

Place Label Here

Pt. Name : _____

UMR : _____

Age : _____ Sex : _____

IP : _____

If label not available, write Pt. Name, IP No., Sex, Date, Name of Treating Physician

OPD Nursing Assessment - Adult

Name: Priyanka Chavara Date of Birth : _____ Age/Sex: 33/F UMR No.: 20310

Assessment :

Height: 156 cms Weight: 61.9 kg. BMI: - Respiration: 20 /min Pulse H/R: 80/min

BP: 104 mmHG Temperature: - °F/C SpO2 99 % BSL -

Chief Complaints: 72 Regular check up

Tick Appropriate :

- Interpreter Needed Yes No
- Nutritional Status: Weight Loss/Gain in Last 3 Months Yes No
- If Weight Loss / Gain-Dietary Referral Yes No
- Psychological Assessment Agitated Anxious Yes No Normal
- (If Agitated, Inform Physician) Irritable

Any Allergies Known Including Drugs : No

Past History: Any Surgeries Explain : No

Any Other illness: Explain : No

Pain Score: Numerical Scales (1-10) - Location - Characteristics -

Need to be seen immediately by the Doctor Yes No

Fall risk: Age 65Yrs. - Tremors - High Grade Fever - H/O Fall in last 3 months -

Cardiac Medicines - Seizure Medications - Fall Prevention Education Done -

Name of Nurse	ID No. of Nurse	Signature of Nurse	Date & Time
<u>Shweta</u>	<u>85</u> <u>024523</u>	<u>85</u>	<u>16/3/24</u>

