Apollo TOUCHING LIVES

MEDICAL SUMMARY

Apollo Clinic VASHI

NAME:	Mrs. Anjali Jha	UHID:	
AGE:	30	DATE OF HEALTHCHECK:	13-1-2024
GENDER:	F		

HEIGHT:	152	MARITAL STATUS:	M
WEIGHT:	45.5	NO OF CHILDREN:	2
BMI:	19.7		

C/O: —

K/C/O: —

PRESENT MEDICATION: — No

P/M/H: — No

P/S/H: LSCS

ALLERGY: — No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING: No

ALCOHOL: No

TOBACCO/PAN: No

FAMILY HISTORY FATHER: —

MOTHER: — Thyroid disorder

O/E:

BP: — 110/80 PULSE: — 80/min

TEMPERATURE: N SCARS:

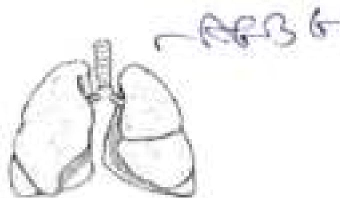
LYMPHADENOPATHY: — NAD

PALLOR/ICTERUS/CYNOSIS/CLUBBING: — NAD

OEDEMA:

S/E:

RS: — AEBE



P/A: — NAD

CVS: S1 S2 N

Extremities & Spine: — NAD

ENT: — NAD

CNS: Conscious, oriented

Skin: — NAD

Vision:

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

• ANDHERI • COLABA • NASHIK • VASHI

Vashi : M/S. Indira Health & Lifestyle Pvt. Ltd. The Emerald, 1st Floor, Plot No. 195, Sector - 12, Besides Neel Siddhi Tower, Vashi - Navi Mumbai - 400703.
Tel.: (022) - 2788 1322 / 23 / 24 8291490000 • Email: apolloclinicvashi@gmail.com

Name:	Age:	Date of Health check-up:

Findings and Recommendation:

Findings:-

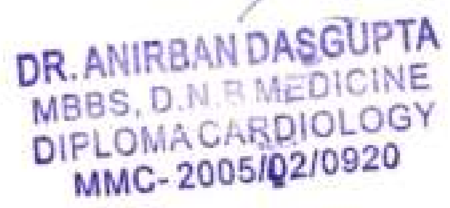
- ECRT, HbA
- Chest X-ray:
- Calcified lesion in lung

Recommendation:-

- HRCT chest
- T. Novastat 10 mg
  0 — 1 × 1 week

Signature:

Consultant –



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OPHTHALMIC EVALUATION

UHID No.:

Date: 13/1/24

Name : Miss Anjali Age : 31. Gender : Male/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 : N (BE)

Anterior Segment Examination : N (BE)

Pupils :

Fundus :

Intraocular Pressure : N

Diagnosis :

Advice :

Re-Check on 1 yr (This Prescription needs verification every year)

Dr.
(Consultant Ophthalmologist)

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

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TOUCHING LIVES

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DENTAL CHECKUP

Name: Anjali Jha	MR NO:
Age/Gender : 30/F	Date: 13/1/24.

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				

TREATMENT ADVICED:

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: ____________

Treatment Adv:-
- Scaling and polishing - 1200.

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Name : Mrs Anjali Jha Age : 30 Sex : F UHID No. : Date : 13/01/2024

30 years | married | P_{2L_2} (Both LSCS) not sterilised

No complaints, willing for PAP smear

MH
LMP - 29/01/2024

O/E

Afebrile
P - 88/min

Rev c̄ reports

PA - Soft

P/S Cx } healthy
Vg }
(PAP smear taken)

Dr. Trupti Shinde

DR. TRUPTI VIJAY SHINDE
MBBS, M.S. (OBS & GYNAE)
REG. NO.: 2014/07/3301

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■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

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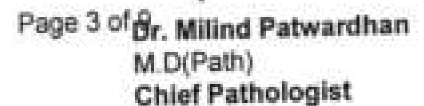
Apollo Clinic VASHI

