

Mrs. Rawas Indira - 34 IF

25/08/23

Review health checkup

PR: 78/14

BP - 90/65

WT: 90 kg

HR: 82 @ MB

HT: 161 cm @ MB

Plasma NY
UR

CR: 1.2 @ MB

- NO fresh leucocytosis

P/H: ADT sgwt/ea
Don Dth / m. 7/21 / 1/2017 COP

DM

- CBE

- LF 7/12/1

- RBS / HBAIC

- 73/14/78/1

- CR (DIA) - MB

- GUR: WAK

- 2D echo - @ JH

WAK

P.T. U

Dental Exo's

- ASD

<u>ENT</u> :	Throat		<u>man</u>
	ell		
	N/GA		

Imp: no significant medical

Comorbidity noted clinically

Done



WE CARE
SUPER SPECIALITY HOSPITAL
State of The Art Trauma Centre

GTB PLAZA, Beside Airtel Office, Ring Road, No.-1, Telibandha, RAIPUR (C.G.)
Ph.: 0771-4024901, Emergency No.: 091091-78901, E-mail : info@wecareraipur.com

Patient Name Mrs. Indira Biswas Age / Sex 34Y/F Date 25/3/23

	Sphere	Cylinder	Axis	Add
Right Eye (OD)	<u>-1.50</u>	<u>—</u>	<u>—</u>	<u>—</u>
Left Eye (OS)	<u>-0.75</u>	<u>—</u>	<u>—</u>	<u>—</u>

Recommends :

1. Anti-Reflective Coating 2. Single Vision 3. Bi-Focal 4. Progressive 5. Reader's Competer 6. Sunglasses



Signature

EYE EXAMINATION

NAME: - Mrs. Jhelina Biswas
AGE/SEX 34 YR

DATE:- 23/3/23

1. EXAMINATION OF EYES : (BY OPHTHALMOLOGIST)

EXTRENAL, EXAMINATION				
SQUINT	None			
NYSTAGMUS	None			
COLOUR VISION	None			
FUDUS	Normal			
INDIVIDUAL COLOUR IDENTIFICATION	Normal			
DISTANT VISION	Normal			
NEAR VISION	$\left\langle \begin{matrix} 6/24R \\ 6/9L \end{matrix} \right\rangle$ 2Ah 6L Acc $\left\langle \begin{matrix} -1.50 Dsph 6L \\ -0.75 Dsph 6L \end{matrix} \right\rangle$			
NIGHT BLINDNESS	None			
	SPH	CYL	AXIS	ADD
RIGHT	-1.50		—	—
LEFT	-0.75		—	—
REMARK :-				
 (SIGN.)				

Dr. Vikash Mishra
MBBS, MS (Oph.)
Consultant-Ophthalmology

PATIENT NAME : MRS.BISWAS INDIRA
UHID NO. : 38410
AGE / SEX : 34 Y Female
CONSULTANT : DR ANIS SIDDIQUI

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COMPLETE BLOOD COUNT(CBC)

RBC

Haemoglobin (HB)	11.6	gm%	12 - 14
Haematocrit (HCT)	30.9	%	35 - 50
RBC Count	3.95	millions/cumm	4 - 5
MCV	78.2	fL	78 - 92
MCH	29.4	pg	27 - 32
MCHC	37.5	g/dl	32 - 36
RDW-CV	17.0	%	11 - 16

WBC.

Total Leucocyte Count (TLC) 8100 4000 - 11000

Differential Leucocyte Count (DLC)

Neutrophils	68	%	40 - 75
Lymphocytes	26	%	20 - 40
Monocytes	04	%	0 - 8
Eosinophils	02	%	
Basophils	00	%	0 - 1

PLATELETS

PLT Count	1.76	lakhs/cmm	1.0 - 4.0
MPV	11.3	fl	8 - 11

Advice

The test results are to be used for help in diagnosing/treating medical diseases & not for forensic applications. These result cannot be used fo medico-legal purposes. These reported results are for the information of referring clinical only.

Test Done By MEDONIC M-SERIES Fully Automatic.