ID: [REDACTED]
Name: [REDACTED]
Age: 53 Years
Gender: Female

2024031608433481
priyanka chavan
53 Years
Female

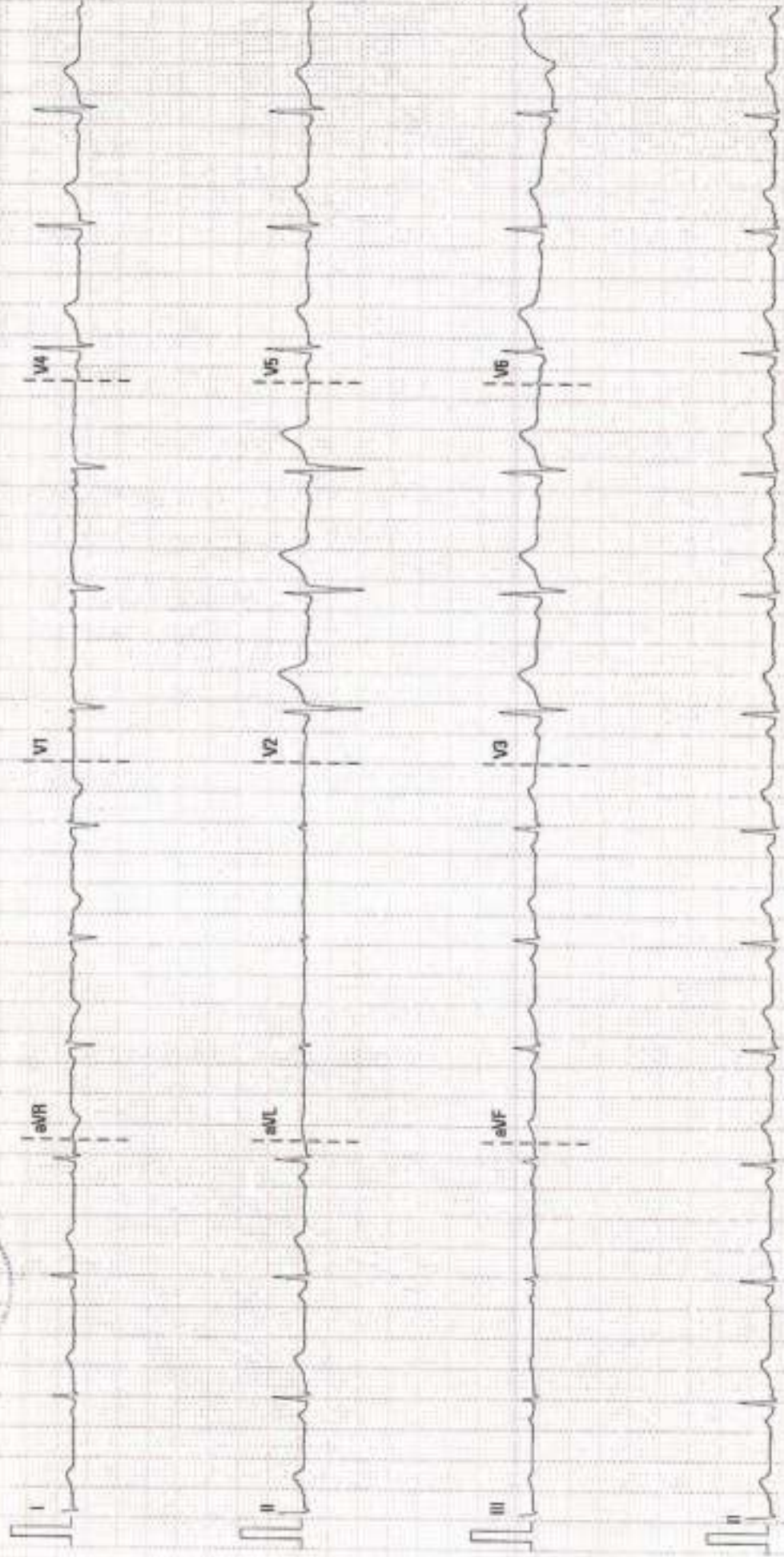
2024-03-16 08:43:24 AM

Ven. Site
PR Interval
QRS Duration
QT/QTc Interval
P/ORS/T Axes
QTc Hodges

77 bpm
134 ms
72 ms
368/398 ms
62/49/47 deg

Sinus rhythm
Normal ECG

Unconfirmed Diagnosis



25 mm/s

10 mm/mV

50 Hz

BCR 35 Hz

02.10.06V25.41

SN-FN 25035810



DEPARTMENT OF LABORATORY


Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20301/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSULTANT
Received Dt : 16-Mar-24 05:45 pm	Report Date : 16-Mar-24 07:32 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
PPBS (POST PRANDIAL BLOOD SUGAR)				
PPBS (POST PRANDIAL BLOOD SUGAR)	Plasma	108.3	Normal range : < 140 Impaired glucose tolerance : <= 199 mg/dL Diabetes Mellitus : >= 200 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.5	Normal < 5.7 Pre-diabetic : 5.7 - 6.5 Diabetic > 6.5	TINIA
FBS (FASTING BLOOD SUGAR)				
FASTING BLOOD GLUCOSE		96.4	Normal Range : 70 - 99 Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase

*** End Of Report ***

Lab Incharge


Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PHARMOLOGIST

Test results related only to the item tested.
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DEPARTMENT OF LABORATORY

Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20301/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 16-Mar-24 05:41 pm	Report Date : 16-Mar-24 06:55 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
CUE (COMPLETE URINE EXAMINATION)			
<u>GENERAL EXAMINATION</u>			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.005	1.010 - 1.030
PH		5.5	4.5 - 8.0
<u>CHEMICAL EXAMINATION</u>			
PROTEIN	Urine	ABSENT	ABSENT
GLUCOSE		ABSENT	ABSENT
BLOOD		ABSENT	ABSENT
LEUCOCYTES		NEGATIVE	NEGATIVE
UROBILINOGEN		NORMAL	NORMAL
KETONE		ABSENT	ABSENT
BILIRUBIN		NEGATIVE	NEGATIVE
NITRITE		NEGATIVE	NEGATIVE
<u>MICROSCOPIC EXAMINATION</u>			
PUS CELLS	Urine	0-1	0 - 5 /hpf
RBC		NIL	0 - 2 /hpf
EPITHELIAL CELLS		0-1	0 - 5 /hpf
CRYSTALS		NIL	ABSENT
CASTS		ABSENT	ABSENT
OTHERS		ABSENT	ABSENT

