DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1

OPD ASSESSMENT FORM

Name: Mrs. Pallavi Arora Age.Sex: 32 / F MR.No.: 5147086

Doctor: Dr. Krunal Gajjar Date: 11/12/23

Ht: 155 cm Wt.: 54.5 kg. Temp: 97°F Pulse: 98 b/m BP: 120/62 mmHg.

SPO2: 98% Post of walk SPO2:

Chief Complaints:

Not-Any.

Drug / Food Allergy:

NO.

Prior Medication Reviewed: Yes ☐ No ☐

On examination:

RS } NAD
CVS }

Past History:

— N.S. —

Provisional Diagnosis:

Nutritional Assessment:

- ☐ Obese
- ☑ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices:
(Write in Capital Letters)

Rx —

Investigation advised:

—

Dr. Krunal Gajjar
M.B.B.S., MD (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No. G-23422
SUNSHINE GLOBAL HOSPITAL

Signature

Follow Up: Date:

In case of emergency Please report to Emergency Department of Hospital OR
Call: 75748 49465, 0261-4111000

DOC. No. SGHS/FMT/OPD002 | DOI 14/06/2014 | Rev. No. 0.1

OPD ASSESSMENT FORM

Name: Mrs. Pallavi Aditya Arora Age.Sex: 32/F MR.No. 5147086

Doctor: Dr Krutika Shah Date: 11/12/23

Ht : ______ Wt. : ______ Temp : ______ Pulse : ______ BP : ______

SPO2 : ______ Post of walk SPO2 : ______

Chief Complaints :

Routine health check-up

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

Calculus +

Past History :

Provisional Diagnosis :

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

℞ Adv: scaling

Investigation advised :

Krutika

Dr. Krutika Shah
Consultant Dental Surgeon
Reg. No. A-8876
Sunshine Global Hospital
Surat

Follow Up : Date : ______ Signature

In case of emergency Please report to Emergency Department of Hospital OR
Call : 75748 49465, 0261-4111000

DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1

OPD ASSESSMENT FORM

Name: Mrs. Pallavi Aditya Arora Age.Sex: 32/F MR.No. S147086

Doctor: Dr Hyrdik Shroff Date: 11/12/23

Ht : ______ Wt. : ______ Temp : ______ Pulse : ______ BP : ______

SPO2 : ______ Post of walk SPO2 : ______

Chief Complaints :

No complain

H/O LASIK BE 1.5 yrs ago

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination : BE Ant-seg NAD

VA $\frac{6/6}{6/6}$ N6. Fundi (central) BE NAD

Past History :

Provisional Diagnosis :

NA ophthalmic

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

℞

—

Investigation advised :

[signature]

Follow Up : SOS Date : ______

Signature

In case of emergency Please report to Emergency Department of Hospital OR
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DOC. No.	SGHS/FMT/IPD009	DOI	14/06/2014	Rev. No.	0.0

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GYNAECOLOGICAL CONSULTATION

MR. NO. S147086

Name: Mrs. Pallavi Aditya Arora

Date: 11/12/23

Age: 32 Ht.: 155cm Wt.: 54.5 B.P.: 120/62 mmHg

Clinical Evaluation / History / Presenting Complain:

Routine

Gynecological History :

	Yes	No
1. Have you ever noticed any bleeding between menstrual periods ? માસિક ના સમય સિવાય વચ્ચે અનીયમીત બ્લીડીંગ થાય છે ?	☐	☑
2. Are / were your periods Irregular ? પીરીયડ રેગ્યુલર છે ?	☐	☑
3 Are you pregnant now ? અત્યારે તમે પ્રેગનન્ટ છો ?	☐	☑
4 Have you had your change of life (Menopause)? મેનોપોઝ ની કોઈ લક્ષણ ની તકલીફ છે ?	☐	☑
5 Are / were you taking birth control pills? તમે ગર્ભનિરોધક ગોળીઓ છે ?	☐	☑
6. Do you have a lump in your beast ? સ્તનમાં દુ:ખાવો / સોજો / ગાંઠ છે ?	☐	☑
7. Did anyone in your family suffer from beast cancer ? કુટુંબમાં કોઈએ બ્રેસ્ટ કેન્સર છે ?	☐	☑
8. Did anyone in you family suffer from any other cancer ? કુટુંબમાં કોઈને કોઈ પણ પ્રકારનું કેન્સર હતું ?	☐	☑