Name	: Mrs. Anjali Deepak Jha	Gender	: Female Age : 30 Years
UHID	: FVAH 10239.	Bill No	: Lab No : V-1702-23
Ref. by	: SELF	Sample Col.Dt	: 13/01/2024 09:25
Barcode No	: 3972	Reported On	: 13/01/2024 21:00

HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
Haemoglobin(Colorimetric method)	**11.3**	g/dl	11.5 - 15
RBC Count (Impedance)	**3.62**	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	**34.6**	%	35 - 55
MCV:(Calculated)	95.6	fl	78 - 98
MCH:(Calculated)	31.2	pg	26 - 34
MCHC:(Calculated)	32.6	gm/dl	30 - 36
RDW-CV:	13.2	%	10 - 16
Total Leucocyte count(Impedance)	6860	/cumm.	4000 - 10500
Neutrophils:	58	%	40 - 75
Lymphocytes:	37	%	20 - 40
Eosinophils:	02	%	0 - 6
Monocytes:	03	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.29	Lakhs/c.mm	1.5 - 4.5
MPV	**11.3**	fl	6.0 - 11.0
ESR(Westergren Method)	**54**	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination) RBCs:	Normochromic,Normocytic		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		



Pooja Surve
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:	**:O:**
Rh Type:	**Positive**
Method :	Matrix gel card method (forward and reverse)
------	---------------------------

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

Test	Result	Unit	Reference
(HbA1C) Glycosylated Haemoglobin :	4.5	%	Normal <5.7 % Pre Diabetic 5.7 - 6.5 % Diabetic >6.5 % Target for Diabetes on therapy < 7.0 % Re-evalution of therapy > 8.0 %
Mean Blood Glucose :	82.45	mg/dL	

Corelation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Method High Performance Liquid Chromatography (HPLC).

INTERPRETATION

- The HbA1c levels corelate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
- This Methodology is better then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints and uremia does not INTERFERE with the results in this methodology.
- It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts.& every 3 - 4 months in well controlled daibetics .
- Mean blood glucose (MBG) in first 30 days (0-30)before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

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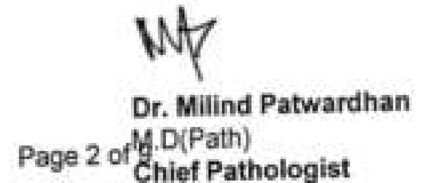
TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	91	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : >= 126 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)
Post Prandial Plasma Glucose :	84	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : >= 200 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)

Method : Hexokinase



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Barcode No	: 3972	Reported On	: 13/01/2024 21:00		

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LIPID PROFILE - Serum			
S. Cholesterol(Oxidase)	205	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	116	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	23.2	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	58.2	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	123.6	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	3.5		3.5 - 5
Ratio of LDL/HDL	**2.1**		2.5 - 3.5

Alsaba Shaikh
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LFT(Liver Function Tests)-Serum

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
S.Total Protein (Biuret method)	7.94	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.87	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.07	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.59		0.9 - 2
S.Total Bilirubin (DPD):	0.24	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	**0.08**	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.16	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	16	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	10	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	90	U/L	35 - 105
S.GGT(IFCC Kinetic):	11	U/L	07 - 32

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	13.3	mg/dl	10.0 - 45.0
BUN (Calculated)	6.2	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	**0.45**	mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	13.78		9:1 - 23:1
S.Uric Acid(Uricase Method)	4.8	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)	1.84	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	104.5	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	2.86	□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 hypothyrodism.
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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URINE REPORT

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
PHYSICAL EXAMINATION			
QUANTITY	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Slightly Hazy		Clear
SEDIMENT	Absent		Absent
CHEMICAL EXAMINATION(Strip Method)			
REACTION(PH)	6.5		4.6 - 8.0
SPECIFIC GRAVITY	1.010		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	1 - 2/hpf		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	2 - 3 /hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