*** End Of Report ***





DEPARTMENT OF LABORATORY

Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20301/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 16-Mar-24 05:41 pm	Report Date : 16-Mar-24 07:22 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA Blood	13.3	11.7 - 15.5 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		5,720	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		306000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.57	3.9 - 5.0 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		37.4	36 - 46 %	Analogical integration
MCV		81.9	82 - 95 fl	Calculated
MCH		29.0	27 - 32 pg	Calculated
MCHC		35.4	32 - 36 g/dL	Calculated
RDW(cv)		11.8	11.5 - 14.0 %	Calculated
MPV		7.3	6 - 9.5 fl	Calculated
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	55.0	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		33.5	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		5.6	00 - 06 %	DHSS/Microscopy
MONOCYTES		4.9	00 - 10 %	DHSS/Microscopy
BASOPHILS		1.0	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA Blood	Normocytic Normochromic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate On Smear		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	* O *		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		18	0 - 20 mm/1st hour	WESTERGREN'S METHOD

*** End Of Report ***





DEPARTMENT OF LABORATORY

Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20301/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 16-Mar-24 05:41 pm	Report Date : 18-Mar-24 09:56 am

Parameters Specimen Result Biological Reference In Method

Lab Incharge


Dr. BAHIRWADE GANESH KISAN, MBBS, MD
CONSULTANT PATHOLOGIST

Test results related only to the item tested.
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DEPARTMENT OF LABORATORY


Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20362/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSULTANT
Received Dt : 18-Mar-24 02:10 pm	Report Date : 18-Mar-24 10:49 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
SERUM ELECTROLYTES				
SERUM SODIUM	SERUM	143.2	136 - 145 mmol/L	ISE
SERUM POTASSIUM		4.00	3.5 - 5.1 mmol/L	ISE
SERUM CHLORIDES		105.4	98 - 107 mmol/L	ISE
BLOOD UREA		22.6	16.6 - 48.5 mg/dL	Urease kinetic

*** End Of Report ***

Lab Incharge


Dr. BAHIRWADE GANESH KISAN, MBBS, MD
CONSULTANT PATHOLOGIST

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DEPARTMENT OF LABORATORY

Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20301/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 16-Mar-24 05:41 pm	Report Date : 18-Mar-24 02:24 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Method</u>
BLOOD GROUPING AND RH			
BLOOD GROUP	Blood	* O *	SLIDE AGGLUTINATION
RH TYPE		POSITIVE	
ESR		18 0 - 20 mm/1st hour	WESTERGREN'S METHOD

*** End Of Report ***



System Name : 14



DEPARTMENT OF LABORATORY

Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20301/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 16-Mar-24 05:43 pm	Report Date : 18-Mar-24 09:56 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM CREATININE		0.74	0.6 - 1.2 mg/dL	Jaffe
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.33	0.1 - 1.2 mg/dL	Colorimetric diazo method
DIRECT BILIRUBIN		0.14	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.19	<= 1.0 mg/dL	
SGPT (ALT)		15.7	<= 33 U/L	Enzymatic
SGOT (AST)		14.4	<= 32 U/L	Enzymatic
ALKALINE PHOSPHATASE (ALP)		161	35 - 104 U/L	PNPP
TOTAL PROTEINS		7.69	6.4 - 8.3 g/dL	Method : Biuret method
SERUM ALBUMIN		4.76	3.5 - 5.2 g/dL	Method : Bromocresol Green (BCG)
GLOBULINS		2.93	1.8 - 3.6 g/dL	
A/G RATIO		1.62	1.1 - 2.2	
GAMMA GLUTAMYL TRANSFERASE(GGT)		15	6 - 42 U/L	Enzymatic colorimetric assay (IFCC)
LIPID PROFILE				
TOTAL CHOLESTEROL		236.6	Borderline High : 200 - 240 mg/dL High risk : > 240 mg/dL Desirable: < 200 mg/dL	Enzymatic, Colorimetric Method
HDL CHOLESTEROL		40.1	Major risk factor for heart disease : < 40 mg/dL Negative risk factor for heart disease : > 60 mg/dL	Homogeneous enzymatic colorimetric assay
LDL CHOLESTEROL		176.16	Optimal : - < 100 mg/dL Near Optimal : 100 - 129 mg/dL Borderline High : 130 - 159 mg/dL High : 160 - 189 mg/dL Very High : - > 190 mg/dL	
VLDL		20.34	6 - 38 mg/dl	
SERUM TRYGLYCERIDES		101.7	Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL Normal : < 150 mg/dL	Enzymatic colorimetric test
CHO/HDL RATIO		5.9	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		4.39	2.5 - 3.5	