Test Done By
Senior Technologist
SATYANARAYAN SINGH

Report Checked By
Technician



Pathologist
Dr. D. Prashant
M.D. (Pathologist)

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HAEMATOLOGY

TEST	RESULT	UNIT	REF. RANGE
HbA1c (Glycosalated Haemoglobin)			
HbA1C-Glycosalated Haemoglobin	4.50	%	4 to 6% Non-diabetic 6 to 7% Excellent control 7 to 8% fair to good control 8 to 10% Unsatisfactory control Above 10% poor Contr

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The test has been performed on fully-Automated Biochemistry Analyser "ERBA EM 200"

ESR	23	mm at 1hr	up to 20 mm(1 hr)
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Blood Group

ABO Group SLIDE METHOD.	O Rh Negative
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Machine Footer



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Senior Technologist
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BIO CHEMISTRY

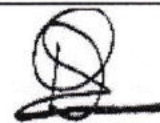
TEST	RESULT	UNIT	REF. RANGE
BSPP	102		<140 mg/dl
Urine SUGAR(PP)	ABSENT		ABSENT
GGT(GAMMA GT)			
GGT(GAMMA GT)	29.5	U/L	<38
LFT(Liver Function Test)			
Bilirubin - Total	0.74	mg/dl	0.2 - 1.3
Bilirubin - Direct	0.33	mg/dl	Adult : 0.0 - 0.4 Neonatal : - 0.0 - 0.6
Bilirubin (Indirect)	0.41	mg/dl	Adult : 0.0 - 0.9 Neonatal : 0.6 - 10.5
Total Proteins	6.25	g/dl	6.4 - 8.3 g/dl
Albumin	4.39	g/dl	3.5 - 5.2 g/dl
Globulin	1.86	g/dl	2.3 - 3.6
A/G Ratio	2.36		1.10 - 2.20
Alkaline Phosphatase	87	U/L	4 - 15 Yrs 54 - 369 20 - 59 Yrs 42 - 98 Yrs 53 - 141
SGOT (AST)	31	U/L	upto 31 U/L
SGPT (ALT)	34	U/L	upto 34 U/L

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Lipid Profile

Total Cholesterol	212	mg/dl	Desirable : <200 Borderline : 200 - 239 High : >= 240
Triglycerides	149	mg/dl	Normal:<161 High : 161 - 199 Hypertriglyceridemic : 200 - 499 Very High : > 499
<i>Note: The National Cholesterol Education Program Adult Treatment Panel III ((NCEP-ATP III) report.</i>			
HDL Cholesterol	67	mg/dl	42-88
LDL Cholesterol	115.20	mg/dl	Less than 100 mg/dl - Optimal 100-129 mg/dl - Near/above optimal 130-159 mg/dl - Borderline high 160-189 mg/dl - High >190 mg/dl - Very high
<i>Note: The National Cholesterol Education Program Adult Treatment Panel III ((NCEP-ATP III) report.</i>			
VLDL Cholesterol	29.80	mg/dl	20 - 50
Total Cholesterol/HDL Ratio	3.16		0 - 5.1
LDLC/HDLC Ratio	1.72		2.5 - 3.5

Correlates with Lipid Profile:

1. Fasting state: Fasting should begin 12 to 14 Hrs before the sample collection. This includes all beverages, although water is permitted. No alcohol should be taken 24 before sample collection.
2. Drugs: Cholesterol and Triglyceride lowering agents. Please repeat with fresh sample if dinically indicated.

The test has been performed on fully-Automated Biochemistry Analyser "ERBA EM 200"

KFT(KIDNEY FUNCTION TEST)

Urea	18	mg/dL	15 - 45
Serum Creatinine	0.65	mg/dl	0.50 - 0.90 mg/dL
Uric Acid	6.5	mg/dL	2.6 - 6.0

Test Done By MICRO LAB 300 Fully Automatic.



