DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
24-02-2024	DEEPIKA JAHA	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 biliary radicles are normal. The portal vein and CBD are normal. The gall bladder is well distended 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
11.1x3.9	10.8x5.2

IMPRESSION :

NO ABNORMALITY DETECTED.

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

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
24-02-2024	DEEPIKA JAHA	F	BODY PROFILE	X-RAY

X-ray CHEST PA view.

No evidence of consolidation or infilteration seen involving both lungs.

Costophrenic sinuses are clear.

Vascular shadows are normal on both sides.

Hilar shadows show evidence of normal size,position & opacity.

Heart & aortic shadows show evidence of normal position & size.

Position of domes of diaphragm is normal.Bony cage show no abnormality.

COMMENTS:

NO EVIDENCE OF ABNORMALITY DETECTED.

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

CHARUSAT HOSPITAL

CHRF CHARUSAT HOSPITAL Care with compassion...

Patient Name :	DEEPIKA .. JHA	Sample No. :	SAMPLE-0107376
Patient ID :	CH-2024-0053933	Visit No. :	OPD/2024/02/0001410
Age/Sex :	33y/Female	Call. Date :	24-Feb-2024 10:34
Referred By :	RIPAL PATEL	S. Coll. Date :	24-Feb-2024 14:31
Ward :	-	Report Date :	24-Feb-2024 14:52

P2BS

Investigation	Result		Normal Value
Post Prandial Blood Sugar (2Hrs) :	100.0	mg/dl [NORMAL]	100 - 140

. NAITIK BHATIA
NSULTANT PATHOLOGIST
B.B.S,D.C.P)

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

CHARUSAT HOSPITAL

atient Name :	DEEPIKA .. JHA	Sample No. :	SAMPLE-0107363
atient ID :	CH-2024-0053933	Visit No. :	OPD/2024/02/0001410
ge/Sex :	33y/Female	Call. Date :	24-Feb-2024 10:34
eferred By :	RIPAL PATEL	S. Coll. Date :	24-Feb-2024 11:00
/ard :	-	Report Date :	24-Feb-2024 14:37

A1C

restigation	Result	Normal Value
ean Blood Glucose	123.0 mg/dl	
A 1c	6.1 %	> 8 : Action Suggested 7-8 : Good Control < 7 : Goal 6-7 : Near Normal Glycemia < 6 : Non-diabetic Level

omments

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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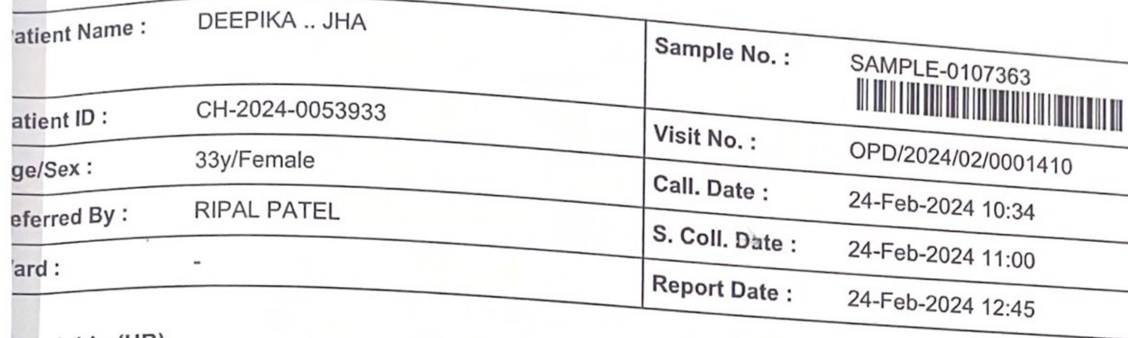

atient Name :	DEEPIKA .. JHA	Sample No. :	SAMPLE-0107363
atient ID :	CH-2024-0053933	Visit No. :	OPD/2024/02/0001410
ge/Sex :	33y/Female	Call. Date :	24-Feb-2024 10:34
eferred By :	RIPAL PATEL	S. Coll. Date :	24-Feb-2024 11:00
ard :	-	Report Date :	24-Feb-2024 12:45

moglobin (HB)

estigation	Result	Normal Value
moglobin	10.4 gm/dl [LOW]	[M : 14-18, F : 12-16]

C

estigation	Result	Normal Value
.C Count :	3.69 mill./c.mm [LOW]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
C :	11280 /c.mm [HIGH]	4000 - 10000

telet count

estigation	Result	Normal Value
telets	2.02 Lakh/cmm [NORMAL]	1.5 - 4.5

C count - Differential

estigation	Result	Normal Value
ymorphs	80 % [HIGH]	40 - 70
nphocytes	14 % [LOW]	20 - 40
inophils	01 % [NORMAL]	1 - 6
nocytes	05 % [NORMAL]	2 - 10
ophils	00 % [NORMAL]	0 - 1