Ms Kaveri Gaonkar
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End of Report
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Anjali, Jha
10239

Female

30 Years

13.01.2024 12:40:11
Apollo Clinic
1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703

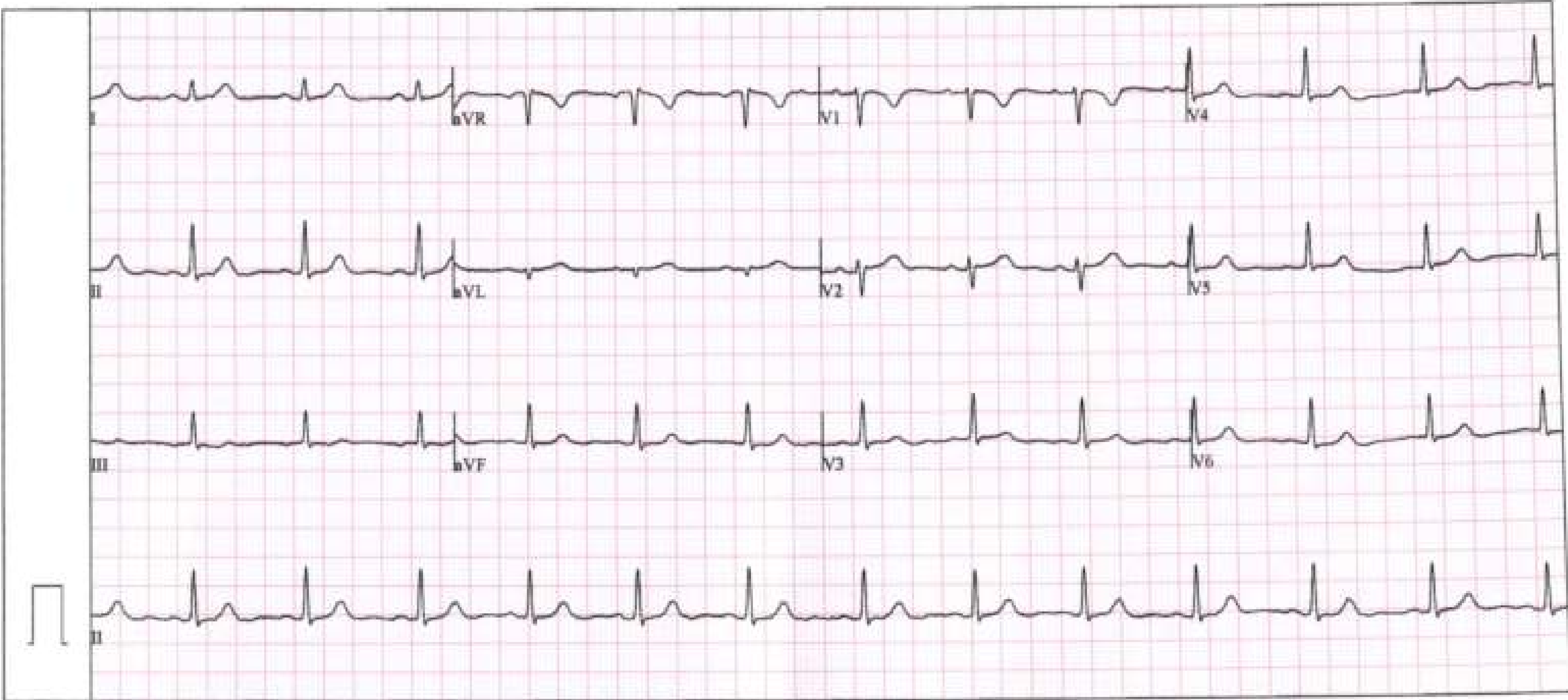
79 bpm
-- / -- mmHg

NORMAL ECG

QRS :	66 ms
QT / QTcBaz :	350 / 401 ms
PR :	144 ms
P :	82 ms
RR / PP :	762 / 759 ms
P / QRS / T :	13 / 74 / 28 degrees

