



# CHARUSAT HOSPITAL

## DOCTORS' NOTES



DATE & TIME

DOCTOR'S NOTES

SIGNATURE

10/2/24

S/B Dr. Jale Shah

news - Ascler

OR: 10 - 34V  
10 - 31V

PR in Kelly's Supplement

Ado



# CHARUSAT HOSPITAL



DATE	PATIENT NAME	SEX	REFERRED BY DR.	INVESTIGATION
10-02-2024	DHARABEN P SHAH	F	BODY PROFILE	UF-TOTAL ABDOMEN USG

## USG OF THE ABDOMEN/ PELVIS WAS PERFORMED

The liver is normal in size and echotexture. No focal solid or cystic lesions are seen. The intra hepatic biliary radicles are normal. The portal vein and CBD are normal. **The gall bladder is contracted with multiple calculi ,no polyp. The wall is not thickened.**

The pancreas reveals a normal echopattern, with no focal calcification or a neoplasm. The spleen reveals a normal sonographic features.

Both kidneys are normal in size and echotexture. Evidence of good cortico medullary differentiation is noted. No evidence of any calculi or hydronephrosis.

No free fluid or lymphadenopathy is seen. The urinary bladder is well distended with no calculi or polyps.

The uterus is antverted, normal size. The endometrium is in the midline. No focal myoma is seen. Both the ovaries are normal in size and shape. No focal solid or cystic lesion is seen.

No adnexal abnormality is seen. No free fluid is seen in the pouch of douglas.

Size in CM.

CBD	Portal vein	Splenic vein	Right Kidney	Left Kidney
0.44	0.85	0.4	9.8X4.6	10.5X5.6

### IMPRESSION :

**CONTRACTED GALL BLADDER WITH MULTIPLE CALCULI.**

**NO OTHER OBVIOUS ABNORMALITY DETECTED.**

Thanks for reference  
DR KIRTI C THAKKAR  
M.B.B.S,D.M.R.D



# CHARUSAT HOSPITAL



DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
30-02-2024	DHARABEN P SHAH	F	BODY PROFILE	X-RAY

## X-ray CHEST PA view.

No evidence of abnormality seen involving both lungs. Costophrenic sinuses are clear.

Hilar shadows show evidence of normal size, position & opacity.


Aortic shadow show evidence of normal position & Size. Cardiac size & position is normal.

Domes of diaphragm & bony cage show no evidence of abnormality.

## COMMENTS:

NO ABNORMALITY DETECTED



Patient Name : DHARA PRATIK SHAH	Sample No. : SAMPLE-0106913 
Patient ID : CH-2024-0053591	Visit No. : OPD/2024/02/0000519
Age/Sex : 36y/Female	Call. Date : 10-Feb-2024 08:56
Referred By : RIPAL PATEL	S. Coll. Date : 10-Feb-2024 11:17
Ward :	Report Date : 10-Feb-2024 11:48

Investigation	Result	Normal Value
Hemoglobin (HB)	11.9 gm/dl [LOW]	[M : 14-18, F : 12-16]


Investigation	Result	Normal Value
WBC	4.08 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC Count :	6620 /c.mm [NORMAL]	4000 - 10000

Investigation	Result	Normal Value
Platelet count	2.82 Lakh/cmm [NORMAL]	1.5 - 4.5

Investigation	Result	Normal Value
BC count - Differential		
Polymorphs	68 % [NORMAL]	40 - 70
Lymphocytes	24 % [NORMAL]	20 - 40
Eosinophils	02 % [NORMAL]	1 - 6
Monocytes	06 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

Investigation	Result	Normal Value
BLOOD UREA		
Blood Urea	15.3 mg/dl [NORMAL]	15 - 40

S.Creatinine

Patient Name : DHARA PRATIK SHAH	Sample No. : SAMPLE-0106913 
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Investigation	Result	Normal Value
Serum Creatinine	0.54 mg/dl [LOW]	Male : 0.9 to 1.5 mg/dl Female : 0.8 to 1.2 mg/dl

Investigation	Result	Normal Value
BUN	07 [LOW]	8.0 to 23.0 (mg/dl)

Investigation	Result	Normal Value
Serum Uric Acid	4.32 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0


Investigation	Result	Normal Value
ESR - After One Hour	08 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

