

NAME:	Mrs. Shivali Sharma	UHID:	FVAH5788
AGE:	32 YRS	DATE OF HEALTHCHECK:	25/12/2023
GENDER:	Female		

HEIGHT:	167 cm	MARITAL STATUS:	M
WEIGHT:	75.8 kg	NO OF CHILDREN:	1
BMI:	26.5		

C/O: - NO

K/C/O: PRESENT MEDICATION: - NO

P/M/H: - NO

P/S/H: COB

ALLERGY: - NO

PHYSICAL ACTIVITY: Active / Moderate / Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER: -) MAD

ALCOHOL:) MAD

MOTHER: -)

TOBACCO/PAN:)

O/E:

LYMPHADENOPATHY:

BP: 110/70 PULSE: - 84/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING:) MAD

TEMPERATURE: M SCARS:

OEDEMA:

S/E:

P/A:) MAD

RS:



CVS: - 1/2

Extremities & Spine: - MAD

ENT:

CNS: Coma, oriented

Skin: - MAD

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

• ANDHERI • COLABA • NASHIK • VASHI

OPHTHALMIC EVALUATION

UHID No.: FVATH5188

Date: 25/2/23

Name: Mrs Shiveni Sharma Age: 32 Gender: Female ✓

Without Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye N6 Left Eye N6

With Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near										

Colour Vision : Normal (BL)

Anterior Segment Examination : _____

Pupils : _____

Fundus : NOD (BL)

Intraocular Pressure : 16 mm (BL)

Diagnosis : _____

Advice : _____

Re-Check on 6 mths (This Prescription needs verification every year)

DR. RUCHIRA SHARMA
M. S. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON
REG. No.: 3262 / 09 / 02

Dr. _____
(Consultant Ophthalmologist)

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: <u>Shivani Sharma</u>	MR NO:
Age/Gender: <u>32/F</u>	Date: <u>25/2</u>

Medical history: Diabetes Hypertension _____

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains				
Mobility				
Caries (Cavities)				
a) Class 1 (Occlusal)				
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

NA

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: Scaling & polishing
 Orthodontic Advice for Braces: Yes / No
 Prosthetic Advice to Replace Missing Teeth: Denture Bridge Implant
 Oral Habits: Tobacco Cigarette Others since ___ years
 Advice to quit any form of tobacco as it can cause cancer.
 Other Findings: NA

DR. SNEHA NITIN GADHIYA
 BDS (BACHELOR OF DENTAL SURGERY)
 REG NO: 39708



• ANDHERI • COLABA • NASHIK • VASHI

Name: Mrs. Shrawan S. Age: 32 Sex: F UHID No.: Date: 21/2/2023

32yrs, P1U
+ spapmen

u/n + mp - growths base altered

a/n + P1U / FTLS

Rst - nil

ac - tar
atechle

u/n
P1U

HA - S4
SECRET

M/S - paperna taken

Dr. _____



Apollo Clinic VASHI

- Consultation
- Diagnostics
- Health Check-Ups
- Dentistry

Name : Mrs. Shivani Sharma Gender : Female Age : 32 Years
UHID : FVAH 5188 . Bill No : Lab No : V-2047-23
Ref. by : SELF Sample Col.Dt : 25/02/2023 09:20
Barcode No : 6743 Reported On : 25/02/2023 18:31

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

ESR(Westergren Method)

Erythrocyte Sedimentation Rate:- 27 mm/1st hr 0 - 20

Vasanti Gondal
Entered By

Ms Kaveri Gaonkar
Verified By



Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST

RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group:

:A:

Rh Type:


Positive

Method :

Tube Agglutination (forward and reverse)

Mrunal Gurav
Entered By

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	87	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	90	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

Alsaba Shaikh
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Lipid Profile- Serum			
S. Cholesterol(Oxidase)	161	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	45	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	9	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	55.9	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable: <40
S. LDL:(calculated)	96.1	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	<u>2.9</u>		3.5 - 5
Ratio of LDL/HDL	<u>1.7</u>		2.5 - 3.5

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Page 8 of 8
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

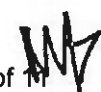
LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.22	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.20	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.02	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.39		0.9 - 2
S.Total Bilirubin (DPD):	0.47	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.18	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.29	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	25	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	28	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	136	U/L	35 - 105
S.GGT(IFCC Kinetic):	9	U/L	07 - 32

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	25.5 mg/dl	10.0 - 45.0
BUN (Calculated)	11.9 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.72 mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	16.53	9:1 - 23:1
S.Uric Acid(Uricase Method)	4.3 mg/dl	2.4 - 5.7

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.58	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	87.37	nmol/L	66 - 181 nmol/L
TSH (Thyroid-stimulating hormone) (ECLIA)	2.41	□IU/mL	Euthyroid : 0.35 - 5.50 □IU/mL Hyperthyroid : < 0.35 □IU/mL Hypothyroid : > 5.50 □IU/mL

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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M.D(Path)

