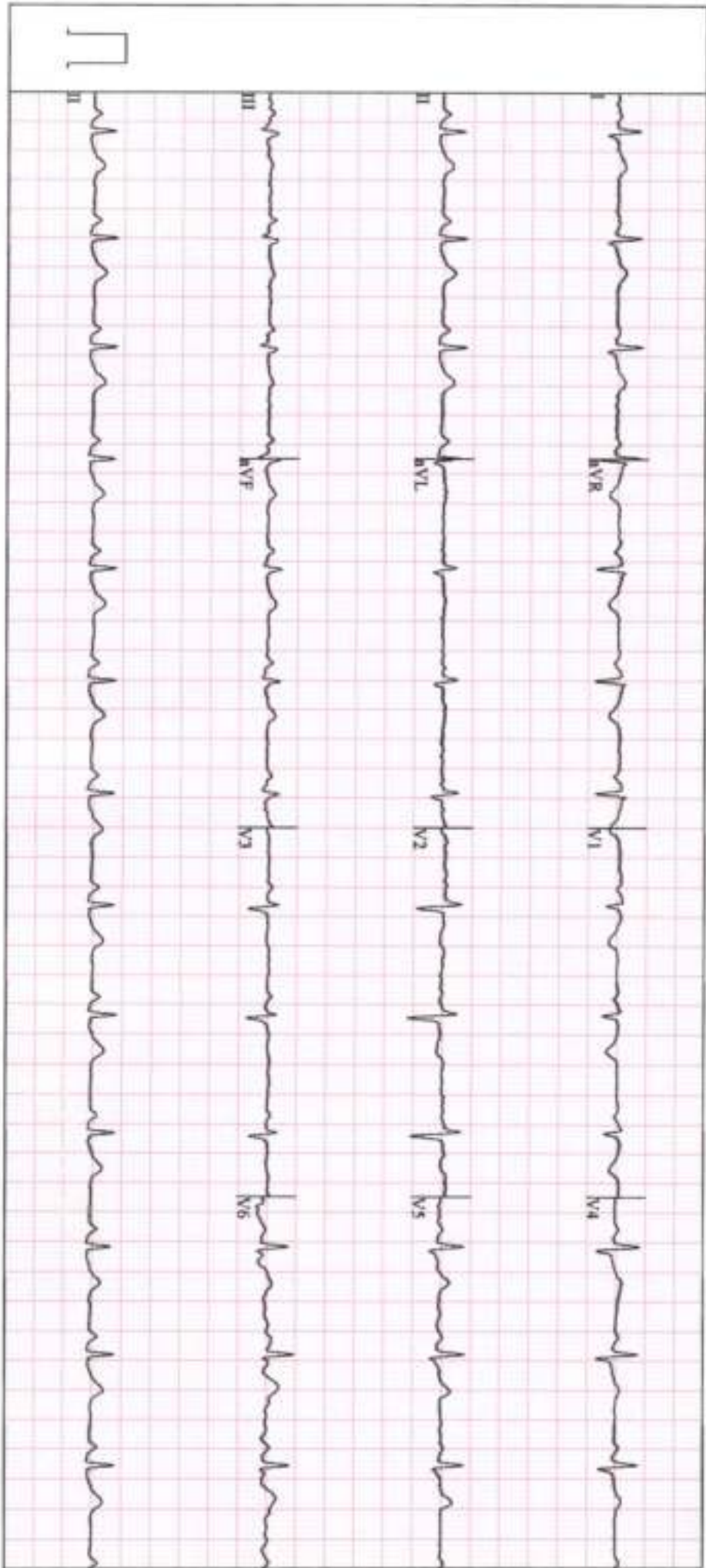
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QRS : 76 ms  
QT / QTc : 360 / 415 ms  
PR : 122 ms  
P : 74 ms  
RR / PP : 754 / 750 ms  
P / QRS / T : 74 / 39 / 46 degrees

Normal sinus rhythm  
Cannot rule out inferior infarct, age undetermined  
Abnormal ECG