Investigation	Result	Normal Value
ABO :	O	
Rh :	Positive	

Investigation	Result	Normal Value
Fasting Blood Sugar :	93.9 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

Investigation	Result	Normal Value
TSH :	1.75 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

Investigation	Result	Normal Value
T3		

Patient Name :	DHARA PRATIK SHAH	Sample No. :	SAMPLE-0106913 
Patient ID :	CH-2024-0053591	Visit No. :	OPD/2024/02/0000519
Age/Sex :	36y/Female	Call. Date :	10-Feb-2024 08:56
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T3-Triiodothyronine : 1.32 ng/ml [NORMAL]      0.69 to 2.15 (ng/ml)

Investigation	Result	Normal Value
T4-thyroxine :	<span style="border: 1px solid black; padding: 2px;">64.8</span> ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)


### LIPID PROFILE

Investigation	Result	Normal Value
Serum Cholesterol (Chol) :	169.8 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	88.9 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	52.2 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	83.64 mg/dl	
VLDL :	<span style="border: 1px solid black; padding: 2px;">33.96</span> mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	<span style="border: 1px solid black; padding: 2px;">1.6</span> - [NORMAL]	< 3.5
TC / HDL Ratio :	<span style="border: 1px solid black; padding: 2px;">3.25</span> - [LOW]	4.0 to 6.0
LDL (DIRECT) :	80.1 mg/dl [Optimal]	< 100.0 (Optimal), 100.0 to 120.0 (Near Optimal), 130.0 to 159.0 (Border line high), 160.0 to 189.0 (High), > 190.0 (Very high)

### LIVER FUNCTION TEST

Investigation	Result	Normal Value
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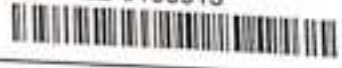


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Total Bilirubin :	0.69 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.22 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	20.7 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	11.6 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	93.2 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP) :	7.23 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	4.01 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.47 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.22 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.2	


### URINE R & M

Investigation	Result	Normal Value
<b>Physical Examination :</b>		
Quantity :	15 ml	
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Alkaline -	
Specific Gravity :	1.005 -	
<b>Chemical Examination :</b>		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	

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Acetone : Absent -  
Urobilinogen : Absent -  
Microscopic Examination :  
Pus Cells : 3-4 -  
RBCs : Absent -  
Epithelial cells : 6-8 -  
Casts : Absent -  
Crystals : Absent -

R. NAITIK BHATIA  
CONSULTANT PATHOLOGIST  
(M.B.B.S,D.C.P)

  
DR. KETAN KAPADIA  
CONSULTANT PATHOLOGIST  
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LDLC :	83.64 mg/dl	
VLDL :	<span style="border: 1px solid black; padding: 2px;">33.96</span> mg/dl [HIGH]	10.0 to 30.0 (mg/dl)

LDL/HDL Ratio :	<span style="border: 1px solid black; padding: 2px;">1.6</span> - [NORMAL]	< 3.5
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TC / HDL Ratio :	<span style="border: 1px solid black; padding: 2px;">3.25</span> - [LOW]	4.0 to 6.0
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### LIVER FUNCTION TEST

Investigation	Result	Normal Value
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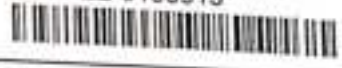


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Total Bilirubin :	0.69 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.22 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	20.7 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	11.6 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	93.2 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP) :	7.23 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
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A/G Ratio :	1.2	


### URINE R & M

Investigation	Result	Normal Value
<b>Physical Examination :</b>		
Quantity :	15 ml	
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Alkaline -	
Specific Gravity :	1.005 -	
<b>Chemical Examination :</b>		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	

Patient Name :	DHARA PRATIK SHAH	Sample No. :	SAMPLE-0106913 
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Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 11:17
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Acetone : Absent -  
Urobilinogen : Absent -  
Microscopic Examination :  
Pus Cells : 3-4 -  
RBCs : Absent -  
Epithelial cells : 6-8 -  
Casts : Absent -  
Crystals : Absent -

R. NAITIK BHATIA  
CONSULTANT PATHOLOGIST  
(M.B.B.S,D.C.P)

  
DR. KETAN KAPADIA  
CONSULTANT PATHOLOGIST  
(M.B.B.S,M.D)



