



OPD ASSESSMENT FORM



Name Mrs. ~~Smita~~ Riadhi Mishra Age Sex 34 F MR.No. 5744608

Doctor Dr. Krunal Gajjar Date 17/10/2023

Ht: 152cm Wt: 55.9kg Temp: 97F Pulse: 58 B/M BP: 130/74 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 :

K110 thalasemia minor.

Provisional Diagnosis :

Nutritional Assessment :

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

**Treatment and further Advices :
(Write in Capital Letters)**

Rx _____

Investigation advised :

[Signature]

Dr. Krunal Gajjar
M.B.B.S. (MD MEDICINE)
CONSULTANT PHYSICIAN

Signature

SUNSHINE HOSPITAL
SURAT.

Follow Up : _____ Date : _____



OPD ASSESSMENT FORM



Name Mrs. Riddhi Mistay Age.Sex 34/F MR.No. 3144608

Doctor Dr. Hardik Shroff Date 12/10/23

Ht : _____ Wt. : _____ Temp : _____ Pulse : _____ BP : _____

SPO2 : _____ Post of walk SPO2 : _____

Chief Complaints :

Drug / Food Allergy :

BE No complaints

Prior Medication Reviewed : Yes No

On examination : BE ANL - S.O.P. NAD Past History :

✓ Rb. by NIB

undi (central) BE NAD

Provisional Diagnosis :

BE NAD of the above

Treatment and further Advices :
(Write in Capital Letters)

Rx

Nutritional Assessment :

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

Investigation advised :

BE Repeat tests as above



Dr. Hardik Shroff

DDMS, DNB (General Medicine)

Reg. No. G-20902

Signature

SUNSHINE GLOBAL HOSPITALS
Piplod, SURAT.

Follow Up : SUC Date : _____

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



GYNAECOLOGICAL CONSULTATION

MR. NO. 5144608

Name: Mrs. Aishwari Snehani

Date: 17/10/23.

Age: 34F Ht: 152cm Wt: 65.9kg B.P.: 130/77

Clinical Evaluation / History / Presenting Complain:

.....
.....
.....
.....
.....

A.H.
D.H

Rushika

Gynecological History :

- | | Yes | No |
|---|--------------------------|-------------------------------------|
| 1. Have you ever noticed any bleeding between menstrual periods ?
કાંઈક ના સમય સિવાય વચ્ચે અનિચિત ખીરડોના કાલ છે ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2. Are / were your periods irregular ?
પીરોડસ રેગ્યુલર છે ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3. Are you pregnant now ?
સવારે તમે ગેવનસ છો ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 4. Have you had your change of life (Menopause)?
મેનોપોઝ ની સોઈ વજા ની અસીક છે ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5. Are / were you taking birth control pills?
તમે ગર્ભનિરોધક ગોળીઓ છે ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6. Do you have a lump in your breast ?
સપાત્ત દુઃખાલો / ગોળો / ગાંઠ છે ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7. Did anyone in your family suffer from breast cancer ?
કુટુંબના કોઈએ બ્રેસ્ટ કેન્સર છે ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8. Did anyone in you family suffer from any other cancer ?
કુટુંબના કોઈને કોઈ પણ પ્રકારનું કેન્સર છે ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Obstetric History :

1. Menstrual History : Menarche at 14 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): 21/9/23

2. Obstetric History :

Gravida Pare Abortion 1 Live 1

Married life with cohabitation.....

Children . M: F: 3 Last Delivery: Yrs back

Any bad Obstetric event / history Yes Yes / No

If yes Describe:

Aishwari

History of Contraception & Family Planning:

Examination

- a. Breast Examination - Right
- b. Per abdomen examination

NO3

Left AS

- c. Local examination
- d. Per Speculum Examination

Vulva :

Vagina AS

1/1 A Gray

AS

1/1 Gray

- 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

2 Feb

Followup Date

DR. BHAVINA DESAI
MD, DGO

REG. NO.-10538

SUNSHINE GLOBAL HOSPITAL

Gynaecologist's Signature



OPD ASSESSMENT FORM



Name Mrs Riddhi mistoy Age.Sex _____ MR.No. _____

Doctor Dr Shailaja Desai Date 17/10/23

Ht : _____ Wt. : _____ Temp : _____ Pulse : _____ BP : _____

SPO2 : _____ Post of walk SPO2 : _____

Chief Complaints :