OD UREA

stigation	Result	Normal Value
od Urea	37.8 mg/dl [NORMAL]	15 - 40

eatinine

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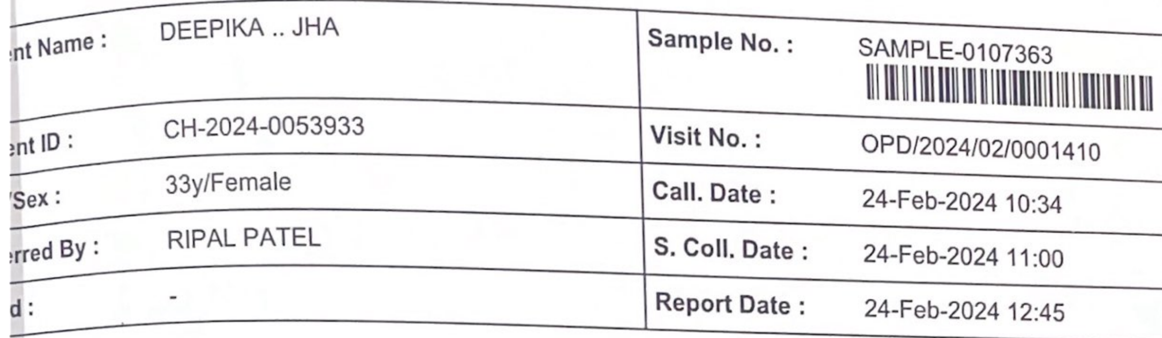

nt Name :	DEEPIKA .. JHA	Sample No. :	SAMPLE-0107363
nt ID :	CH-2024-0053933	Visit No. :	OPD/2024/02/0001410
/Sex :	33y/Female	Call. Date :	24-Feb-2024 10:34
rred By :	RIPAL PATEL	S. Coll. Date :	24-Feb-2024 11:00
d :	-	Report Date :	24-Feb-2024 12:45

vestigation	Result	Normal Value
erum Creatinine	0.81 mg/dl [NORMAL]	Male : 0.9 to 1.5 mg/dl Female : 0.8 to 1.2 mg/dl

JN

vestigation	Result	Normal Value
UN :	19 [NORMAL]	8.0 to 23.0 (mg/dl)

RIC ACID

vestigation	Result	Normal Value
erum Uric Acid	6.84 mg/dl [HIGH]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

SR

ivestigation	Result	Normal Value
ESR - After One Hour	06 mm [NORMAL]	[M : 3 - 5, F : 4 - 7]

lood Group

ivestigation	Result	Normal Value
ABO :	B	
Rh :	Positive	

ASTING BLOOD GLUCOSE

nvestigation	Result	Normal Value
Fasting Blood Sugar :	83.9 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

TSH

nvestigation	Result	Normal Value
TSH :	4.02 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3

nvestigation	Result	Normal Value

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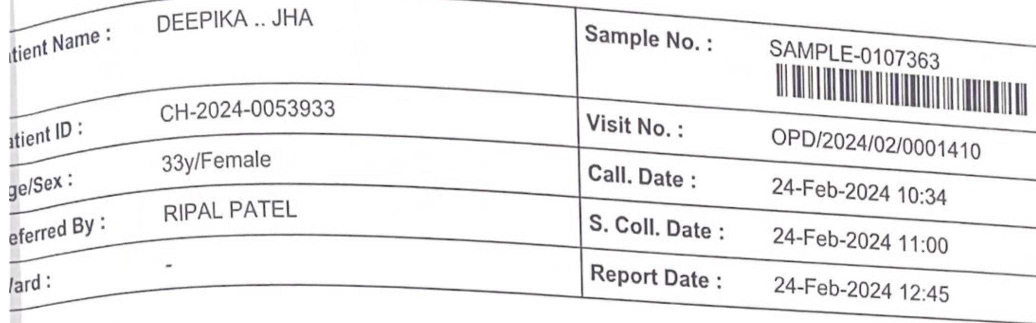

tient Name :	DEEPIKA .. JHA	Sample No. :	SAMPLE-0107363
tient ID :	CH-2024-0053933	Visit No. :	OPD/2024/02/0001410
ge/Sex :	33y/Female	Call. Date :	24-Feb-2024 10:34
eferred By :	RIPAL PATEL	S. Coll. Date :	24-Feb-2024 11:00
/ard :	-	Report Date :	24-Feb-2024 12:45

vestigation	Result	Normal Value
3-Triodothyronine :	0.89 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

vestigation	Result	Normal Value
4-thyroxine :	87.6 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