Obstetric History :

1. Menstrual History : Menarche at .... Yrs

Menses:
- a. Scanty / Average / Excess
- b. No of Days: 3-5 / 5-7 / More than 7 days
- c. Interval .... days, Reg / Irregular
- d. Pain : Before / During / After / Painless

Last menstrual Period (LMP): 2 W per...

2. Obstetric History :

Gravida .... Pare .... Abortion .... Live ....

Married life with cohabitation......................

Children M: 7y F: 24v Last Delivery: Yrs back

Any bad Obstetric event / history Yes / No

If yes Describe:

2 FTND

History of Contraception & Family Planning:

Examination

a. Breast Examination - Right Left

b. Per abdomen examination

c. Local examination Vulva : Vagina

d. Per Speculum Examination

e. Per vaginal examination :

Cervi : Uterus : AV/RV : Normal / Bulky

Adnexa :

PAP's Smear Taken Yes / No

Clinical Impression:

Recommendation:

A. Additional Inv. / Referral Suggested

B. Therapeutic Advice

Followup Date

Gynaecologist's Signature

PAT. NAME: Pallavi Arora	**Date** : 11/12/2023
REF. DOCTOR : Hosp. Dr.	**AGE** : 32 Yrs / F
INV. : USG Abdomen & Pelvis	**MR NO.** : S147086

Findings:

Liver is mildly enlarge in size (15.9 cm), shape and shows normal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is distended and appears normal. No e/o calculus, sludge or mass lesion is seen. CBD and Portal Vein appears normal is size and calibre.

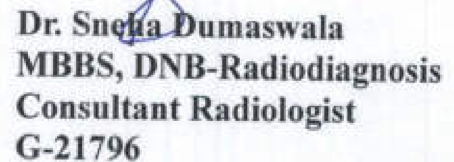
Pancreas appears normal in size and shows normal echopattern to the extent assessed. Spleen appears normal in size, shape and homogenous echopattern.

Both kidneys appear normal in size, shape and echopattern. The corticomedullary differentiation is well maintained. No e/o any calculus or hydronephrosis is seen.

Aorta and para-aortic regions appears normal. No e/o any lymphadenopathy.
Urinary bladder appears well distended and normal.
Uterus appears normal size, shape and echopattern. No e/o any focal or diffuse lesion noted.
Endometrial thickness is normal.
Both ovaries appear normal in size, shape and echopattern.
No e/o free fluid in abdomen / pelvis.

IMPRESSION:

- **Mild hepatomegaly.**



Dr. Sneha Dumaswala
MBBS, DNB-Radiodiagnosis
Consultant Radiologist
G-21796

Transcribed By: Asha

Date & Time of report: 11/12/2023 – 11:58 AM

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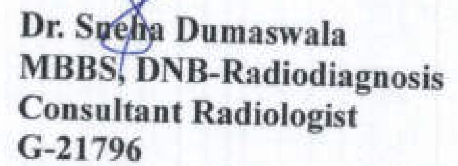
PAT. NAME: Pallavi Arora	Date : 11/12/2023
REF. DOCTOR : Hosp. Dr.	AGE : 32 Yrs / F
INV. : Radiograph of Chest PA	MR NO. : S147086

Clinical Details: HC

Observation:

- Both the lung fields appears normal.
- Both costophrenic angles appear clear.
- Both the hila appears normal.
- Trachea appears in midline.
- Cardiac size and other mediastinal shadows appears normal.
- Both domes of diaphragm appear normal.
- Bony thorax appears normal.



