



भारत सरकार
राष्ट्रीय पहचान कार्ड



पिंकी कुमारी
Pinki Kumari
जन्म तिथि/DOB: 09/11/1983
लिंग/SEX: FEMALE
Mobile No: 7361846060
4572 3773 5830
VID: 9154 3361 0630 5449

मेरा आधार, मेरी पहचान



राष्ट्रीय पहचान पहचान प्राधिकरण
NATIONAL IDENTIFICATION AUTHORITY OF INDIA

पता:
C/O सती कुमारी, - - गवर्नर कॉलोनी, रोड नं. 9, बंग
रौ, अलीकहाद, पटना,
बिहार - 800002
Address:
C/O Sati Kumar, - - Mahaveer Colony,
Road No. 9, Baur Road, Alishahad,
Patna,
Bihar - 800002





STAR HOSPITAL

(A unit of Magadh Nursing Home)

An ISO 9001:2015 Certified Hospital



Between East of Alok Petrol Pump & West of Mahindra Show Room in Bypass Fourlane, Fatuha Road, Bari Pahari, Patna
Ph.: 9431046838, 9334269730, 7488893768

NABH PREACCREDITED

Pinki Kumari
41y 12

Att- 6570g Gb Ccm for Annual Health Check up
HT- 160cm
PmE- 25-4
Pb- $\frac{140}{80}$ mmHg
Pulse- 78/min
SpO2- 98%

Lungs
C/o
P/L

P/L

Liver
Spleen

Heart
L/A/S

Wrist Per \angle R 6/6 Neck \angle N-6
 \angle 6/6 \angle N-6
Calcium - Normal

Chest x-ray findings: within Normal limit

EKG - Normal

Clg of WtA - mild osteoarthritis others N/A/S

Blood investigation: within Normal limit

ENT Examination: Tympanic membrane healthy, nasal cavity healthy, oral nasopharynx healthy.

Dent Consultation: No specific advice. Amc within Normal limit



Sw L



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NABH PREACCREDITED

Pinkii Kumari
41178 F

27/1/24

etc came for annual health check up

HT - 160 cm

WT - 65 kg

BMI - 25.4

Pulse - 75/min

BP - 140/80 mmHg

SpO₂ - 98%

Char / NAD
CVS / NAD

Pellor / Nil
Lymphaden / Nil
Spleen / Nil

MH - pr. cycle 2-3 days
25±2

2m - LSC - 3 in hospital death
OH 2+0 24/4/2018 of 46 yrs old.

PIA - Abdomen soft
Liver / NAD
Spleen / NAD

RES - vesica / normal
vagina / normal

PLS - Ca smooth & healthy



Pinkii Kumari
27/1/24



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DR. ASHISH RANJAN SINGH

BDS (Hon) MU

Consultant Oral & Dental Surgeon

Ph.: 9470585838, 9852542738

DR. VINAY KUMAR

BDS, MIDA

Consultant Oral Dental Surgeon

Not for Medico Legal Purpose

Name: Pinki Kumari

Date: 27/01/24

Add: Patna

Age/Sex: 42y/F

Qc:- Pt comes for dental checkup

Q/E:-

- Dental Caries wt $\frac{7}{87} \mid \frac{57}{78}$
- Missing tooth wt $\frac{\quad}{6} \mid \frac{\quad}{6}$
- Stain +
- Calculus ++

Adv:-

OPG (Pan) to be done



Ashish
27/01/24



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Collection Date/Time : 27/01/2024/ 10:35:35 AM
Bill No : 232411496
Patient's Name : MRS. PINKI KUMARI
Referred By : Dr. Self

Reporting Date/Time 27/01/2024/ 4:36:38 PM
Uhid/Lab ID : 23241358 /
Age / Sex : 41 Years/Female
Bed No : //

HAEMATOLOGY EXAMINATION

Investigation Name	Result	Reference Range
HGB	10.90 gm/dl	12 — 15
R.B.C	3.60 million/Cu mm	3.5 — 5.5
H.C.T.	34.70 %	36 — 50
M.C.V	64.0 fl	73 — 91
M.C.H	20.0 pg	27 — 32
M.C.H.C	31.30 g/dL	31.5 — 34.5
PLATELET COUNT	0.91 Lakh's/Cu. mm	1.50 — 4.50
W.B.C	7500 /cu mm	4000 — 11000
DIFFERENTIAL COUNT		
NEUTROPHILS	68 %	40 — 70
LYMPHOCYTES	26 %	20 — 40
EOSINOPHILS	04 %	01 — 06
MONOCYTES	02 %	02 — 10
BASOPHILS	00 %	00 — 02



