

Shareen Bano Israr Khan

07/03/2024

42 yrs Female

No fresh complaints

No comorbidities

No PH.

No SH.

LMP - 13/01/2024, irregular ∴ 2-3 months

O/H - G₄P₄A₀L₄D₀.

G₁ - female, 25 yrs, FTND

G₂ - female, 22 yrs, FTND

G₃ - male, 27 yrs, FTND

G₄ - male, 20 yrs, FTND.

BP - 130/80 mmHg

P - 80/min

SpO₂ - 99%

PT is fit and can resume
her normal duties

consult with physician for blood change

Blood Sugar is high



HELPLINE

022 - 2588 3531

S-1, Vedant Complex,
Vartak Nagar, Thane (W) 400 606

www.siddhivinayakhospitals.org



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

SHAREEN BANO ISRAR KHAN

AGE

42

DATE -

07.03.2024

Specs : Without Glasses

	RT Eye	Lt Eye
NEAR	N/18	N/18
DISTANT	6/9	6/9
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS



Name - Mrs. SHIREEN KHAN	Age - 42 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 07 /03/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.
Cardiac and aortic shadows appear normal
No evidence of pleural of effusion is seen.
Both domes of diaphragm appear normal.
No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





Name - Mrs. Shireen Khan	Age - 42 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 07/03/2024

USG ABDOMEN & PELVIS

FINDINGS:

The liver dimension is enlarged in size (16.7 cm). It appears normal in morphology with raised echogenicity. No evidence of intrahepatic ductal dilatation.

The GB-gallbladder is distended normally with no stones within.

The CBD- common bile duct is normal. The portal vein is normal.

The pancreas appears normal in morphology.

The spleen is normal in size (10.9 cm)and morphology

Both kidneys demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 9.7 x 4.5 cm.

The left kidney measures 9.8 x 4.9 cm

Urinary bladder: normally distended. Wall thickness - normal.

Uterus :is normal in size.

Endometrium: 8.4 mm, it appears normal in morphology.

Bilateral ovaries are obscured by gases.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- Hepatomegaly with fatty liver (Grade I).

DR. AMOL BENDRE

MBBS; DMRE

CONSULTANT RADIOLOGIST





Name - Mrs. Shireen Khan	Age - 42 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 07/03/2024

USG - BOTH BREASTS

Real time sonography of both breast was performed with high frequency probe.

Both breast show normal, medium level, homogeneous echotexture. No evidence of any solid or cystic focal mass lesion.

No evidence of calcification noted.

The pectorallis major muscles appear normal.

No evidence of axillary lymphadenopathy seen.

IMPRESSION:

- No significant abnormality is noted.

Thanks for the referral.....