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PATHOLOGY

TEST	RESULT	UNIT	REF. RANGE
BSF (Fasting Sample Required)	94		<110 mg/dl



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CLINICAL PATHOLOGY

TEST	RESULT	UNIT	REF. RANGE
URINE SUGAR(F)			
Urine Sugar (Fasting)	Not Collected		ABSENT



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THYROID HORMONES

TEST	RESULT	UNIT	REF. RANGE
THYROID HORMONES			
T3 (Triiodothyronine)	0.98	ng/ml	0.5 - 2.0
<p><i>Remarks:1. Decreased values of T3 (T4 and TSH normal) have minimal clinical significance and not recommended for diagnosis of hypothyroidism</i></p> <p><i>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), Nephrosis etc.</i></p>			
T4 (Thyroxine)	7.9	µg/dl	4.8 - 11.6
<p><i>Remark:1. 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), Nephrosis etc.</i></p>			
TSH	3.97	µIU/ml	0.39- 6.16 µIU/ml
<p><i>Remarks:1. 4.51 to 15 µIU/ml - Suggested clinical co-relation or repeat the test with new sample as physiological factors can give falsely high TSH.</i></p> <p><i>2. TSH values may be transiently altered because of non thyroidal illness like severe infection, liver disease, renal and heart failure, severe burns, trauma and surgery etc.</i></p> <p><i>3. Drugs that decreases TSH values e.g. L-dopa, Glucocorticoids Drugs that increases TSH values e.g. Iodine, Lithium, Amiodarone.</i></p>			
METHOD - ELISA ACCUBIND			



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ROUTINE URINE ANALYSIS TEST

TEST	RESULT	UNIT	REF. RANGE
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Urine Routine ANALYSIS TEST

General Examination

Volume	20	ml	
Colour	Pale Yellow		Pale Yellow
Appearance	Slightly Turbid		Clear
pH	6.5		5.5 - 8.0


Chemical Examination

Urine Protein(Albumin)	Absent	g/L	Absent
Urine Glucose(Sugar)	Absent	mmol/L	Absent
Urine Ketons(Acetone)	Absent	mmol/L	Absent
Specific Gravity	1.010		


Microscopic Examination

Pus cells	2-3/HPF	/hpf	<5
RBC (Urine)	0-1/HPF	/hpf	Nil
Epithelial cell	0-1/HPF		0-4
Casts	Absent		Absent
Crystals	Absent		Absent

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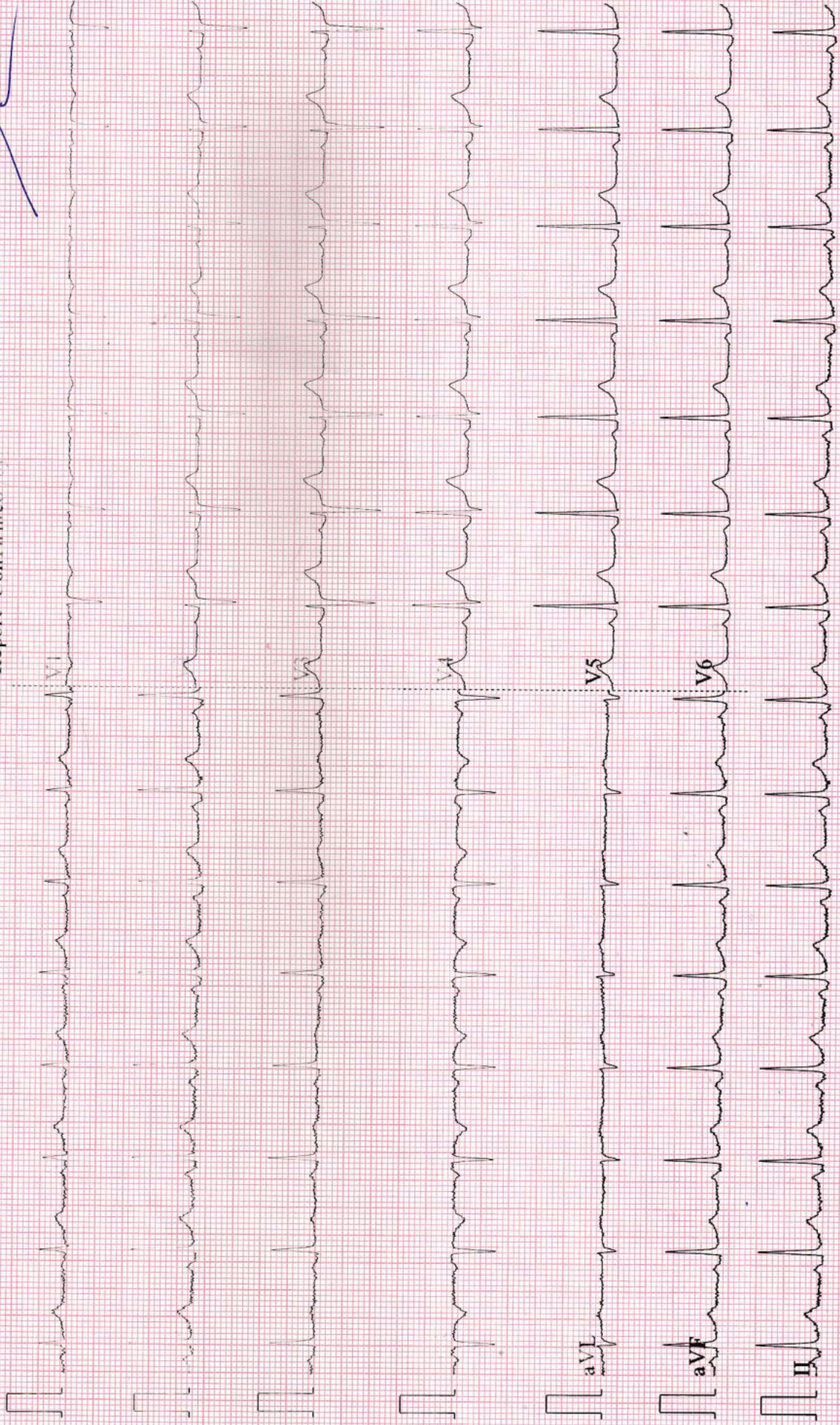
MRS BISWAS INDIRA
Female 34Years