LABORATORY TECHNICIAN

Dr. T.K. Chakraverti
M.B.B.S. M.D.
(Microbiology)
Reg No.-35997/08

PATHOLOGIST



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Age / Sex: 41 Years/Female
Bed No: //

HAEMATOLOGY EXAMINATION

Investigation Name	Result	Reference Range
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* PERIPHERAL BLOOD PICTURE, WHOLE BLOOD
Microscopy

RBCs are predominantly normocytic normochromic. No nucleated cell is noted.

Anisocytosis + Poikilocytosis +

Reticulocyte count is normal, indicating normal bone marrow response.

WBC: Normal in count and morphology. No immature cell is noted.

IMPRESSION: Normal Study.

-\$ End of Report \$:-



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PATHOLOGIST
DR. T. K. CHAKRAVERTI
MBBS, MD(MICRO)



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CLINICAL PATHOLOGY EXAMINATION

REPORT ON THE EXAMINATION OF URINE

PHYSICAL EXAMINATION

Volume	30 ml
Colour	Straw
Appearance	Clear
Sediments	Nil

CHEMICAL EXAMINATION

Specific Gravity	1.015
PH	6.0
SUGAR	Nil
ALBUMIN	Nil

MICROSCOPIC EXAMINATION

Erythrocytes / RBC	2-4 /hpf
Pus Cells	1-2 /hpf
Epithelial Cells	0-2 /hpf
Casts	Nil
Crystals	Nil
YEAST CELLS	Absent
MICRO-ORGANISM	Absent
Others	Nil

-\$ End of Report \$:-



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IMMUNOLOGY EXAMINATION

Investigation Name	Result	Reference Range
THYROID PROFILE		
T3	0.75 ng/ml	0.52 - 1.90 ng/ml
T4	8.01 µg/dL	M- 4.4 - 10.8 µg/dL F - 4.8 - 11.6 µg/dL
TSH	2.91 µIU/ml	0.30 - 6.02 µIU/ml

Method :- Enhanced Pulse Chemiluminescence Assay by Lumax
Quality Control :- by appropriate lyphochek Immunoassay Plus Control (BIO-RAD, U.S.A).

The guidelines for pregnancy related reference ranges for T3, T4 & TSH :-

Levels in Pregnancy	Total T3 (ng/ml)	Total T4 (µg/dL)	TSH (µIU/ml)
1 st Trimester	0.52 - 1.90	6.6 - 12.4	0.1 - 2.5
2 nd Trimester	0.52 - 1.90	6.6 - 15.5	0.2 - 3.0
3 rd Trimester	0.52 - 1.90	6.6 - 15.5	0.3 - 3.0

The guidelines for age related reference ranges of T3, T4 & TSH :-

AGE	TOTAL T3 (ng/ml)	TOTAL T4 (µg/dL)	TSH (µIU/ml)
Premature Infants			0.8 - 5.2
CORD BLOOD	0.4 - 1.3	6.0 - 13.1	1.0 - 17.4
1 - 2 days	0.8 - 2.6	10.7 - 25.8	1.0 - 17.4
3 - 30 days	0.7 - 2.0	7.8 - 19.7	1.7 - 9.1
1 - 12 Months	1.0 - 2.3	5.4 - 13.8	0.8 - 9.1
1 - 7 years	1.2 - 2.0	5.3 - 12.3	0.8 - 8.2
7 - 13 years	1.1 - 2.0	6.0 - 11.1	0.7 - 7.0
13 - 18 years	1.0 - 1.8	4.9 - 10.7	0.7 - 5.7



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Bed No : //

HAEMATOLOGY EXAMINATION

Investigation Name	Result	Reference Range
GLYCOCYLATED HAEMOGLOBIN (HbA1c)	3.80 %	Normal < 8.0 % Good Control : 8.0 - 9.0 % Fair Control : 9.0 - 10.0 % Poor Control : > 10.0 %

INTERPRETATION :

HbA1c is an indicator of glycaemic control. HbA1c has been thought to represent average glycaemia over the past 6-8 wks. A pt. in stable control will have 50 % of their HbA1c formed in the month before sampling, 25 % is in the month before that & the remaining 25 % in the month 2-4 months before.