VER FUNCTION TEST

vestigation	Result	Normal Value
otal Bilirubin :	0.64 mg/dl [NORMAL]	0.0 to 1.2
irect Bilirubin (DBIL) :	0.24 mg/dl [NORMAL]	0.0 to 0.30
LT (SGPT) :	28.0 IU/L [NORMAL]	[0.0 - 40]
ST (SGOT) :	12.8 IU/L [NORMAL]	<= 45.0
lkaline Phosphatase (ALP) :	65.3 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP) :	7.7 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	4.43 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.40 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.3 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.1	

URINE R & M

Investigation	Result	Normal Value
Physical Examination :		
Quantity :	10 ml	
Colour :	Pale Yellow -	
Appearance :	Hazy -	

HARUSAT Campus, Changa, District Anand 388 421 (Guj) India. Ph # +91-2697-265500/02/04 • Mobile : 95379 27873 / 75748 38111
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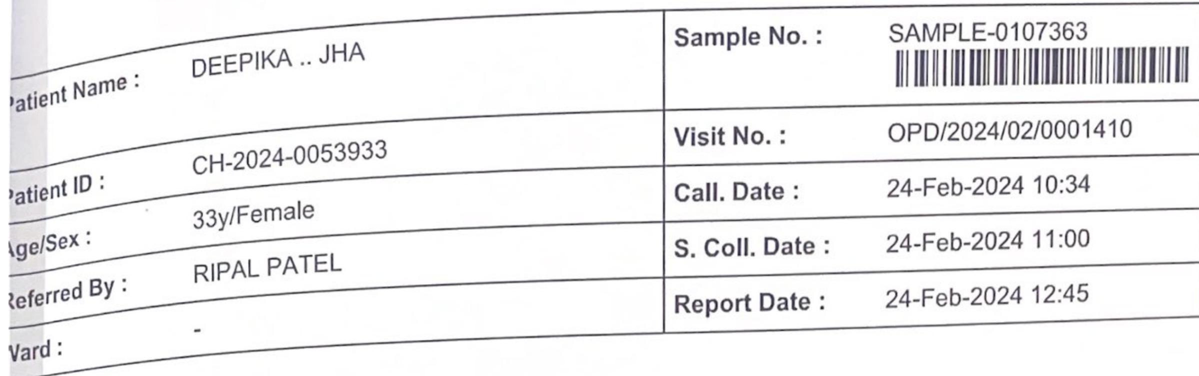

Patient Name :	DEEPIKA .. JHA	Sample No. :	SAMPLE-0107363
Patient ID :	CH-2024-0053933	Visit No. :	OPD/2024/02/0001410
Age/Sex :	33y/Female	Call. Date :	24-Feb-2024 10:34
Referred By :	RIPAL PATEL	S. Coll. Date :	24-Feb-2024 11:00
Ward :	-	Report Date :	24-Feb-2024 12:45

Odour :	URINIOD -
Reaction :	Acidic -
Specific Gravity :	1.025 -
Chemical Examination :	
Albumin :	Absent -
Sugar :	Absent -
Bile Salts :	Absent -
Bile Pigments :	Absent -
Acetone :	Absent -
Urobilinogen :	Absent -
Microscopie Examination :	
Pus Cells :	4-6 -
RBCs :	Absent -
Epithelial cells :	8-10 -
Casts :	Absent -
Crystals :	Absent -

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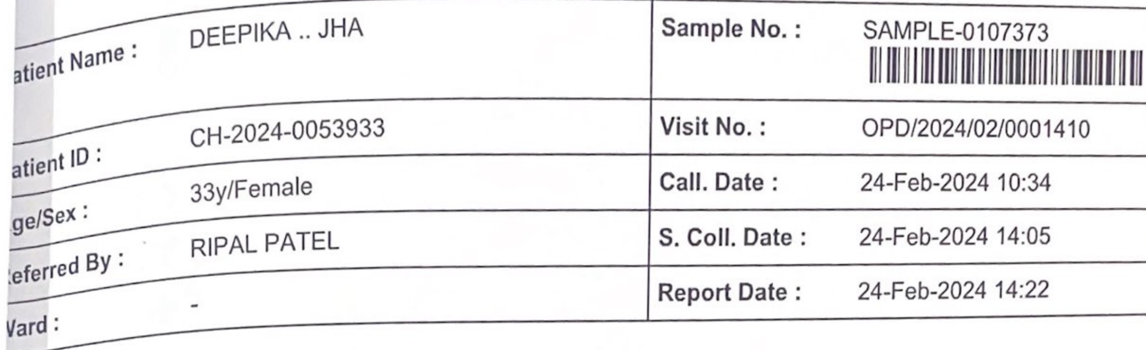