Diagnosis Information:
Sinus Rhythm
QS Wave in lead V1

HR : 87 bpm
P : ms
PR : 135 ms
QRS : 77 ms
QT/QTc : 339/410 ms
P:QRS/T : 66/72/48 °
RV5/SV1 : 1.47/0.632 mV

Normal

Report Confirmed by:



PATIENT'S NAME: BISWAS INDIRA 34YR F	STUDY TIME: 25-03-23
REFERRED BY: DR A SIDDIQUI	PRINT TIME: 25/03/23 12:57 PM
MRD NO: XR CHEST 38410 KH 54 HC MEDIWHEEL	PAGE 1 OF 1

STUDY: XRAY OF THE CHEST PA VIEW

INDICATION: Routine check up

COMPARISON: None.

OBSERVATIONS & CONCLUSION:


NO ACUTE BONY PATHOLOGY IS SEEN.

NO PULMONARY INFILTRATE, COLLAPSE OR CONSOLIDATION, EFFUSION, OR PNEUMOTHORAX IS SEEN.

TRACHEA IS IN MIDLINE.

NO CARDIOMEGALY IS SEEN.

THE SOFT TISSUES DEMONSTRATE NO ACUTE PATHOLOGY.

	
DR NEERAJ GAUTAM DNB RADIODIAGNOSIS CONSULTANT RADIOLOGIST	DR GAGANDEEP SINGH SALUJA MD RADIODIAGNOSIS CONSULTANT RADIOLOGIST

PATIENT'S NAME: BISWAS INDIRA 34YR F
REFERRED BY: DR A SIDDIQUI
MRD NO: USG ABD HC 38454

STUDY TIME: 25-03-23
PRINT TIME: 25/03/23 12:49 PM
PAGE 1

STUDY: USG OF THE ABDOMEN

INDICATION: Routine health check up.
COMPARISON: None.

OBSERVATIONS:

Liver is mildly enlarged measuring 161 mm in craniocaudal extent. Normal parenchymal echogenicity is noted. No obvious focal lesion is seen. Intrahepatic biliary radicles are not dilated.

Spleen is enlarged measuring 138 mm in size. No focal lesion is seen within splenic parenchyma.

Pancreas appears normal in size and echopattern. Pancreatic duct is not dilated. No obvious pancreatic parenchymal calcifications are seen either.

Gall bladder is well distended. No calculus is seen. Wall thickness is normal. CBD is normal.

Portal vein is normal. IVC and aorta are unremarkable.