LEVEL OF HbA1c : < 5.3 % :- may represent an acute & chronic possibility for severe hypoglycaemia events < 5.4-5.7 % :- Represents a very good level of diabetic control (caution should be used to avoid hypoglycaemia). 5.8-7.2 % :- Represents a good level of diabetes control (continue to monitor frequently and strive for a reduction of HbA1c level to between 5.8 - 7.0 %). 8.0 % :- Represents a fair level of diabetes control (Suggest physician//patient / evaluation to determine where improvement can be made. >8.0 % :- Represents a sub-optimal level of diabetic control. (This level represents a significant increase in the risk for developing possible chronic complications). Effective intervention is strongly suggested, along with specific diagnostic tests.



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Bed No : //

BIO-CHEMISTRY EXAMINATION

Investigation Name	Result	Reference Range
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LIVER FUNCTION TEST

SERUM BILIRUBIN

TOTAL 0.57 mg/dl 0.3 — 1.0

DIRECT 0.18 mg/dl 0.1 — 0.3

INDIRECT 0.39 mg/dl 0.2 — 0.7

SGPT 22.0 lu/LT 05 — 40

SGOT 29.0 U/Lt 05 — 40

SERUM ALKALINE PHOSPHATASE 129.0 U/Lt Adult :- 39 - 137 U/L

New born : 95 - 368 U/L

(<14 yrs) :- 58 - 460 IU/L

SERUM PROTEIN

PROTEIN 6.70 gm/dl 6.0 — 8.0

ALBUMIN 3.60 gm/dl 3.7 — 5.3

GLOBULIN 3.1 gm/dl 2.3 — 3.6

A : G RATIO 1.16 1.0 — 2.3



LAB TECHNICIAN

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Age / Sex : 41 Years/Female
Bed No : //

Quality Control : by Human Chemistry Control (BIO-RAD,U.S.A)

HAEMATOLOGY EXAMINATION

BLOOD GROUP

ABO GROUP

"AB"

RH TYPE

POSITIVE

ESR

15 mm/hr

0 — 15



LABORATORY TECHNICIAN

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Reg No.-35897/06

PATHOLOGIST



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Bed No : //

BIO-CHEMISTRY EXAMINATION

Investigation Name	Result	Reference Range
BLOOD SUGAR FASTING	89.0 mg/dl	70 — 110
BLOOD SUGAR PP	98.0 mg/dl	70 — 140
GAMMA-GT	31.0 U/Lt	9 — 52 (Male: <55 (Female: <38

KIDNEY FUNCTION TEST

BLOOD UREA	24.0 mg/dl	5.0 — 40.0
SERUM CREATININE	0.80 mg/dl	0.6 — 1.4
SERUM URIC ACID	3.70 mg/dl	2.5 — 6.0
BUN	11.21 mg/dl	7.5 — 23.0

LIPID PROFILE

TOTAL CHOLESTEROL	149.0 mg/dl	140 — 200
TRIGLYCERIDE	110.0 mg/dl	30 — 160
HDL CHOLESTEROL	35.0 mg/dl	35 — 90
VLDL CHOLESTEROL	22 mg/dl	06 — 32
LDL CHOLESTEROL	92 mg/dl	85 — 130
LDL /HDL RATIO	2.63	1.5 — 3.0
TC / HDL	4.26	

< 3.0 · Low Risk
3.0 - 5.0 Avg. Risk
> 5.0 High Risk





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Patient Name:-Pinki kumari

Date 27/01/2024

Referred by : Dr.self

Age-41yr/sex: F

Cytopath : 01
Specimen : Cervical /Vaginal
Microscopic intermediate : The smear show mainly superficial and
Squamous cell with few Polymorphs,
No Trichomonas or fungal organisms seen.
Impression : Negative for intraepithelial lesion and malignancy