*System Name : M



DEPARTMENT OF LABORATORY

Patient Name : Mrs. PRIYANKA CHAVAN	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : PUBC20301/PUU20310	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 16-Mar-24 05:43 pm	Report Date : 18-Mar-24 09:56 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
COMMENT			10-12 hours fasting is compulsory for all lipid parameters. if not , results may not be accurate.
BUN(BLOOD UREA NITROGEN)			
BUN (Blood Urea Nitrogen.)		10.6	7.0 - 21.0 mg/dL
SERUM URIC ACID		5.4	2.4 - 5.7 mg/dL
			Calculated Enzymatic colorimetric test
T3,T4 AND TSH			
T3		0.770	0.8 - 2.0 ng/mL
T4		5.45	5.1 - 14.1 ug/dL
TSH(THYROID STIMULATING HORMONE)		2.01	0.27 - 4.2 uIU/mL
			Method : ECLIA Method : ECLIA Method : ECLIA

*** End Of Report ***

Lab Incharge


Dr. BAHIRWADE GANESH KISAN, MBBS, MD
CONSULTANT PATHOLOGIST

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System Name : M



Patient ID:	PUU20310	Patient Name:	PRIYANKA CHAVAN
Age:	33 Years	Sex:	F
Accession Number:	PUR20310 PK	Modality:	DX
Ref. By:	HC	Study:	CHEST
Study Date:	16-Mar-2024		16.01

X RAY CHEST PA VIEW

FINDINGS : Chest PA view with no comparison study shows.

- The visualized lung fields are clear.
- No obvious consolidation is seen.
- There is no pleural effusion or pneumothorax seen.
- No pneumoperitoneum is seen.
- The cardiac silhouette appears within normal limits.
- The diaphragmatic shadow and mediastinal structures are within normal limits.
- Visualized osseous structures demonstrate no obvious abnormality.

IMPRESSION :

- ❖ No radiographically evident acute cardiopulmonary process in the present study.

Dr. Sunita Shewale (MBBS, DMRE)
Consulting Radiologist
(typed by sk)





DEPARTMENT OF RADIOLOGY

Patient Name : Mrs. Priyanka Chavan	Age : 33 yrs / F
Ref. By : Health check up	OPD/IPD No: PUU: 20310
Date of USG: 16/03/2024	Date of Reporting: 16/03/2024

USG ABDOMEN AND PELVIS

Liver : is normal in size (measures 14.4 cm in craniocaudal axis) and shape. **It shows increased echotexture.** No focal lesion is seen. No IHBRD.

CBD : Visualized part is normal in caliber at the porta.

Portal Vein: is normal in caliber at the porta. No evidence of thrombosis of the visualized part at the porta.

Gall Bladder : is partially distended. No evidence of calculus seen. Sonographic Murphy's sign is negative. No evidence of pericholecystic collection.

Pancreas : Visualized part of head and body appears normal in caliber and echogenicity.

Spleen : is normal in size (measures 8.0 cm), shape and echogenicity. No focal lesion is noted.

Kidneys : Right Kidney: 10.2 x 3.4 cm. Left Kidney: 11.1 x 4.4 cm.
Both kidneys appear normal in size, shape, echogenicity and corticomedullary differentiation. No evidence of hydronephrosis. No focal lesion or calculus is noted.

Urinary Bladder : is well distended and show normal wall thickness.
No calculus/focal lesion is seen.

Uterus : is normal in size and shape. It measures 7.9 x 4.3x 3.5 cm.
Endometrium is thin & central.
No focal lesion is seen.

Ovaries : Right ovary : 3.5 x 2.5x 2.2 cm, - 10 cc. Left ovary : 3.5 x 3.0 x 2.6 cm, - 15 cc
Mildly bulky left ovary with peripherally arranged subcentimetric follicles.
Right ovary is normal in size, shape and morphology.
No adnexal mass lesion is seen.

Retro peritoneum is obscured by bowel gases.
No free fluid is noted. No pleural effusion.
Visualized bowel loops are gaseous.