# CHARUSAT HOSPITAL



Patient Name :	PRATI K DINESHCHANDRA SHAH	Sample No. :	SAMPLE-0106922
Patient ID :	CH-2024-0053592	Visit No. :	OPD/2024/02/00000520
Age/Sex :	37y/Male	Call. Date :	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 15:11
Ward :		Report Date :	10-Feb-2024 16:49

PP2BS


Investigation Post Prandial Blood Sugar (2Hrs) : **94.2** mg/dl [LOW]

Result Normal Value 100 - 140

DR. NATTIK BHATTIA  
CONSULTANT PATHOLOGIST  
(M.B.B.S,D.C.P)

DR. KETAN KAPADIA  
CONSULTANT PATHOLOGIST  
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Patient Name :	PRATIK DINESHCHANDRA SHAH	Sample No. :	SAMPLE-0106904 
Patient ID :	CH-2024-0053592	Visit No. :	OPD/2024/02/0000520
Age/Sex :	37y/Male	Call. Date :	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 09:56
Ward :		Report Date :	10-Feb-2024 15:37

## HBA1C

### Investigation

Mean Blood Glucose

Hb A 1c

### Result

102 mg/dl

5.2 %

### Normal Value

> 8 : Action Suggested  
7-8 : Good Control  
< 7 : Goal  
6-7 : Near Normal Glycemia  
< 6 : Non-diabetic Level

### Comments

Hb A1C also known as Glycosylated Haemoglobin is the most important test for the assessment of longterm Blood glucose control (also called glycemic control).  
Hb A1C reflects mean glucose concentration over past 60-90 week and provides a much better indication of longterm glycemic control than blood glucose determination.  
This Reaction is irreversible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications), nephropathy(Kidney-complications) & neuropathy(nerve complications) are potentially serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.

  
**DR. NAITIK BHATIA**  
CONSULTANT PATHOLOGIST  
(M.B.B.S.,D.C.P)

**DR. KETAN KAPADIA**  
CONSULTANT PATHOLOGIST  
(M.B.B.S.,M.D)

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
10-02-2024	PRATIK D SHAH	M	BODY PROFILE	UM-TOTAL ABDOMEN USG

### USG ABDOMEN report.

Liver: show evidence of normal size, parenchymel echotexture & no evidence of focal solid or cystic mass lesion seen. Normal hepatic vasculature seen with no evidence of intrahepatic biliary dilatation seen.

Gall bladder is physiologically distended with no evidence of calculus or sludge. Thickness of gall bladder wall is normal with no evidence of pericholecystic fluid collection.

CBD, portal vein & splenic vein size are normal.

Spleen size & parenchymel echotexture is normal with no focal mass lesion seen.

Pancreas show evidence of normal size & parenchymel echotexture with no evidence of focal mass lesion.

Aorta show normal caliber & no evidence of paraaortic mass lesion seen.

Right kidney show evidence of normal size, position, corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.

No evidence of focal solid or cystic mass lesion seen.

Left kidney show evidence of normal size, position, corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.

No evidence of focal solid or cystic mass lesion seen.

Bladder walls are normal & no evidence of stone or mass seen.

Prostate show evidence of normal size & parenchymel echotexture.

No evidence of ascitis or abnormal bowel loops seen.

### COMMENTS:

No abnormality detected.

  
Thanks for reference  
DR KIRTI C THAKKAR  
M.B.B.S, D.M.R.D

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
10-02-2024	PRATIK D SHAH	M	BODY PROFILE	X-RAY

### X-ray CHEST PA view.

No evidence of abnormality seen involving both lungs. Costophrenic sinuses are clear.

Hilar shadows show evidence of normal size, position & opacity.

Aortic shadow show evidence of normal position & size. Cardiac size & position is normal.

Domes of diaphragm & bony cage show no evidence of abnormality.