Lab technician

Dr. T.K. Chakraverti
M.B.B.S. M.D.
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Reg. No.-35857/08
PATHOLOGIST
DR. T. K. CHAKARVERTI
MBBS, MD(MICRO)



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ECHOCARDIOGRAPHY & COLOR DOPPLER REPORT

Patient's Name : PINKI KUMARI

Age/Sex : 41YrF

Ref. by : OPD

Date :27/1/2024

ECHOCARDIOGRAPHIC WINDOW :Good

2D & M MODE ECHOCARDIOGRAPHY

Left ventricle

EDD:	47	mm (50 - 28 mm / m ²)	ESD:	26	mm (27 - 37 mm)
IVS:	12	mm (6 - 11 mm)	PW:	9	mm (6 - 11 mm)
Ejection fraction:	74 % (67 - 8%)		FS:	40	% (34 - 44 %)

Left atrium/ Aorta 28/ 29 mm
 Right ventricle Normal
 Right atrium Normal
 Pericardium Normal with no pericardial effusion

2D:

Normal LA/LV size and normally contracting left ventricle.
No LVH, No RWMA

AML/ PML: Normal
 Tricuspid valve Normal
 Aortic valve Normal
 Pulmonary valve Normal

Continuous & Pulse Wave Doppler study

Valve	Velocity (m/sec)			Gradient (mmHg)			Valve area (PHT Method)	Regurg.
	Peak	Mean	EDV	Peak	Mean	EDG		
Mitral	E=1 A=1.2	E<A					4 cm ²	NIL
Tricuspid	E=0.3 8 A=0.4							Nil
Aortic	1.2			6				NIL
Pulmonary	01.2			6.4				Nil





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Colour Flow Imaging

NO MR/TR/PR OR AR

No flow shunt

IMPRESSION:

GRADE I DIASTOLIC DYSFUNCTION, NORMAL BIVENTRICULAR FUNCTION, VALVES ARE
NOORMAL, NO RWMA, NO, PE, NO CLOT

Please correlate clinically

Not valid for medico legal purposes





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No: 03.

January 27, 2024

Mrs. Pinki Kumari. 41/F.

Refd. by Star Hospital.

U. S. G. of Whole Abdomen

LIVER: Normal in shape, size and echotexture. Intra hepatic ducts and vessels are of normal caliber. Right lobe measures 126 mm and left lobe measures 75 mm in cranio caudal length.

GALL BLADDER: Normal in shape and size. Lumen is echofree. Wall thickness is normal.

C.B.D. & PORTAL VEIN: No abnormality seen. CBD measures 3.1 mm and PV 8.5 mm in caliber.

PANCREAS: Normal in shape, size and echotexture.

BOTH KIDNEYS: Right kidney measures 86 mm x 40 mm. Left kidney measures 91 mm x 43 mm. No mass, cyst or calculus. P C S Not Dilated. No Hydronephrosis. The C M D is maintained.

SPLEEN: Mild enlarged with normal outlined and echopattern. No focal lesion seen. Size of spleen measures 120 mm x 46 mm. Splenic vein is of normal caliber.

URINARY BLADDER: Echofree and no abnormality seen. UB wall is of normal thickness. Pre void urine volume 290 ml and the post void residual urine 15 ml (insignificant)

UTERUS: Normal in shape, size and echotexture. Endometrial lining is central and normal thickness. Endometrial canal is empty. Uterus measures 78 x 34 mm. Cervix appears normal.

BOTH OVARIES: Normal in shape, size and echotexture. No mass or cyst seen. Right ovary size measures 30 x 17 mm and Left ovary size measures 31 x 16 mm.

OTHER: POD (Culde sac) is free from any collection. No hydrosalpinx. No evidence of ascites. No basal pleural effusion. No enlarged lymph nodes. No mass, lump or abscess in iliac scan.

OPINION: Mild Splenomegaly.
No evidence of ascites.



Consultant Sonologist



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NABH PREACCREDITED

MRS. PINKI KUMARI

41 YRS /F.

27 JANUARY, 2024.

Refd. by Star Hospital.

X-Ray Chest PA View:-

The lung fields are clear.
Both C P angles are clear.
The heart is normal.