Dr. Sneha Dumaswala
MBBS, DNB-Radiodiagnosis
Consultant Radiologist
G-21796

Transcribed By: Asha

Date & Time of report: 11/12/2023 – 11:47 AM

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MR No.	: **S147086**	**Collection Date**	: 11/12/2023 9:56AM
Patient Name	: **Mrs. Pallavi Aditya Arora**	**Age**	: 32 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 11/12/2023 11:57AM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	14.1	gm/dl	12.0 - 15.0
PCV	43.8	%	36 - 46
RBC COUNT	4.86	mill/cmm	4.0 - 5.0
MCV	90.1	fl	76 - 96
MCH	29.0	pg	26 - 32
MCHC	32.2	%	32 - 36
RDW	12.3	%	11 - 15
PLATELET COUNT	2.91	lacs/cmm	1.5 - 4.5
WBC COUNT	7590	/cmm	4000 - 11000
ESR	07	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	49	%	40 - 70
LYMPHOCYTES	40	%	20 - 40
EOSINOPHILS	04	%	1 - 6
MONOCYTES	07	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Normochromic Normocytic		
WBC MORPHOLOGY	Within Normal Range		
PLATELET ON SMEAR	Adequate		
HEMOPARASITES	Not Seen		

SYSMEX XN-550

******* End Report *******

Dr. Shobha Choksi
MD, DCP (Pathology)
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MR No.	: **S147086**	**Collection Date**	: 11/12/2023 9:56AM
Patient Name	: **Mrs. Pallavi Aditya Arora**	**Age**	: 32 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 11/12/2023 11:51AM

HAEMATOLOGY

Parameter	Result		Normal Range
BLOOD GROUP & RH FACTOR			
BLOOD GROUP	"O"		
RH FACTOR	POSITIVE		

BIOCHEMISTRY

FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	88	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

CLINICAL CHEMISTRY

THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.08	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	7.70	ug/dl	5.1 - 14.0
TSH (CLIA)	1.58	uIU/ml	0.2 - 4.5

Note:-
Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechnism involving concentrations of FT3 (free T3) and FT4 (freeT4). Additionally the hypothalamic tripeptide. thyrotropin releasing hormone (TSH) directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy also stimulate the thyroid gland to synthesize and secrete T3 and T4.
Quantification of TSH significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism. TSH levels are significantly elevated whiled in secondary and tertiary hypothyroidism . TSH levels are low.

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MR No.	**: S147086**	**Collection Date**	**: 11/12/2023 9:56AM**
Patient Name	**: Mrs. Pallavi Aditya Arora**	**Age**	**: 32 Y Sex : Female**
Ref By	: Dr. Hospital A Doctor	**Report Date**	**: 11/12/2023 11:52AM**

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	5.3	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**105.41**	mg/dl	

The test is done on Cobas Integra 400plus-Turbidimetric Inhibition ImmunoAssay

Note:- Criteria for the diagnosis of diabetes HbA1c >/=6.5*

1. HbA1c is important test for the assessment of long term blood glucose control (also called glycemic control).
2. HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of long term glycemic control than blood glucose determination.
3. HbA1C is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefor remains unaffected by short term fluctuations in blood glucose levels.
4. Long term complications of diabetes such as retinopathy,nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.
5. Genetic Variants (Hb-S trait,Hb-C trait) elevated fetal haemoglobin & chemically modified derivatives of haemoglobin (eg carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1C measurement.

******* End Report *******

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MR No.	: S147086	Collection Date	: 11/12/2023 9:56AM
Patient Name	: Mrs. Pallavi Aditya Arora	Age	: 32 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	Report Date	: 11/12/2023 11:53AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	142	mg/dl	50 - 200
HDL CHOLESTEROL Direct	44	mg/dl	40 - 60
LDL CHOLESTEROL Direct	83.9	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	71	mg/dl	50 - 150
VLDL Calc	14.2	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	3.23		0 - 5
LDL / HDL RATIO	1.91		0 - 3

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment.
- Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Details on test interpretation available from the lab.