# NORMAL ECG

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





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

**Station**  
Telephone:

## EXERCISE STRESS TEST REPORT

Patient Name: MADHURI, KUMARI  
Patient ID: 10183  
Height:  
Weight:

DOB: 15.12.1983  
Age: 40yrs  
Gender: Female  
Race: Asian

Study Date: 10.01.2024  
Test Type: Treadmill Stress Test  
Protocol: BRUCE

Referring Physician: --  
Attending Physician: DR. ANIRBAN DASGUPTA  
Technician: Anita Gaikwad

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	00:23	0.00	0.00	93	90/70	
	STANDING	00:15	0.00	0.00	89		
	HYPERV.	00:14	0.00	0.00	88		
	WARM-UP	00:29	0.60	0.00	93	90/70	
EXERCISE	STAGE 1	03:00	1.70	10.00	125	120/80	
	STAGE 2	02:31	2.50	12.00	179	140/80	
RECOVERY		02:24	0.00	0.00	108	160/80	

The patient exercised according to the BRUCE for 5:30 min:s, achieving a work level of Max. METS: 7.00. The resting heart rate of 87 bpm rose to a maximal heart rate of 179 bpm. This value represents 99 % of the maximal, age-predicted heart rate. The resting blood pressure of 90/70 mmHg, rose to a maximum blood pressure of 160/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

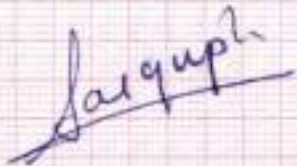
### Interpretation

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: none.  
Overall impression: Normal stress test.

### Conclusions

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

Physician-DR. ANIRBAN DASGUPTA



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



PATIENT'S NAME	MADHURI KUMARI	AGE :- 40Y/F
UHID	10183	11 Jan 2024

### X-RAY BILATERAL MAMMOGRAMS

*Film screen mammography of the breasts was performed using low radiation dose. Medio-lateral oblique and cranio - caudal projections were obtained.*

**Indication:** Screening mammogram.

**Comparison:** No previous mammogram is available for comparison.

**Findings-**

**ACR D-Severe dense breasts, limits sensitivity of the mammogram.**

**Right breast:**

No dominant mass, suspicious calcifications or architectural distortion is seen.

**Left breast:**

No dominant mass, suspicious calcifications or architectural distortion is seen.

**IMPRESSION-**

**No mass is observed- ACR BIRADS category 1.**

**Recommendation: Routine screening follow up and regular self breast examinations.**

**DISCLAIMER:** Not all breast abnormalities show up on mammography. The false negative rate of mammography is approximately 10%. The management of a palpable abnormality must be based on clinical grounds. If you detect a lump or any other change in your breast before your next screening mammogram, consult your doctor immediately.

**Lexicon:** ACR BIRADS category 1- negative for malignancy; ACR BIRADS category 2- benign finding; ACR BIRADS category 3- probably benign finding, 98 % benign and 2 % risk of malignancy; ACR BIRADS category 4a- low suspicion of malignancy, 2-10% risk of malignancy; ACR BIRADS category 4b- intermediate suspicion of malignancy, 10-50% risk of malignancy; ACR BIRADS category 4c- high suspicion of malignancy, 50-95 % risk of malignancy; ACR BIRADS category 5- highly suggestive of malignancy, > 95% risk of malignancy; ACR BIRADS category 6- biopsy proven malignancy



**DR. DISHA MINOCHA**  
**DMRE (RADIOLOGIST)**

PATIENT'S NAME	MADHURI KUMARI	AGE :- 40 y/F
UHID NO	10183	10 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

PATIENT'S NAME	MADHURI KUMARI	AGE :- 40Y/F
UHID	10183	10 Jan 2024

### 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. PV = 11 mm. CBD = 2.3 mm.

**Gall Bladder** is physiologically 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 9.6 x 3.2 cm. **Left Kidney** measures 10.1 x 3.7 cm. 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 both 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 7 x 3.6 x 3.5 cm in size. The endometrium measures 9.4 mm. Both ovaries are unremarkable.

There is no free fluid or abdominal lymphadenopathy.

**IMPRESSION: NO 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 APTIL**  
Con. Radiologist