- Routine dental checkup

Drug / Food Allergy :

Prior Medication Reviewed : Yes No

On examination :

- healthy

Past History :

Provisional Diagnosis :

Nutritional Assessment :

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

**Treatment and further Advices :
(Write in Capital Letters)**

Rx

1) scaling

Investigation advised :

Dr. Shailaja Desai
Dr. Shailaja Desai
B.D.S. (Dental Surgeon)
A.G.P.S.

Dental Surgeon
Sunshine Global Hospital, *Sunshine* Signature

Follow Up : _____ Date : _____



MR NO: S144668



ECHO CARDIOGRAPHIC REPORT

Patient's Name : Mrs. Riddhi Snehal Mistry Date : 17/10/23 12:PM

Sex : f Age : 34 Ref. by Dr. : _____ Done by Dr. Sanjendra Singh

LV Size : (n) LVEF : 68 % (VISUAL)

DIASTOLIC DYSFUNCTION : NO LVH : _____

RWMA: ANTERIOR WALL NO
ANTERIOR SEPTUM
IVS
LV APEX NO RWMA
POSTERIOR WALL
LATERAL WALL
INFERIOR WALL

MITRAL VALVE : _____ AORTIC VALVE

PULMONARY VALVE : (n) TRICUSPID VALVE (n)

PAH : _____ PASP : _____

RA : _____ LA : _____

RV : (n) IVC : (n)

IAS : _____
IVS : 1mm

IVS (s) cm LV(s) cm PW (s) cm LVEF = 68 %
IVS (d) cm LV (d) cm PW (d) cm FS = _____ %

CONCLUSION :

NO NEG/CLT/PLS



PAT. NAME: Riddhi Mistry	Date : 17/10/2023
REF. DOCTOR : Hosp. Dr.	AGE : 34 Yrs / F
INV. : USG Abdomen & Pelvis	MR NO. : S144608

Findings:

Liver is normal in size, 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 in 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:

- No significant abnormality seen.


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

Transcribed By: Asha

Page: 1 out of 1
Date & Time of report: 17/10/2023 - 11:22 AM

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PAT. NAME: Riddhi Mistry	Date : 17/10/2023
REF. DOCTOR : Hosp. Dr.	AGE : 34 Yrs / F
INV. : Radiograph of Chest PA	MR NO. : S144608

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

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MR No. : S144608	Collection Date : 17/10/2023 8:59AM
Patient Name : Mrs. Riddhi Snehal Mistry	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 17/10/2023 11:21AM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	12.1	gm/dl	12.0 - 15.0
PCV	39.4	%	36 - 46
PLATELET COUNT	4.95	mill/cmm	4.0 - 5.0
RDW	79.6	fl	76 - 96
MCH	24.4	pg	26 - 32
MCHC	30.4	%	32 - 36
RDW	15.5	%	11 - 15
PLATELET COUNT	2.92	lacs/cmm	1.5 - 4.5
WBC COUNT	5460	/cmm	4000 - 11000
ESR	08	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	61	%	40 - 70
LYMPHOCYTES	31	%	20 - 40
EOSINOPHILS	02	%	1 - 6
MONOCYTES	06	%	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 *****

ESC
Dr. Shobha Choksi
MD, DCP (Pathology)

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MR No. : S144608	Collection Date : 17/10/2023 8:59AM
Patient Name : Mrs. Riddhi Snehal Mistry	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 17/10/2023 11:16AM

HAEMATOLOGY

Parameter	Result	Normal Range
BLOOD GROUP & RH FACTOR		
BLOOD GROUP	*A*	
RH FACTOR	Negative	

BIOCHEMISTRY

FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	90	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

CLINICAL CHEMISTRY

THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.10	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	8.59	ug/dl	5.1 - 14.0
TSH (CLIA)	4.89	uIU/ml	0.2 - 4.5

Note:-
Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to negative feedback mechanism 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 while in secondary and tertiary hypothyroidism, TSH levels are low.