### COMMENTS:

NO ABNORMALITY DETECTED

Thanks for reference  
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# LALITABEN P. D. PATEL OPD SERVICES REGISTRATION FORM (OPD)



DR. Pavan

Date & Time : 20-2-2024

Registration No. : CH-2024-0053592

Name : Pavik. Dinesh Chandrai. Shah Contact No. : (M) \_\_\_\_\_

Age : 37 Sex : M (O) \_\_\_\_\_

Address : \_\_\_\_\_

B.P. : 110/80 mmHg Pulse : 82 bpm SpO<sub>2</sub> : 100%

BMI : \_\_\_\_\_ Height : 170 cm Weight : 59.6 kg

## OPD-INITIAL ASSESSMENT FORM

Chief Complaints : H/O cough cold 2 days

## CASE ANALYSIS

Past History : \_\_\_\_\_

Present History : \_\_\_\_\_

G/E Vitals : \_\_\_\_\_

Systemic Examination : \_\_\_\_\_

### FAMILY HISTORY :

- Diabetes
- IHD
- Hypertension
- Others (Specify) : \_\_\_\_\_

### PATIENT'S MEDICAL/OTHER HISTORY :

- Hypertension
- Epilepsy
- Food Allergy
- Drug Allergy
- IHD
- Asthma
- AIDS/HIV
- Pregnancy
- T.B.
- Hepatitis B
- Bleeding Disorder
- Jaundice
- Hepatitis C

### HABBITS :

- Smoking
- Alcohol
- Tobacco

Others (Specify) : \_\_\_\_\_

Investigation/s Advised : \_\_\_\_\_


Provisional Diagnosis : \_\_\_\_\_

Allergy : \_\_\_\_\_

Nutritional Advice : \_\_\_\_\_

TREATMENT ADVISED

DATE	DOCTOR'S NOTE	REMARK
	<p>Pain &amp; Swelling</p> <p>T. Diclofenac 75mg 1-0-1</p> <p>T. AZITHRO 500 0-1-0</p> <p>T. ASPIRIN 1-0-0</p>	<p>(3) 4</p>

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### Hemoglobin (HB)

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### WBC

Investigation	Result	Normal Value
R.B.C Count :	4.33 mill./c.mm [LOW]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	4780 /c.mm [NORMAL]	4000 - 10000

### Platelet count

Investigation	Result	Normal Value
Platelets	3.18 Lakh/cmm [NORMAL]	1.5 - 4.5

### WBC count - Differential


Investigation	Result	Normal Value
Polymorphs	62 % [NORMAL]	40 - 70
Lymphocytes	28 % [NORMAL]	20 - 40
Eosinophils	02 % [NORMAL]	1 - 6
Monocytes	08 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

### BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	31.4 mg/dl [NORMAL]	15 - 40

### S.Creatinine



Patient Name : PRATIK DINESHCHANDRA SHAH	Sample No. : SAMPLE-0106904 
Patient ID : CH-2024-0053592	Visit No. : OPD/2024/02/0000520
Age/Sex : 37y/Male	Call. Date : 10-Feb-2024 09:00
Referred By : RIPAL PATEL	S. Coll. Date : 10-Feb-2024 09:56
Ward : -	Report Date : 10-Feb-2024 11:53

Investigation	Result	Normal Value
Serum Creatinine	1.12 mg/dl [NORMAL]	Male : 0.9 to 1.5 mg/dl Female : 0.8 to 1.2 mg/dl

### BUN

Investigation	Result	Normal Value
BUN :	15 [NORMAL]	8.0 to 23.0 (mg/dl)

### URIC ACID

Investigation	Result	Normal Value
Serum Uric Acid	7.87 mg/dl [HIGH]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

### ESR

Investigation	Result	Normal Value
ESR - After One Hour	14 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

### Blood Group

Investigation	Result	Normal Value
ABO :	B	
Rh :	Positive	

### FASTING BLOOD GLUCOSE


Investigation	Result	Normal Value
Fasting Blood Sugar :	88.9 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

### TSH

Investigation	Result	Normal Value
TSH :	0.507 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

### T3

Investigation	Result	Normal Value

Patient Name : PRATIK DINESHCHANDRA SHAH	Sample No. : SAMPLE-0106904 
Patient ID : CH-2024-0053592	Visit No. : OPD/2024/02/0000520
Age/Sex : 37y/Male	Call. Date : 10-Feb-2024 09:00
Referred By : RIPAL PATEL	S. Coll. Date : 10-Feb-2024 09:56
Ward : -	Report Date : 10-Feb-2024 11:53

T3-Triiodothyronine : 1.26 ng/ml [NORMAL] 0.69 to 2.15 (ng/ml)

#### T4


Investigation	Result	Normal Value
T4-thyroxine :	87.2 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