Right kidney measures 88 mm in size. Right kidney is normal in size, shape, position and echogenicity. Corticomedullary differentiation is maintained. No focal lesion is noted. No evidence of calculus or hydronephrosis is noted.

Left kidney measures 98 mm in size. Left kidney is normal in size, shape, position and echogenicity. Corticomedullary differentiation is maintained. No focal lesion is noted. No evidence of calculus or hydronephrosis is noted.

Urinary bladder is collapsed. Uterus and bilateral ovaries cannot be commented upon.

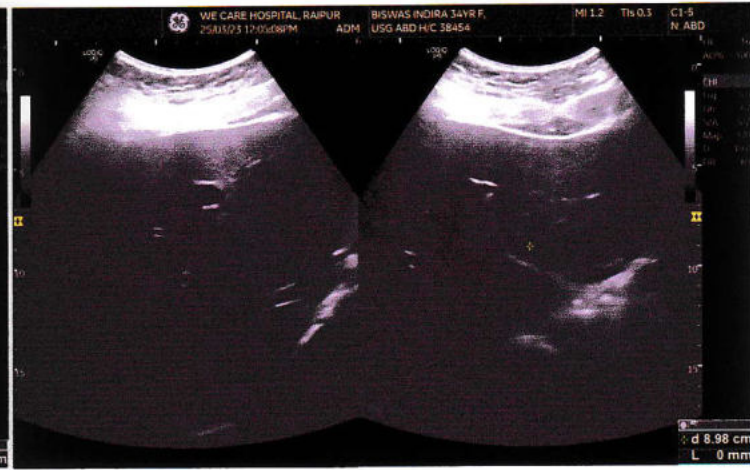
No free fluid is seen. No significant lymphadenopathy is seen.

CONCLUSION:

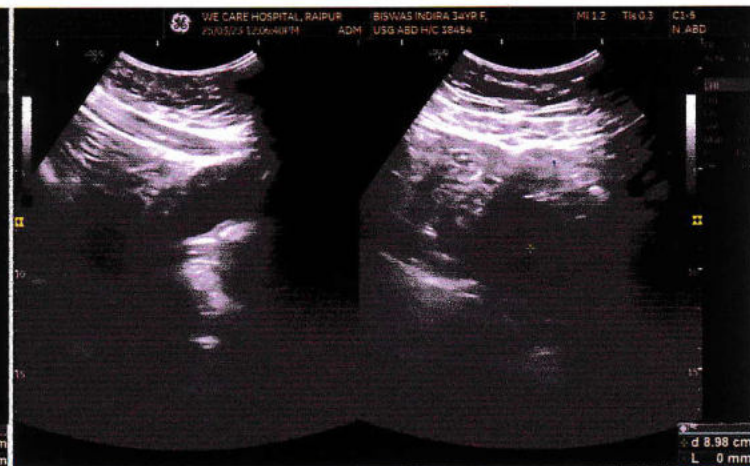
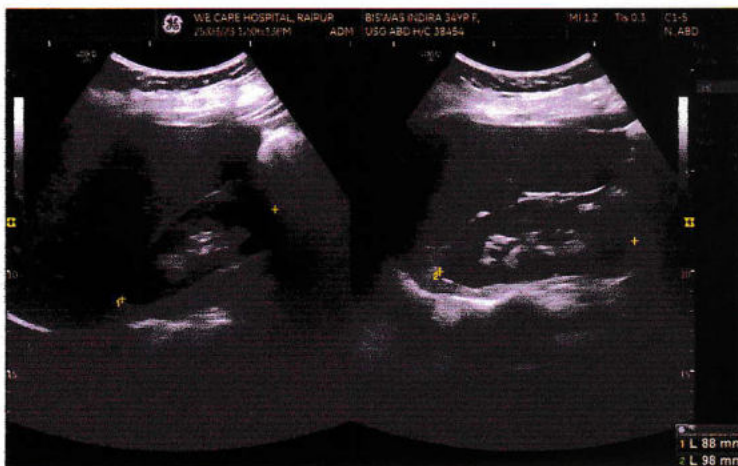
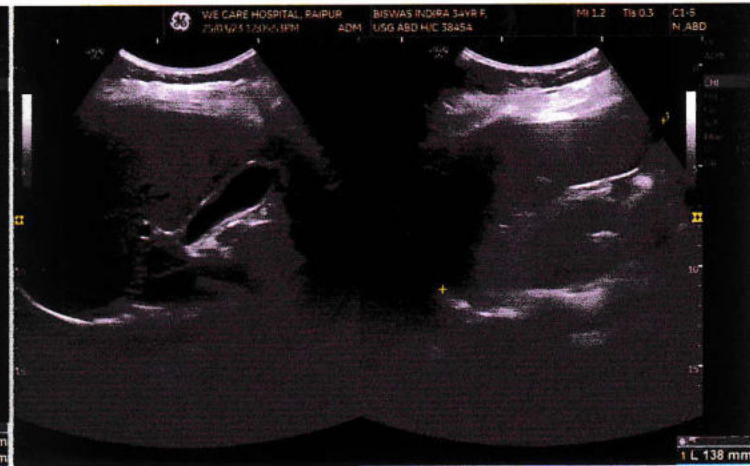
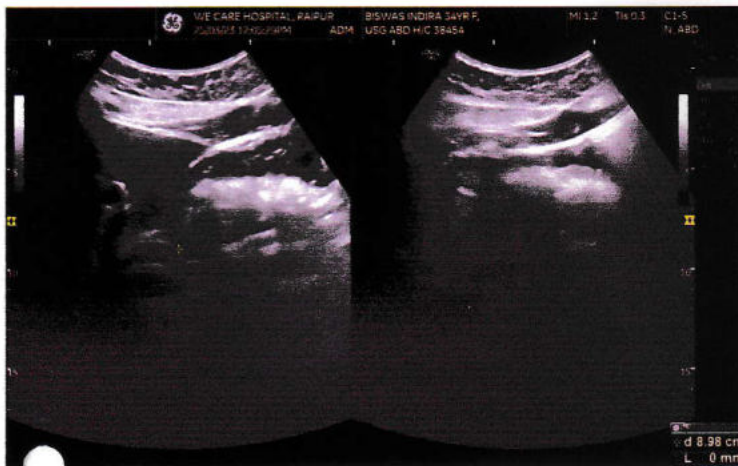
Mild Hepatosplenomegaly.