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

Dr. Shobha Choksi
MD, DCP (Pathology)

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MR No. : S144608	Collection Date : 17/10/2023 8:59AM
Patient Name : Mrs. Riddhi Snehal Mistry	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 17/10/2023 11:17AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	5.7	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	116.89	mg/dl	

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

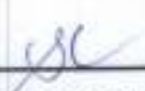
Note:- Criteria for the diagnosis of diabetes HbA1c \geq 6.5*

- HbA1c is important test for the assessment of long term blood glucose control (also called glycemc control).
- HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of long term glycemc control than blood glucose determination.
- 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.
- Long term complications of diabetes such as retinopathy,nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.
- 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.

SERUM URIC ACID

SERUM URIC ACID (Uricase)	2.3	mg/dl	2.4 - 5.7
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***** End Report *****


Dr. Shobha Choksi
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MR No. : S144608	Collection Date : 17/10/2023 8:59AM
Patient Name : Mrs. Riddhi Snehal Mistry	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 17/10/2023 11:18AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	182	mg/dl	50 - 200
HDL CHOLESTEROL Direct	37	mg/dl	40 - 60
LDL CHOLESTEROL Direct	122	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	116	mg/dl	50 - 150
VLDL Calc	23.2	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	4.92		0 - 5
LDL / HDL RATIO	3.3		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 *****

Dr. Shobha Choksi
MD, DCP (Pathology)

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MR No. : S144608	Collection Date : 17/10/2023 8:59AM
Patient Name : Mrs. Riddhi Snehal Mistry	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 17/10/2023 11:19AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	42	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.2	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.1	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.1	mg/dl	0.0 - 0.8
SGPT (IFCC)	09	U/L	5 - 41
SGOT (IFCC)	11	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	6.5	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.2	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.3	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	1.83	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFEE)	0.5	mg/dl	0.5 - 1.2
BUN [BLOOD UREA NITROGEN]			
BUN	6.8	mg/dl	8 - 23

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

Dr. Shobha Choksi
MD, DCP (Pathology)

Reg. No.: G-9074

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MR No. : S144608	Collection Date : 17/10/2023 8:59AM
Patient Name : Mrs. Riddhi Snehal Mistry	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 17/10/2023 11:30AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	21.4	mg/L	
URINE CREATININE (JAFJE)	108.2	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	19.7	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

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

Dr. Shobha Choksi
MD, DCP (Pathology)

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Page 1 of 1



MR No. : S144608	Collection Date : 17/10/2023 8:59AM
Patient Name : Mrs. Riddhi Snehal Mistry	Age : 34 Y Sex : Female
Ref By : Dr. Hospital A Doctor	Report Date : 17/10/2023 11:22AM

CLINICAL PATHOLOGY

Parameter	Result	Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION		
TYPE OF SPECIMEN - URINE	Random	
PHYSICAL EXAMINATION		
QUANTITY	20	ml
COLOUR	Pale Yellow	
APPEARANCE	Clear	
REACTION (pH)	6.0	
SPECIFIC GRAVITY	1.010	
CHEMICAL EXAMINATION		
PROTEIN	Absent	
GLUCOSE	Absent	
KETONE	Absent	
BILE SALT	Absent	
BILE PIGMENT	Absent	
OCCULT BLOOD	Absent	
NITRITE	Absent	
MICROSCOPIC EXAMINATION		
PUS CELLS	4-6	/hpf
EPITHELIAL CELLS	12-15	/hpf
..BC	Absent	/hpf
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

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

SC
Dr. Shobha Choksi
MD, DCP (Pathology)

Reg. No.: G-9074

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Page 1 of 1

DOB:

yr. FEMALE

*Pidhi Snehel
mistouy*

Heart rate: 70 BPM
PR int: 138 ms
QRS dur: 80 ms
QT/QTc: 392/413 ms
P-R-T axes: 50 48 34

SINUS RHYTHM
NONSPECIFIC ST & T-WAVE ABNORMALITY
BORDERLINE ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS
Reviewed by -----