#### LIPID PROFILE

Investigation	Result	Normal Value
Serum Cholesterol (Chol) :	192.6 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	88.2 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	36.3 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	117.78 mg/dl	
VLDL :	38.52 mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	3.24 - [NORMAL]	< 3.5
TC / HDL Ratio :	5.31 - [NORMAL]	4.0 to 6.0
LDL (DIRECT) :	102.3 mg/dl [Near Optimal]	< 100.0 (Optimal), 100.0 to 120.0 (Near Optimal), 130.0 to 159.0 (Border line high), 160.0 to-189.0 (High), > 190.0 (Very high)

#### LIVER FUNCTION TEST

Investigation	Result	Normal Value
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Patient Name : PRATIK DINESHCHANDRA SHAH	Sample No. : SAMPLE-0106904 
Patient ID : CH-2024-0053592	Visit No. : OPD/2024/02/0000520
Age/Sex : 37y/Male	Call. Date : 10-Feb-2024 09:00
Referred By : RIPAL PATEL	S. Coll. Date : 10-Feb-2024 09:56
Ward :	Report Date : 10-Feb-2024 11:53


Total Bilirubin :	0.58 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.18 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	24.3 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	12.1 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	120.3 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP) :	7.26 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	3.98 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.40 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.28 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.2	

### URINE R & M

Investigation	Result	Normal Value
<b>Physical Examination :</b>		
Quantity :	15 ml	
Colour :	Pale Yellow	
Appearance :	Clear	
Odour :	URINIOD	
Reaction :	Acidic	
Specific Gravity :	1.020	
<b>Chemical Examination :</b>		
Albumin :	Absent	
Sugar :	Absent	
Bile Salts :	Absent	
Bile Pigments :	Absent	







Patient Name :	PRATIK DINESHCHANDRA SHAH	Sample No. :	SAMPLE-0106904 
Patient ID :	CH-2024-0053592	Visit No. :	OPD/2024/02/0000520
Age/Sex :	37y/Male	Call. Date :	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 09:56
Ward :	-	Report Date :	10-Feb-2024 11:53

Acetone : Absent -  
Urobilinogen : Absent -  
Microscopic Examination :  
Pus Cells : 2-3 -  
RBCs : Absent -  
Epithelial cells : 1-2 -  
Casts : Absent -  
Crystals : Absent -

DR. NAITIK BHATIA  
CONSULTANT PATHOLOGIST  
(M.B.B.S,D.C.P)

  
DR. KETAN KAPADIA  
CONSULTANT PATHOLOGIST  
(M.B.B.S,M.D)



Patient Name :	PRATIK DINESHCHANDRA SHAH	Sample No. :	SAMPLE-0106916 
Patient ID :	CH-2024-0053592	Visit No. :	OPD/2024/02/0000520
Age/Sex :	37y/Male	Call. Date :	10-Feb-2024 11:54
Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 12:19
Ward :	-	Report Date :	10-Feb-2024 12:19


### HIV

Investigation	Result	Normal Value
HIV 1-2 :	Negative -	
HIV 1 & 2		
Comments	Test Result Align Can not be used to diagnose HIV 1 & 2 interaction. A Negative Test Result does not Preciuse the Possibility of exposure to or infection with HIV. This may usuallu happen during initial phase of about 3 months after exposure and in immunocompromised but infected person, kindly contact the lab if required. Test results may also vary according to the sensitivity and specificity of the kit. IN CASE OF POSITIVE RESULTS CONFORMATORY TESTS ARE ADVISED.	

### CALCIUM TOTAL

Investigation	Result	Normal Value
S.Calcium Total :	8.9 mg/dl [NORMAL]	8.4 to 10.4 (mg/dl)