27-01-2024 10:24:20 AM

ID: 5

pinkhi kumari

Female 41 Years

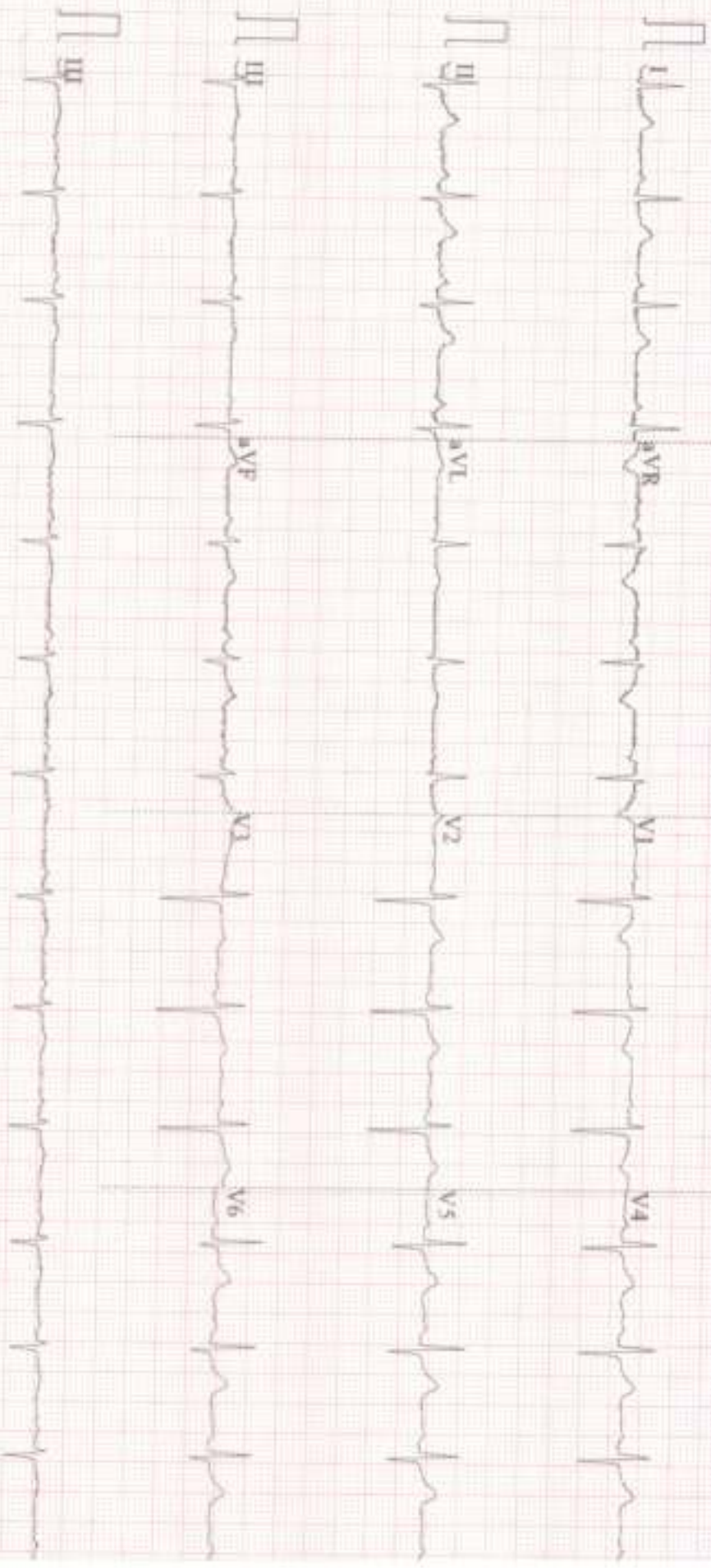
cm kg / mmHg

Room No. :

HR	: 78	bpm
P	: 99	ms
PR	: 155	ms
QRS	: 81	ms
QT/QTc	: 372/425	ms
P/QRST	: 53/-6/-44	°
RV5/SV1	: 0.72/270/932	mV

Diagnosis Information:
Sinus Rhythm
Normal ECG

Report Confirmed by:



0.67-35Hz AC50 25mm/s 10mm/mV 4*2.5s+1r 78 SE-1200Express V2.01 SEMIP V1.7 STAR HOSPITAL