atient Name :	DEEPIKA .. JHA	Sample No. :	SAMPLE-0107373
atient ID :	CH-2024-0053933	Visit No. :	OPD/2024/02/0001410
ge/Sex :	33y/Female	Call. Date :	24-Feb-2024 10:34
:eferred By :	RIPAL PATEL	S. Coll. Date :	24-Feb-2024 14:05
Vard :	-	Report Date :	24-Feb-2024 14:22

PID PROFILE

vestigation	Result	Normal Value
erum Cholesterol (Chol) :	196.4 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
erum Triglyceride :	161.0 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
;.HDL Cholesterol :	55.7 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
.DLC :	101.42 mg/dl	
'LDL :	39.28 mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
.DL/HDL Ratio :	1.82 - [NORMAL]	< 3.5
'C / HDL Ratio :	3.53 - [LOW]	4.0 to 6.0
.DL (DIRECT) :	108.3 mg/dl [Near Optimal]	< 100.0 (Optimal), 100.0 to 120.0 (Near Optimal), 130.0 to 159.0 (Border line high), 160.0 to 189.0 (High), > 190.0 (Very high)

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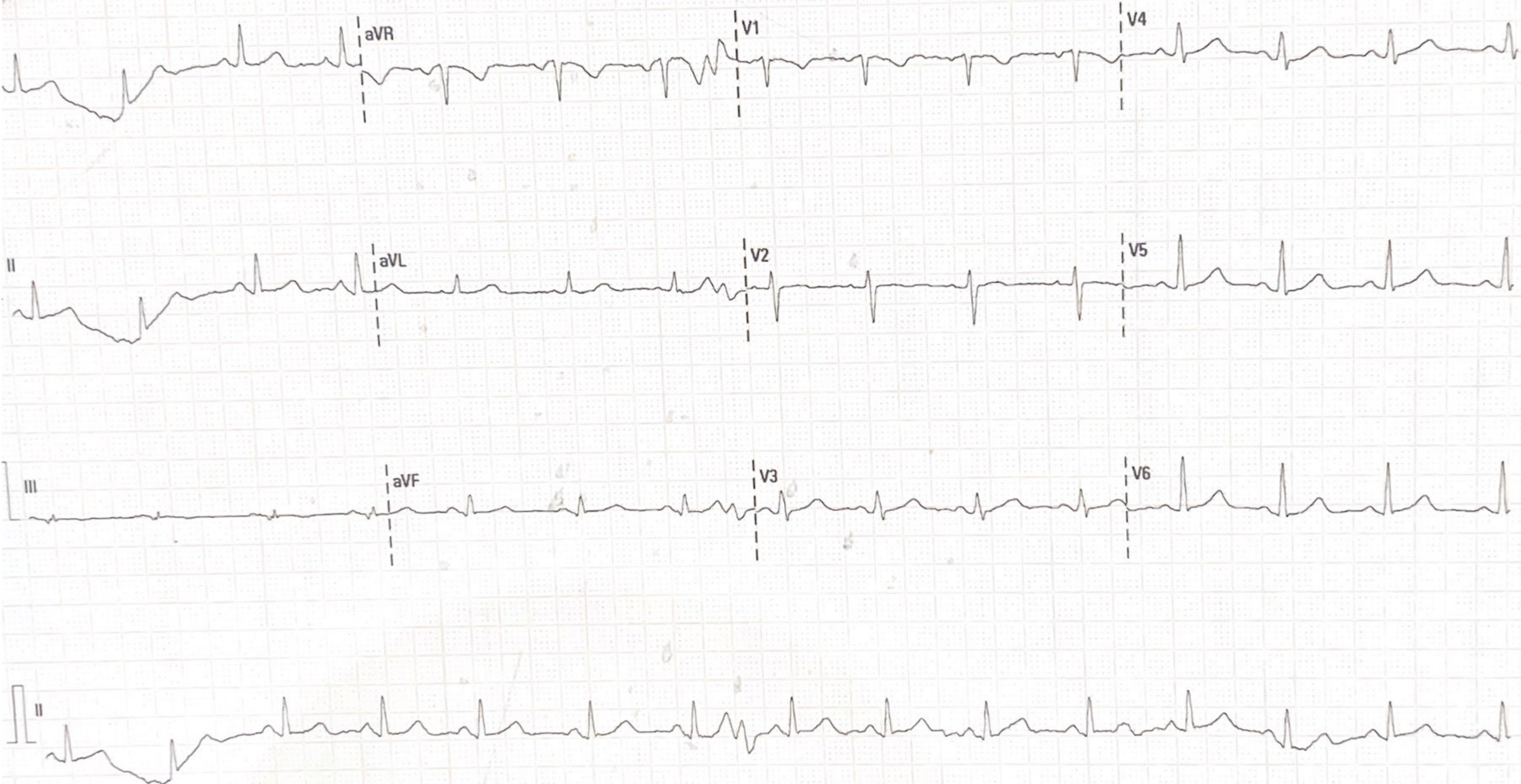
QT/QTc Interval	356/402 ms
P/QRS/T Axes	45/22/23 deg