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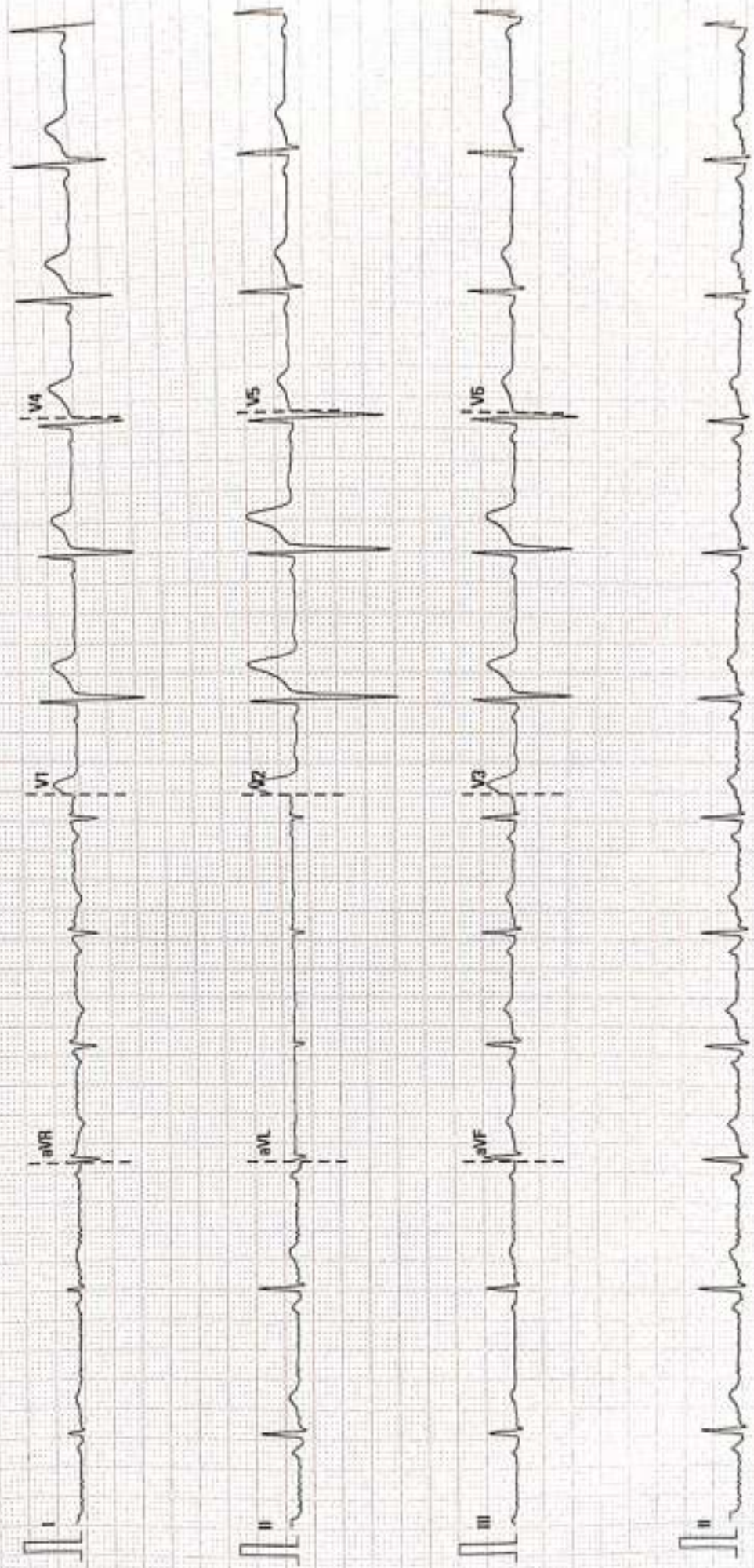
ID: ch-2024-0053592  
Name: pratik d. shah  
Age: 37 Years  
Gender: Male

10-02-2024 10:42:23 AM

Heart Rate: 71 bpm  
PR Interval: 134 ms  
QRS Duration: 76 ms  
QT/QTc Interval: 356/385 ms  
P/QRS/T Axes: 61/57/61 deg  
QTc: Hodges

Sinus arrhythmia

Unconfirmed Diagnosis



25 mm/s

10 mm/mV

50 Hz

DDR 20 Hz

CHARUSAT HOSPITAL

02.03.00.V23.4.1

SN.FH.52001657





# DENTAL REGISTRATION FORM



Date & Time : 20-2-2024

Registration No. : CH-2024-0053592

Name : Pichai R. Dinesh Chandran Srinivasan Contact No. : \_\_\_\_\_  
 Age : 37 Emergency Contact No. : \_\_\_\_\_  
 Sex : M Address : \_\_\_\_\_

## OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine checkup.

### Family History :

- Diabetes
- Hypertension
- IHD
- Others (Specify) :
- Habits :  Tobacco

- Hypertension
- Diabetes
- Epilepsy
- Bleeding Disorder
- Smoking

### Medical/Other History :

- IHD
- Asthma
- AIDS/HIV
- Pregnancy
- Other (Specify) :
- T.B.
- Hepatitis B
- Food Allergy
- Others (Specify) :
- Jaundice
- Hepatitis C
- Drug Allergy