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST



ID: 1044

07-03-2024 10:27:46 AM

Shahen Khath
Female
Years 42

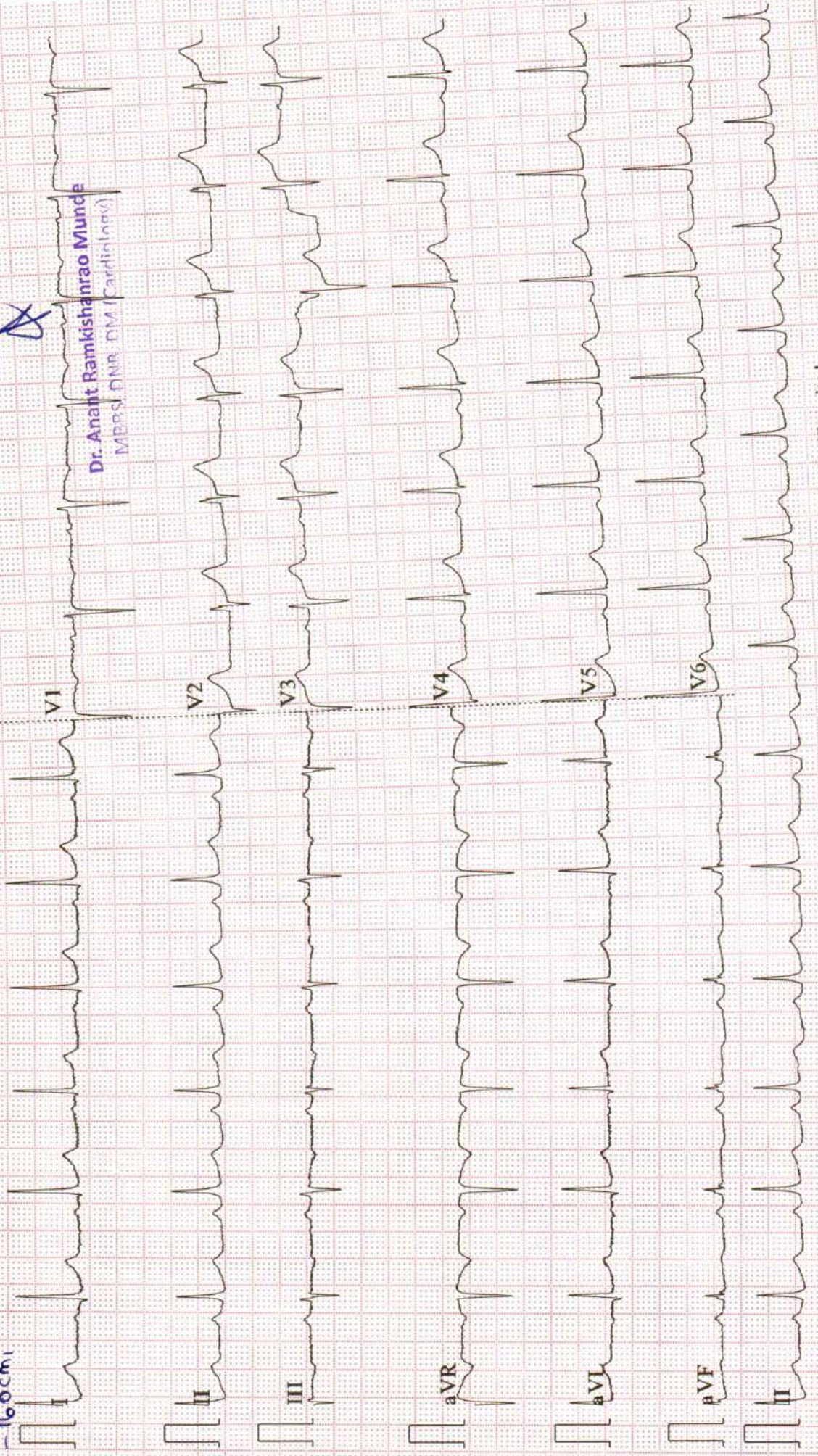
Req. No. :
BP - 130/80 mm Hg.
SpO2 - 100%
PR - 81 bpm
wt - 65 kg
Ht - 160cm

Diagnosis Information:
Sinus Rhythm
Normal ECG

HR : 78 bpm
P : 98 ms
PR : 171 ms
QRS : 87 ms
QT/QTcBz : 379/434 ms
P/QRS/T : 67/18/18 °
RV5/SVI : 1.302/1.092 mV

Report Confirmed by:

Dr. Anant Ramkishanrao Munde
MBBS, DNB, DDM (Cardiology)





ECHOCARDIOGRAM

NAME	MRS. SHIREEN KHAN
AGE/SEX	42 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	07/03/2024

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	CHAMBERS: LEFT ATRIUM: Normal <ul style="list-style-type: none"> • Left atrial appendage: Normal LEFT VENTRICLE: Moderate concentric LV hypertrophy <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
GREAT VESSELS: <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	SEPTAE: <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact
CORONARIES: Proximal coronaries normal CORONARY SINUS: Normal PULMONARY VEINS: Normal	VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration
	PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	33 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	43.8 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	26.1 mm	RVEF	%
Ascending aorta	mm	IVSd	12.3 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	12.3 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	71 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MRS. SHIREEN KHAN
AGE/SEX	42 YRS/F
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DATE OF EXAMINATION	07 /03/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.5	1.15
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm ²)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)				
REGURGITATION		TRIV= m/s PASP= mmHg		
E/A				
E/E'				

FINAL IMPRESSION: MODERATE HYPERTENSIVE HEART DISEASE.