TEST	NEAR OPTIMAL (Moderate Risk)	BORDER LINE (Risk)	HIGH (Risk)	VERY HIGH
CHOLESTROL	160-199	200-239	240-279	280
HDL	50-59	40-49	< 40	
LDL	100-129	130-159	160-190	>190
TRIGLYCERIDES	150-169	170-199	240-499	>500
CHO/HDL RATIO	3.3-4.4	4.4-11.0	>11.0	
LDL/HDL RATIO	0.5-3.0	3.0-6.0	>6.0	

******* End Report *******

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Patient Name	**: Mrs. Pallavi Aditya Arora**	**Age**	: 32 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 11/12/2023 11:54AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	42	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.3	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.1	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.2	mg/dl	0.0 - 0.8
SGPT (IFCC)	07	U/L	5 - 41
SGOT (IFCC)	14	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.0	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.7	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.3	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	2.04	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	0.7	mg/dl	0.5 - 1.2
SERUM URIC ACID			
SERUM URIC ACID (Uricase)	4.5	mg/dl	2.4 - 5.7
BUN [BLOOD UREA NITROGEN]			
BUN	12.5	mg/dl	8 - 23
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	**255.4**	mg/L	
URINE CREATININE (JAFFE)	**129.9**	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	196.6	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

******* End Report *******

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MR No.	: **S147086**	**Collection Date**	: 11/12/2023 9:56AM
Patient Name	: **Mrs. Pallavi Aditya Arora**	**Age**	: 32 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 11/12/2023 12:01 PM

CLINICAL PATHOLOGY

Parameter	**Result**		**Normal Range**
URINE ROUTINE & MICROSCOPIC EXAMINATION			
TYPE OF SPECIMEN - URINE	Random		
PHYSICAL EXAMINATION			
QUANTITY	05	ml	
COLOUR	Reddish		
APPEARANCE	Sl.Turbid		
REACTION (pH)	6.0		
SPECIFIC GRAVITY	1.030		
CHEMICAL EXAMINATION			
PROTEIN	Present(Trace)		
GLUCOSE	Absent		
KETONE	Absent		
BILE SALT	Absent		
BILE PIGMENT	Absent		
OCCULT BLOOD	Present(++++)		
NITRITE	Absent		
MICROSCOPIC EXAMINATION			
PUS CELLS	2-3	/hpf	
EPITHELIAL CELLS	10-12	/hpf	
RBC	Plenty	/hpf	
CASTS	Absent		
CRYSTALS	Absent		
BACTERIA	Absent		
YEAST CELLS	Absent		

******* End Report *******

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MR No.	**: S147086**	**Collection Date**	**: 11/12/2023 9:56AM**
Patient Name	**: Mrs. Pallavi Aditya Arora**	**Age**	**: 32 Y Sex : Female**
Ref By	: Dr. Hospital A Doctor	**Report Date**	**: 11/12/2023 1:55 PM**

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
POST PRANDIAL BLOOD GLUCOSE [PPBS]			
POST PRANDIAL BLOOD GLUCOSE (Hexokinase)	**83**	mg/dl	100 - 140
POST PRANDIAL URINE GLUCOSE	SNR		
POST PRANDIAL URINE KETONE	SNR		

******* End Report *******

Dr. Shobha Choksi
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11/12/2023 01:55PM