IMPRESSION:

1. **Grade I fatty infiltration of liver.**
2. **Mildly bulky left ovary with peripherally arranged subcentimetric follicles.**



Madhuri Avhad

Dr. Madhuri Avhad (MBBS DMRD)
Consultant Radiologist

212
33 Yrs/ F
61 Kg / Ht-156 cms

Date: 16-03-2024
Time: 09:44 AM

Summary

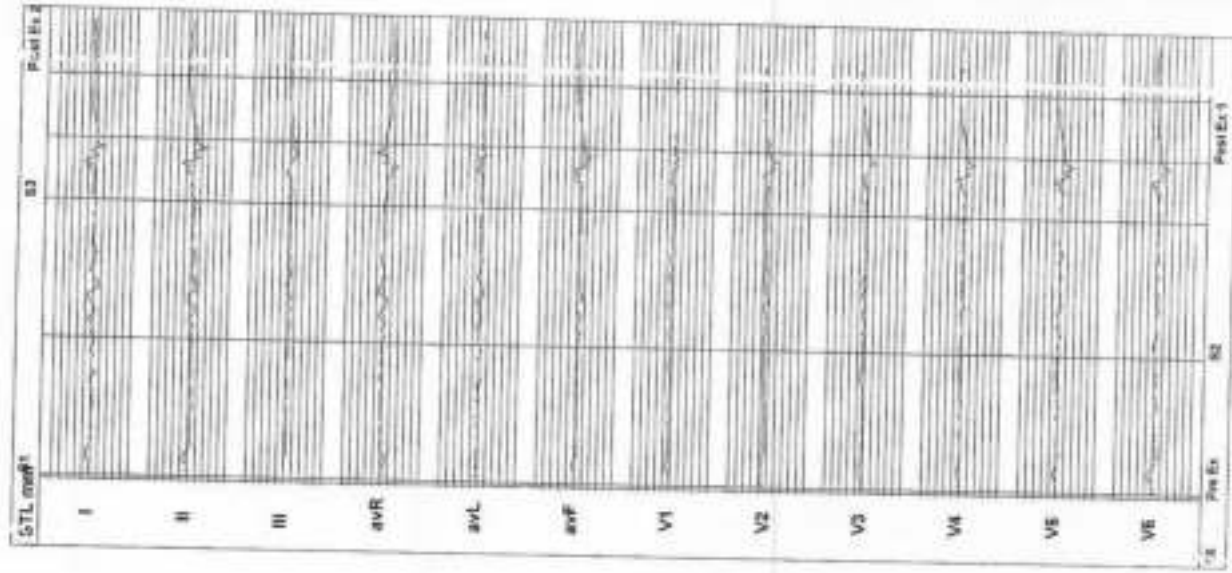
History:
Medication:

Ref By:

Protocol: Bruce

Ref. No.:

Stage	Stg Time (mm:ss)	Speed (mph)	Grade (%)	ME/s	HR (bpm)	BP (mmHg)	RPP	PVCs
Pre Ex				1	92	100/70	92	
S1	02:11	1.7	10.0	1.6	139	110/70	153	
S2	02:11	2.5	12.0	4.4	154	112/72	172	
Peak Ex	01:00	3.4	14.0	5.6	178	114/74	203	
Post Ex 1	01:00			1	144	110/70	158	
Post Ex 2	01:00			1	125	110/70	133	
Finish				1	110/70			1



Findings: Exercise Time : 05:22 mins
 Max HR attained : 181 bpm 96 % of Target 187 bpm
 Max BP : 114/74mmHg
 Max Workload attained : 5.6 METs (.Avg Effort Tolerance)
 Reason for Test Termination: Patient Completed Test

No significant ST segment changes noted during exercise or recovery stages.
 No Angina / Arrhythmia / S3 / Murmur
 Final Impression : Test is negative for inducible ischaemia.