- No RWMA
- Normal LV systolic function (LVEF 71 %)
- Moderate concentric LV hypertrophy
- Good RV systolic function
- Normal diastolic function
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE Control HTN

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

Dr. Anant Ramkishanrao Munde

MBBS, DNB, DM (Cardiology)

Reg. No. 2005021228



Name : Mrs. SHAREEN BANO KHAN (A) Collected On : 7/3/2024 9:47 am
Lab ID. : 185972 Received On : 7/3/2024 9:57 am
Age/Sex : 39 Years / Female Reported On : 7/3/2024 3:53 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	156.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	38.0	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	121.7	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	24	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	94	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	2.47		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.11		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
SHAISTA Q

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





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COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	11.4	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	34.2	%	36 - 46
RBC COUNT	4.76	x10 ⁶ /uL	4.5 - 5.5
MCV	72	fl	80 - 96
MCH	23.9	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	17.6	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	10890	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	56	%	40 - 80
LYMPHOCYTES	35	%	20 - 40
EOSINOPHILS	03	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	256000	/cumm	150000 - 450000
MPV	11.6	fl	6.5 - 11.5
PDW	15.7	%	9.0 - 17.0
PCT	0.300	%	0.200 - 0.500
RBC MORPHOLOGY	Hypochromia(mild),anisocytosis(mild)		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Slightly hazy		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Present(Trace)		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Present(++)		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Present(Trace)		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	10-12	/ HPF	0 - 5
EPITHELIAL	4-6	/ HPF	0 - 5
CASTS	Absent		

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent

REMARK Result relates to sample tested. Kindly correlate with clinical findings.

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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TFT (THYROID FUNCTION TEST)

SPECIMEN	Serum		
T3	139.3	ng/dl	84.63 - 201.8
T4	8.16	µg/dl	5.13 - 14.06
TSH	3.28	µIU/ml	0.270 - 4.20

DONE ON FULLY AUTOMATED ANALYSER COBAS e411.

INTERPRETATION T3 (Triiodo Thyronine) T4 (Thyroxine)

AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 years	105-269	1-4 months	7.2-14.4
6-10 years	94-241	4-12months	7.8-16.5
11-15 years	82-213	1-5 years	7.3-15.0
15-20 years	80-210	5-10 years	6.4-13.3
		11-15 years	5.6-11.7

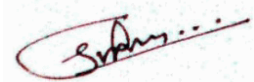
TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	0.30-3.0

INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

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* 1 8 5 9 7 2 *

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GROUP			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'O'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
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***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	15.4	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	7.20	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.86	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	4.3	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	137.8	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	3.90	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	98.9	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.35	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	8.9	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.16	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	3.7	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	3.46	g/dl	1.9 - 3.5
A/G RATIO calculated	1.07		0 - 2

NOTE

BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200)
ANALYZER.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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* 1 8 5 9 7 2 *

Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Hypochromia(mild),anisocytosis(mild)
WBC	Total leukocytes count is normal on smear.
	NEUTROPHILS:56%
	LYMPHOCYTES:35%
	EOSINOPHILS:03%
	MONOCYTES:06%
	BASOPHILS:00%
PLATELET	Adequate on smear
HEMOPARASITE	No parasites seen.

Result relates to sample tested, Kindly correlate with clinical findings.
----- END OF REPORT -----

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LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.38	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.18	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.20	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	26.0	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	28.3	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	113.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	7.16	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	3.7	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	3.46	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.07		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

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* 1 8 5 9 7 2 *

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	29	mm/1hr.	0 - 20

METHOD - WESTERGREIN

Result relates to sample tested, Kindly correlate with clinical findings.

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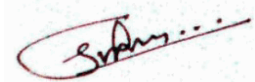
BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>GLYCOCELATED HEMOGLOBIN (HBA1C)</u>			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	10.6	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	257.5	mg/dL	65.1 - 136.3
METHOD Particle Enhanced Immunoturbidimetry			
HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.			
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	255.9	mg/dL	70 - 110
BLOOD GLUCOSE PP	279.6	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting speciman. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

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Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms + Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

GAMMA GT 51.7 U/L 5 - 55

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
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