QTc:Hodges



25 mm/s 10 mm/mV 50 Hz~ BDR 20 Hz CHARUSAT HOSPITAL 02.03.00/V28.4.1 SN:FN-52001657

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

Dr. Pavan

Date & Time : 24/2/24
Registration No. : CH-24-0053933

Name : Deepika Jha
Contact No. : (M)
Age : 33 Sex : F
(O)
Address :
B.P. : 150/90 mm Hg Pulse : 96/min/R SpO$_2$: 99 % on RA
BMI : Height : Weight :

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : Came for Health check up

CASE ANALYSIS

Past History : NAD

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		

☐ Others (Specify) :

CHRF/OPD/5083

HABITS : ☐ Smoking ☐ Alcohol ☐ Tobacco

Investigation/s Advised :

Provisional Diagnosis :

Allergy :

Nutritional Advice :

TREATMENT ADVISED

DATE	DOCTOR'S NOTE
24/2/24	S/B Dr Jaideep
	20 < 34 yrs / 34 yrs — Jharkhand
	[illegible]
24/2/24	S/B Dr Jaideep
	D = [illegible] + HTN
	1) SRD/BP Record
BP 150/90	2) Aggressive [illegible]
24/2/24	S/B Dr. Sanjay

C/o [illegible]

- ITT + [illegible] → Physiotherapy
- D_3 60k 1/week × 12
- R/A 3 [illegible]

Signature with Stamp

DENTAL REGISTRATION FORM

Date & Time : 24/2/24

Registration No. : CH-24-0053933

Name : Deepika Jha

Age : 33

Sex : F

Contact No. :

Emergency Contact No. :

Address :

OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine checkup.

Family History :

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

Medical/Other History :

- ☐ Hypertension
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Bleeding Disorder
- ☐ IHD
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Pregnancy
- ☐ Other (Specify) :
- ☐ T.B.
- ☐ Hepatitis B
- ☐ Food Allergy
- ☐ Others (Specify) :
- ☐ Jaundice
- ☐ Hepatitis C
- ☐ Drug Allergy

Habits : ☐ Tobacco ☐ Smoking

સંમતિ પત્રક

હું .... ડોક્ટરને મારી સારવાર કરવાની મંજૂરી આપુ છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ફાયદા-ગેરફાયદા, દવાની કે ઈંજેક્શનની આડ અસર અને સારવારની સફળતા, નિષ્ફળતા વિશે મને તથા મારા સંબંધીઓને સમજૂતી આપેલ છે. મેં ડોક્ટરને 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 ડોક્ટર કે ચારુસેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની ડિપોઝીટ પેટે અપાયેલ રકમ મેળવવા માટે હક્કદાર 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 : Stains +

Treatment Plan : Scaling.

: 24/2/24

:

Name of Doctor Dr. Marlwah

Signature :

CHRF/DENTAL/5016

ચારુસેટ સારથી

OPHTHALMIC REGISTRATION FORM

Reg. No. : CH-24-0053933

Date : 24/2/24

Patient's Name : Deepika Jha   Age : 33

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 /

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 / N.A.D / RE / LE / BE

Family History : Glaucoma / RP / DM /

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

N.A.D.

EYE DETAILS :

	RE	LE
V/A with PH	6/6 Ⓟ	6/6 Ⓟ
IOP	19 mmHg	18 mmHg
OWN GLASS :	–	–
AR :	+0.25/-1.25 X1°	-0.50/-0.25 X157°

GLASS PRESCRIPTION

	R. E. V/A 6/6			L. E. V/A 6/6		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	+0.25 DSph	———	6/6	-0.50 DSph	———	6/6
Nr.						
Comp						

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

CHRF/OPTH/5089

Remark :

Signature : [signature]