(Signature)
 DR SURAJ PATIL

212
 33 Yrs / F
 PRIYANKA CHAVAN
 61 Kg / Ht-156 cms Ref.No.:

INDRAYANI NAGR RD, BHOSAI-II, PIMPRI CHINCHWAD, PUNE, MAHARASHTRA
 Date: 16-03-2024
 Protocol: Bruce
 Filter: 0.1 - 100 Hz
 Gain: 10 mm/mV
 Time: 09:44 AM
 Notch: On
 BLC: On
 S-sweep: 25 mm/s

Average 6 Leads
 Frontal

Stage	Pre Ex	S1	S2	Peak Ex	Post Ex 1	Post Ex 2	Finish
Ex Time min:sec	02:11	04:22	05:22	---	---	---	---
Stg Time min:sec	02:11	02:11	01:00	01:00	01:00	01:00	01:00
Speed mm/sec	1.7	2.5	3.4				
Grade %	10.0	12.0	14.0				
HR bpm	92	139	154	176	144	125	
BP mmHg	100/70	112/72	114/74	110/70	110/70	110/70	110/70
STL mm	0.0	-0.3	-0.2	-0.1	0.6	0.4	0.0
STs uWS	0.0	-0.2	0.6	0.4	1.3	0.9	0.4
I	0.0	-0.4	-0.3	-0.6	0.9	0.6	0.0
II	0.2	0.2	1.2	1.2	2.4	1.8	1.3
III	0.0	-0.2	-0.2	-0.8	0.3	0.2	0.0
a/R	0.3	0.6	0.7	1.2	0.9	0.5	0.5
a/R	0.0	0.4	0.3	0.4	-0.7	-0.5	0.0
a/R	-0.1	0.0	-0.8	-0.8	-1.9	-2.3	-0.9
a/L	0.0	0.0	0.0	0.3	0.1	0.1	0.0
a/L	-0.1	-0.3	0.6	-0.1	0.1	0.0	-0.2
a/F	0.0	-0.3	-0.3	-0.6	0.6	0.4	0.0
a/F	0.2	0.2	0.9	0.5	1.8	1.4	1.1

212
 33 Yrs/F
 PRIYANKA CHAVAN
 61 Kg / Ht-156 cms Ref.No.:

Date: 16-03-2024
 Time: 09:44 AM
 Protocol: Bruce
 Notch: On
 Filter: 0.1 - 100 Hz
 Gain: 10 mm/mV
 Sweep: 25 mm/s

Average 6 Leads
Precordial

Stage	Pre Ex	S1	S2	Peak Ex	Post Ex 1	Post Ex 2	Finish
Ex Time		02:11	04:22	05:22			
Stg Time		02:11	02:11	01:00	01:00	01:00	
Speed		1.7	2.5	3.4			
Grade %		10.0	12.0	14.0			
HR bpm	92	139	154	178	144	125	
BP mmHg	100/70	110/70	112/72	114/74	110/70	110/70	110/70
STL mm	0.3	0.2	0.2	0.2	0.1	0.2	0.0
STS uW/s	0.1	0.0	-0.2	-0.2	-0.5	-0.2	-0.7
V1		0.4 0.1	0.5 1.1	0.4 0.8	1.1 1.8	0.9 1.1	0.0 0.9
V2		0.3 0.4	0.1 1.3	0.0 1.2	1.1 2.3	1.0 1.9	0.0 1.4
V3		0.3 0.4	0.1 1.4	-0.2 0.9	1.1 2.3	0.9 1.8	0.0 1.4
V4		0.1 0.3	-0.1 1.1	-0.4 0.8	0.8 1.9	0.6 1.5	0.0 1.2
V5		0.0 0.1	-0.2 0.8	-0.4 0.5	0.5 1.4	0.4 1.1	0.0 1.0
V6							