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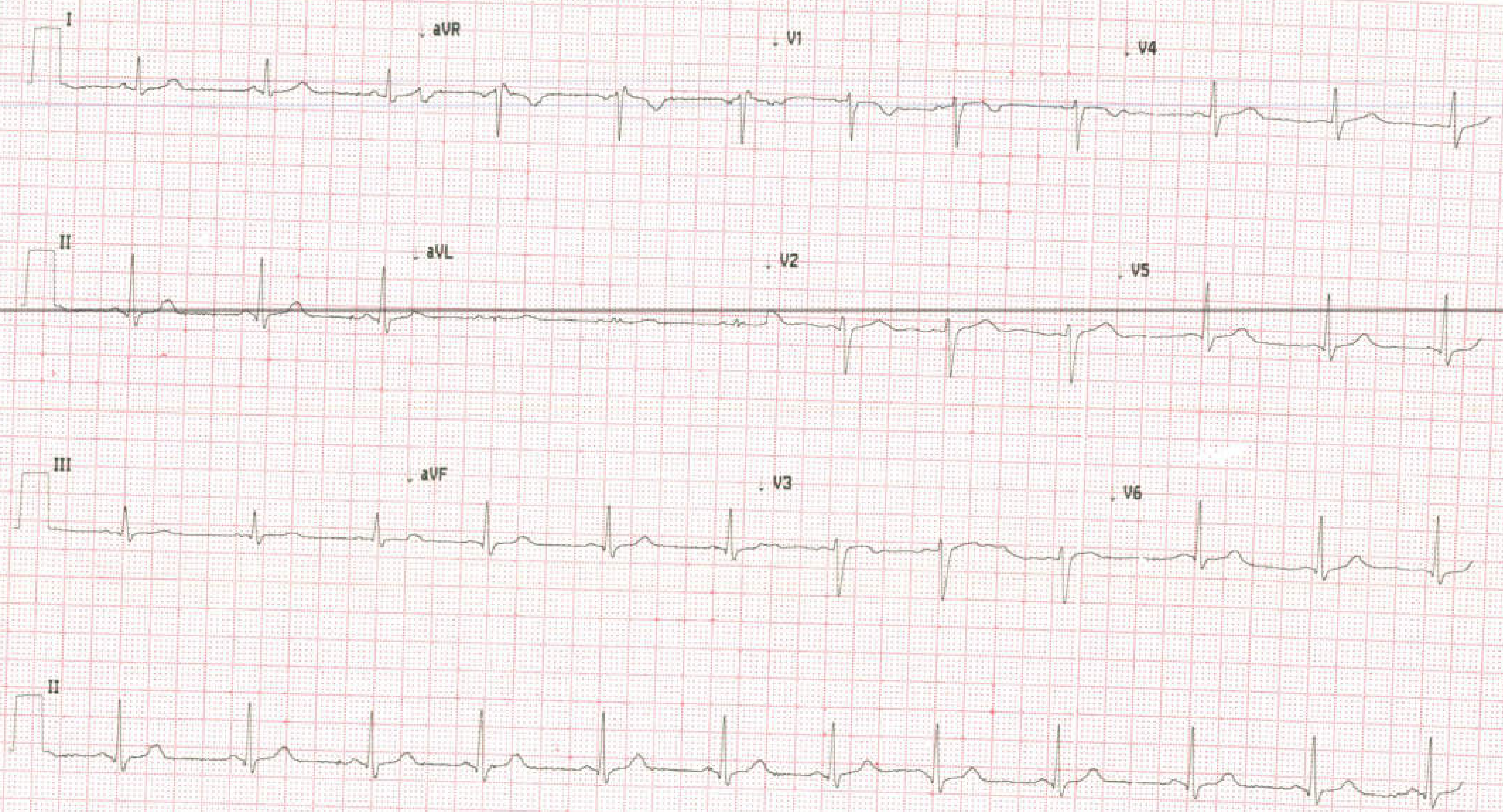
DOB:
yr, FEMALE

Vent rate: 71 BPM
PR int: 113 ms
QRS dur: 102 ms
QT/QTc: 372/394 ms
P-R-T axes: 37 54 41

SINUS RHYTHM WITH SINUS ARRHYTHMIA WITH SHORT PR INTERVAL
BORDERLINE ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS

Reviewed by ------------------

Mrs. Pallavi Arora
32 F



Version 1.20.02 Sequence #11144 25mm/s 10mm/mV 0.05-40 Hz 50Hz