DR NEERAJ GAUTAM
DNB RADIODIAGNOSIS
CONSULTANT RADIOLOGIST





P



NAME MRS. BIWAS INDIRA

AGE 34 YR/F

REF BY: DR. A SIDDIQUI

DATE: 25/03/2023

ECHOCARDIOGRAPHY

M-MODE

<u>MEASUREMENT</u>	<u>PT'S VALUE</u>	<u>NORMAL VALUE</u>
AO	28.1 mm	20-37 mm
LA	39.4 mm	19-40 mm
IVS (d)	12.1 mm	6-11 mm
LVID (d)	47.8 mm	35-50 mm
LVPW (d)	9.2 mm	6-11 mm
LVID (S)	22.9 mm	23-39 mm
EF	60%	

2 D ECHO & CFI

CHAMBERS	-	NORMAL.
VALVES	-	NORMAL.
SEPTAE	-	IVS / IAS Intact
RWMA	-	NO RWMA PRESENT AT REST.
EF	-	60%

CLOT / VEGETATION/ PERICARDIAL EFFUSION – NULL.

<u>VALVE</u> <u>(mmHg)</u>	<u>REGURGITATION</u>	<u>GRADIENT</u>
Mitral Valve	NILL	Not Significant
Aortic Valve	NILL	Not Significant
Tricuspid Valve	NILL	Not Significant
Pulmonary Valve	NILL	Not Significant

PULSE WAVE DOPPLER

- Mitral Valve inflow shows E Wave < A Wave.

IMPRESSION.

- NO RWMA PRESENT AT REST.
- NORMAL BIVENTRICULAR SYSTOLIC FUNCTION.
- GLOBAL LVEF 60%.
- NO AS/MS/TR/NO AR/NO MR.
- NO INTRACARDIAC CLOT, VEGETATION.


Dr. ANIS SIDDIQUI (MD, PGCCDM)