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	40	mL	
COLOUR	Yellow		
APPEARANCE	Slightly Hazy		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	5.0		4.6 - 8.0
SPECIFIC GRAVITY	1.030		1.005 - 1.030
URINE ALBUMIN	Absent		Absent
URINE SUGAR(Qualitative)	Absent		Absent
KETONES	Absent		Absent
BILE SALTS	Absent		Absent
BILE PIGMENTS	Absent		Absent
UROBILINOGEN	Normal(<1 mg/dl)		Normal
OCCULT BLOOD	Absent		Absent
Nitrites	Absent		Absent

MICROSCOPIC EXAMINATION

PUS CELLS	<u>2 - 4 / hpf</u>		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	<u>4 - 6 / hpf</u>		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

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CYTOPATHOLOGY REPORT

Specimen No: AP-325-23

Specimen Adequacy: ADEQUATE

CELLS

ENDOCERVICAL: Absent

ENDOMETRIAL: Absent

SQUAMOUS: **SUPERFICIAL(++) AND INTERMEDIATE(++) SQUAMOUS CELLS**

HISTIOCYTES: Absent

RBCs: Absent

POLYMORPHS: **Present(+++)**

LYMPHOCYTES: Absent

FLORA

TRICHOMONAS VAGINALIS: Absent

MONILIA: Absent

BACTERIA: Absent

DODERLEIN BACILLI: Absent

LEPTOTHRIX: Absent

CELLULAR CHANGES

METAPLASIA: Absent

DYSPLASIA: Absent

MALIGNANT CELL: Absent


ATROPHIC CHANGES: Absent

COMMENTS: **INFLAMMATORY SMEAR**

IMPRESSION: **NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY**

Anushka Chavan
Entered By

Ms Kaveri Gaonkar
Verified By



Dr. Milind Patwardhan
Page 1 of 1 M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

Shivani, Sharma
5188

32 Years

Female

25.02.2023 10:00:37
Apollo Clinic
1st Flr, The Emerald, Sector-12,
Vashi, Mumbai-400703