## સંમતિ પત્રક

હું ..... ડૉક્ટરને મારી સારવાર કરવાની મંજૂરી આપું છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ડાયગ્નોસ્ટિક-ગેરડાયગ્નોસ્ટિક, દવાની કે ઇન્જેક્શનની આડ અસર અને સારવારની સફળતા, નિષ્ફળતા વિશે મને તથા મારા સંબંધીઓને સમજૂતી આપેલ છે. મેં ડૉક્ટરને મારી શારીરિક સ્થિતિ તથા તેને લગતી દવા વિશે સંપૂર્ણ માહિતી આપેલ છે. જો કોઈપણ સંજોગોમાં સારવાર અધૂરી છોડીશ કે અનિયમિત રહીશ તો તેની નિષ્ફળતા માટે ડૉક્ટર કે યાસ્સેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની કિંમતો પેટે અપાયેલ રકમ મેળવવા માટે હક્કદાર રહીશ નહીં. આ સંમતિ હું સ્વેચ્છાએ કોઈપણ દબાણ વગર આપું છું.

તારીખ : \_\_\_\_\_  
 સમય : \_\_\_\_\_

દર્દી / સગાની સહી

## CONSENT

I ..... hereby request and authorize Doctor ..... to perform the required dental treatment. Doctor has informed me and my relatives about the treatment plan in details with success and failure of the treatment with all expenditure, possible complications from medicines or local anesthesia. I have informed the Doctor about my medical history and drug history in details. If in any circumstances, I am irregular or leave the treatment in between, the doctor and CHARUSAT Hospital will not be responsible for the same and treatment charges will not be returned back.

I give my consent to proceed with my dental treatment.

Date : \_\_\_\_\_  
 Time : \_\_\_\_\_

Patient's / Relative's Sign.

Investigation Advised : \_\_\_\_\_

Final Diagnosis : \_\_\_\_\_

Treatment Plan : \_\_\_\_\_

Date : 10/2/24  
 Time : \_\_\_\_\_

Name of Doctor Dr. Narasimhan  
 Signature : \_\_\_\_\_



# OPHTHALMIC REGISTRATION FORM



Reg. No. : CH-2024-0053542

Date : 20-2-2024

Patient's Name : Poetik. Dinesh Chandra. Sheth Age : 37

Address : \_\_\_\_\_

Telephone No. : \_\_\_\_\_ Mobile No. : \_\_\_\_\_

Referred by / Care of : \_\_\_\_\_

Profession : \_\_\_\_\_

Type or work in daily routine : Driving / Watching TV / Computer / Reading / \_\_\_\_\_

History / Complain of : Diminution of Vision / Pain / Watering / Redness / Eyeache / Headache / Itching /

Routine eye checkup . Stickness / Swelling / Irritation / Burning / F. B. Sensation / Photophobia /

Diplopla / Squinting / Blackout / Floaters / Flashes / Injury /

Eye Involve : RE / LE / BE<sup>\*</sup> Duration : \_\_\_\_\_

Ophthalmic History : Surgery / Laser / FFA / Oct / Glaucoma / RP / Corneal Opacity / Injury / Amblyopia /

Treatment  
Any Surgery : Cataract / Glaucoma / \_\_\_\_\_ / RE / LE / BE

Family History : Glaucoma / RP / DM / NAD

SYSTEMIC : DM / HT / IHD / COPD / PROSTATE / WROID / ALLERGY / SMOKING / ALCOHOL

NAD.

EYE DETAILS : V/A with PH 6/6<sup>RE</sup> 6/6<sup>LE</sup>

IOP 12 mmHg 12 mmHg

OWN GLASS : -0.25 x 23° -0.25 / -0.25 x 136°

AR : \_\_\_\_\_

## GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
	SPH.	CYL.	AXIS	SPH.	CYL.	AXIS
Dis	<u> plano </u>		<u> 6/6 </u>	<u> plano </u>		<u> 6/6 </u>
Nr. hdt.			<u> N6 </u>			<u> N6 </u>
Comp						

Bifocal / Distant / Near only / Constant / Progressive / Photocromatic

Remark : \_\_\_\_\_  
Signature : PK