Normal sinus rhythm
Normal ECG

Dr. ANIRBAN DASGUPTA
M.B.,B.S., D.N.B. Medicine
Diploma Cardiology
MMC -2005/02/0920



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

PATIENT'S NAME	ANJALI DEEPAK JHA	AGE :- 30Y/F
UHID	10239	DATE :- 13-01-24

2D Echo and Colour Doppler Report

All cardiac chambers are normal in dimension

No obvious resting regional wall motion abnormalities (RWMA)

Interatrial and Interventricular septum – Appears Normal

Valves – Structurally normal

Trivial MR, TR

Good biventricular function.

IVC is normal.

Pericardium is normal.

Great vessels - Origin and visualized proximal part are normal.

No coarctation of aorta.

Doppler study

Normal flow across all the valves.

No pulmonary hypertension.

No diastolic dysfunction.

Measurements

Aorta annulus	17 mm
Left Atrium	28 mm
LVID(Systole)	19 mm
LVID(Diastole)	33 mm
IVS(Diastole)	08 mm
PW(Diastole)	10 mm
LV ejection fraction.	55-60%

Conclusion

- Good biventricular function
- No RWMA
- Valves – Structurally normal
- No diastolic dysfunction
- No PAH

Performed by: Dr. Anirban Dasgupta
D.N.B. Internal Medicine, Diploma Cardiology (PGDCC-IGNOU).

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PATIENT'S NAME	ANJALI D JHA	AGE :- 30Y/F
UHID	10239	DATE :-.15 Jan. 24

X-RAY CHEST PA VEIW

OBSERVATION:

Right upper lung shows few calcified lesion.
Remaining 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:

- **Right upper lung shows few calcified lesion.**
- **No other significant abnormality seen.**

DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

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PATIENT'S NAME	ANJALI D JHA	AGE :- 30Y/F
UHID	10239	13 Jan 2024

USG ABDOMEN AND PELVIS (TAS)

Liver is normal in size, shape and echotexture. There is no focal lesion seen. The portal vein and common bile duct are normal in course and caliber. There is no evidence of intra-hepatic biliary duct dilatation seen. PV = 10.8 mm. CBD = 2.2 mm.

Gall Bladder is physiologically distended. No calculus, abnormal wall thickening or pericholecystic fluid collection is seen.

The visualized **Pancreas** is normal in size, shape and echotexture. There is no focal lesion seen.

Spleen is normal in size, shape and echotexture. There is no focal lesion seen.

Right Kidney measures 8.3 x 3.1 cm. **Left Kidney** measures 9.9 x 3.7 cm.
Both kidneys are normal in size, shape and echotexture. No evidence of any focal lesion is noted. No hydronephrosis, hydroureter or calculus is noted in both kidney. Cortico medullary differentiation is well maintained.

Urinary Bladder is well distended. There is no evidence of focal lesion. No evidence of any calculus is seen.

Uterus is normal in size and echotexture. No evidence of any focal lesion. It measures about 7.1 x 4.2 x 2.7 cm in size. The endometrium measures 10.4 mm. Both ovaries are unremarkable.

There is no free fluid or abdominal lymphadenopathy.

IMPRESSION: NO SIGNIFICANT ABNORMALITY IS DETECTED AT PRESENT STUDY.

Clinico-haematological correlation and imaging follow-up is recommended.

Thanking you for the referral,
With regards,

DR. SIDDHI APTIL
Con. Radiologist

Vashi : **M/S. Indira Health & Lifestyle Pvt. Ltd.** The Emerald, 1st Floor, Plot No. 195, Sector - 12, Besides Neel Siddhi Tower, Vashi - Navi Mumbai - 400703.
Tel.: (022) - 2788 1322 / 23 / 24 8291490000 • Email: apolloclinicvashi@gmail.com