NORMAL ECG

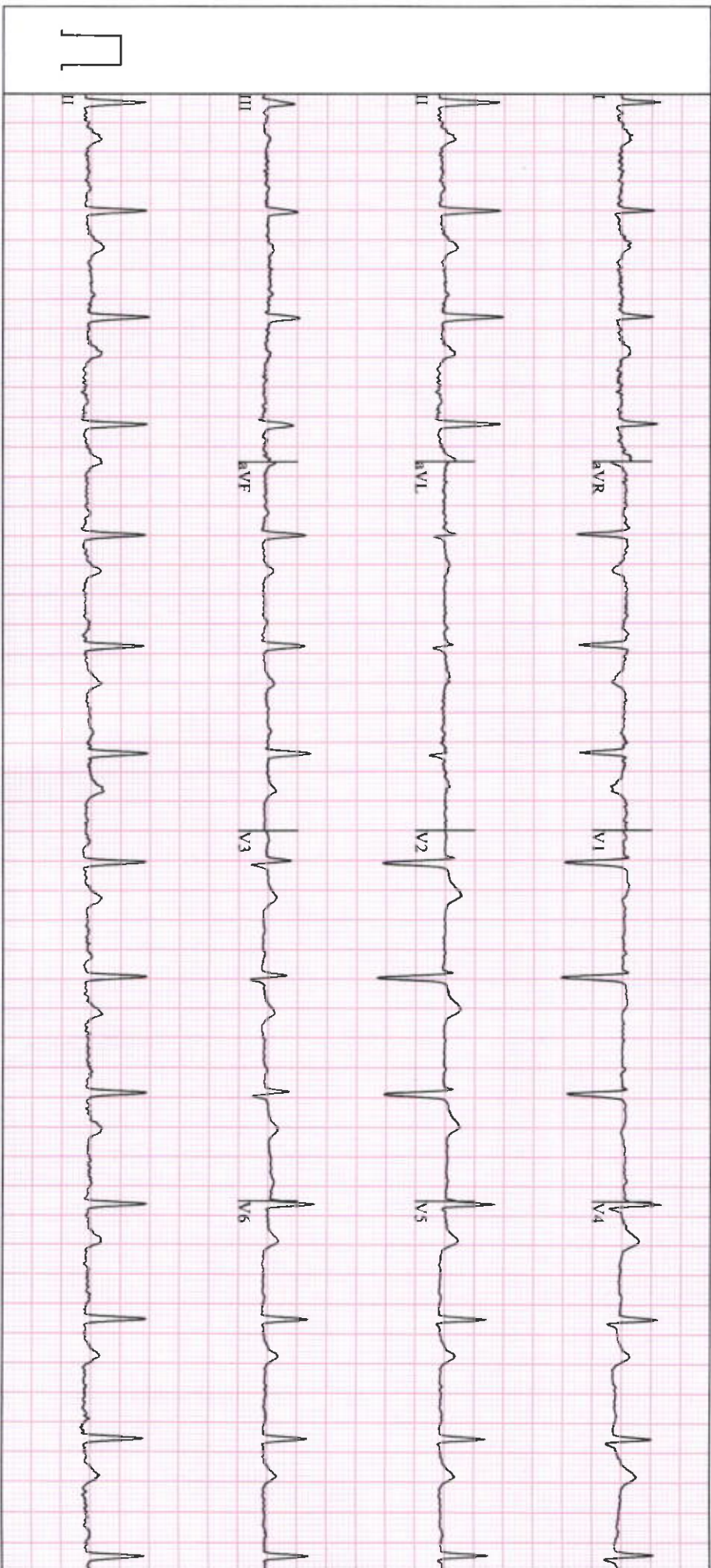
79 bpm
--/-- mmHg

Dr. Rishi A. Bhargava

DR. RISHI A. BHARGAVA
MD, DM (Cardiology)
CONSULTANT CARDIOLOGIST
Reg. No.: 2019/02/0494

QRS : 76 ms
QT / QTcBaz : 366 / 419 ms
PR : 140 ms
P : 48 ms
RR / PP : 756 / 759 ms
P / QRS / T : 99 / 54 / 37 degrees

Normal sinus rhythm
Normal ECG



GE MAC2000

1.1

12SL™ v241

25 mm/s

10 mm/mV

ADS

0.56-20 Hz

50 Hz

Unconfirmed
4x2.5x3_25_R1

1/1

Apollo Clinic
The Emerald, Plot No-195/B, Sector-12,
Neel Siddhi Towers, Vashi-400703

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: SHIVANI, SHARMA
Patient ID: 5 88
Height:
Weight:

DOB: 20.07.1990
Age: 32yrs
Gender: Female
Race: Asian

Study Date: 25.02.2023
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR. RISHI BHARGAVA
Technician: Anu Salve

Medications:
--

Medical History:
--

Reason for Exercise Test:
Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:05	0.00	0.00	82	120/80	
	STANDING	00:16	0.00	0.00	82	120/80	
	HYPERV.	00:17	0.00	0.00	86	120/80	
	WARM-UP	00:14	0.60	0.00	91	120/80	
EXERCISE	STAGE 1	01:55	1.70	10.00	141	140/80	
	STAGE 2	02:20	2.50	12.00	166	160/80	
RECOVERY		01:19	0.00	0.00	91	130/80	

The patient exercised according to the BRUCE for 4:13 min:s, achieving a work level of Max. METS: 7.00. The resting heart rate of 83 bpm rose to a maximal heart rate of 166 bpm. This value represents 88 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 160/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions

TMT IS NEGATIVE FOR INDUCIBLE MYOCARDIAL ISCHAEMIA AT THE WORKLOAD ACHIEVED.

Physician-DR. RISHI BHARGAVA

Dr. RISHI A. BHARGAVA
MD, DM (Cardiology)
CONSULTANT CARDIOLOGIST
Reg. No.: 2019/02/0494

PATIENT'S NAME	SHIVANI SHARMA	AGE :- 32Y/F
UHID	5188	25 Feb 2023

X-RAY CHEST PA VIEW

OBSERVATION:

Bilateral lung fields are clear.
Both hila are normal.
Bilateral cardiophrenic and costophrenic angles are normal.
The trachea is central.
Aorta appears normal.
The mediastinal and cardiac silhouette are normal.
Soft tissues of the chest wall are normal.
Bony thorax is normal.

IMPRESSION:

- No significant abnormality seen.



DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

PATIENT'S NAME	SHIVANI SHARMA	AGE :- 32Y/F
UHID	5188	25 Feb 2023

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, shape and shows bright echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of **PANCREAS** appear normal.

SPLEEN is normal in size, and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen. **RIGHT KIDNEY** measures 11.0 x 4.0 cm. **LEFT KIDNEY** measures 11.2 x 4.6 cm.

URINARY BLADDER is well distended; no e/o wall thickening or mass or calculi seen.

UTERUS is anteverted and is normal in size, shape and echotexture; No focal lesion seen. It measures 7.0 x 4.9 x 3.5 cm; ET measures 8.4 mm.

Both ovaries are normal in size, shape and position.

Visualised **BOWEL LOOPS** appear normal. There is no free fluid seen.

IMPRESSION –

- **Grade I fatty liver.**
- **No other significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



DR.CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg: No. 073826

• ANDHERI • COLABA • NASHIK • VASHI

Name: Mrs. Shivani Sharma

Age: 324

Date of Health check-up: 25/2/23


Findings and Recommendation:

Findings:-

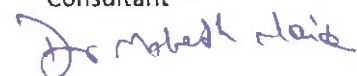
- HB - 11.2
- WBC - 3330
- EIT - 11.5.
- Hemoglobin - 136.
- Pap smear Inflammatory smear
- U/G. Add. Co. 2 fatty liver

Recommendation:-

- weight loss, Regular exercise
- low fat, fibre diet
- plenty of water.
- Iron rich food in diet
- Repeat - CBC in 8 days

Signature: 

Consultant -



DR MAHESH NAIK
PHYSICIAN