212
 33 Yrs/ F
 Date: 16-03-2024 Time: 09:44 AM
 Post J: 74 mS

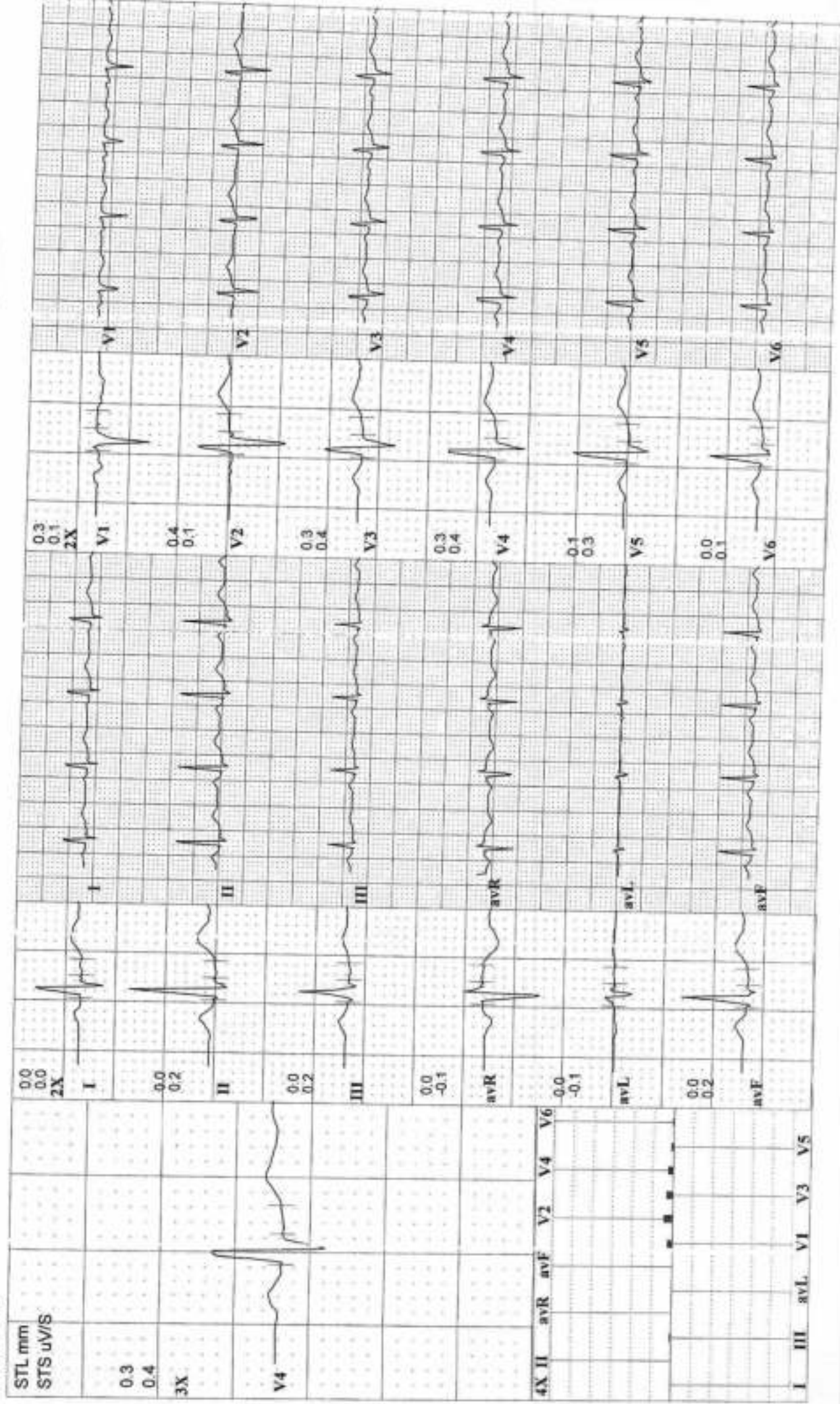
PRIYANKA CHAVAN

61 Kg / HI-156 cms Ref.No.:

Speed: --- mph Hr: 92
 Grade: --- % Mets: 1
 Protocol: Bruce BP: 100/70 mmHg Curr Time: 00:05 NotchOn

Target H: 49 % of 187
 Ex Time: --- min:sec
 Filter: 0.1 - 100 Hz Gain: 10 mm/mV
 BLC: On Sweep: 25 mm/s
 Median Sweep: 25 mm/s

Linked Medians
Pre Ex





16/3/2024

Mrs. Priyanka Chauhan 38/F

pt for regular checkup.

O/E
A/K
Thut
Ulcer
|
asul

2
No active
ENT 2

DR. SURAJ GIRI
M.B.B.S., MS-ENT
Reg. No. 08/2010/2603

PFT-(M)



Name: Mrs. Priyanka. Chavhan

Age: 33yr (Female)

H/o: Lactating Mother

18/3/2024

GC: 54

Implant 54

Cap. # 4

RC1 -> 5! (5) - Res

OPG - tray

CBCT.

Dr. Roshani J. Kotian
B.D.S (NHDC)
Consultant General Dentist
Reg. : A-28340