DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1

OPD ASSESSMENT FORM

Name: mrs Madhuri Kanuri Age.Sex: 42/f MR.No.: S150657

Doctor: Dr Krunal Gajjar Date: 06/03/24

Ht: 157 cm Wt.: 69.3 Kg Temp: 97 F Pulse: 88 b/m BP: 160/105 mmHg

SPO2: 97% Post of walk SPO2:

Chief Complaints:

Not - Any.

Drug / Food Allergy:

No.

Prior Medication Reviewed: Yes ☐ No ☐

On examination:

RS, CVS } NAD.

Past History:

— N.S. —

Provisional Diagnosis:

Nutritional Assessment:

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

Treatment and further Advices:
(Write in Capital Letters)

Rx

→ Salt Restriction.

→ Tab. Tazloc (40) 1-0-0 × (02) months.
ABF

→ frequent B.P. monitoring.

Investigation advised:

Dr. Krunal Gajjar
M.B.B.S., MD (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No. G-20422
SUNSHINE GLOBAL HOSPITAL
SURAT.

Signature

Follow Up: Date: ____________

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

DOC. No.	SGHS/FMT/OPD007	DOI	14/06/2014	Rev. No.	0.0

ECHO CARDIOGRAPHIC REPORT

Patient's Name : mrs. madhuri kamari Date : 06/03/24 11:35 PM

Sex : F Age : 49 Ref. by Dr. : ________ Done by Dr. Sarvendra singh

LV Size : (n)

LVEF : 55-60% (VISUAL)

DIASTOLIC DYSFUNCTION : No

LVH : No

RWMA : ANTERIOR WALL
ANTERIOR SEPTUM
IVS
LV APEX
POSTERIOR WALL
LATERAL WALL
INFERIOR WALL
} No RWMA

MITRAL VALVE :
PULMONARY VALVE : } (n)

AORTIC VALVE
TRICUSPID VALVE } (n)

PAH : ——

PASP : 10 mmHg

RA :
RV : } (n)

LA :
IVC : } (n)

IAS :
IVS : } Intact

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

CONCLUSION :

No veg/clot/ PE

2D echo for health checkup plan

[signature]

MR No.	**: S150657**	**Collection Date**	**: 06/03/2024 9:20AM**
Patient Name	**: Mrs. Madhuri Kanuri**	**Age**	: 42 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 06/03/2024 11:09AM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	13.4	gm/dl	12.0 - 15.0
PCV	42.0	%	36 - 46
RBC COUNT	**5.34**	mill/cmm	4.0 - 5.0
MCV	78.7	fl	76 - 96
MCH	**25.1**	pg	26 - 32
MCHC	**31.9**	%	32 - 36
RDW	12.8	%	11 - 15
PLATELET COUNT	**5.08**	lacs/cmm	1.5 - 4.5
WBC COUNT	10600	/cmm	4000 - 11000
ESR	**24**	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	59	%	40 - 70
LYMPHOCYTES	31	%	20 - 40
EOSINOPHILS	04	%	1 - 6
MONOCYTES	06	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Normochromic Normocytic		
WBC MORPHOLOGY	Within Normal Range		
PLATELET ON SMEAR	Increased		
HEMOPARASITES	Not Seen		

SYSMEX XN-550

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

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MR No.	**: S150657**	**Collection Date**	**:** 06/03/2024 9:20AM
Patient Name	**: Mrs. Madhuri Kanuri**	**Age**	**:** 42 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 06/03/2024 11:05AM

HAEMATOLOGY

Parameter	Result		Normal Range
BLOOD GROUP & RH FACTOR			
BLOOD GROUP	"O"		
RH FACTOR	POSITIVE		

BIOCHEMISTRY

Parameter	Result	Unit	Normal Range
SERUM URIC ACID			
SERUM URIC ACID (Uricase)	5.5	mg/dl	2.4 - 5.7
FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	**138**	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

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

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MR No.	**: S150657**	**Collection Date**	:
Patient Name	**: Mrs. Madhuri Kanuri**	**Age**	: 42 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 06/03/2024 11:05AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	6.9	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**151.33**	mg/dl	

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

Note:- Criteria for the diagnosis of diabetes HbA1c >/=6.5*

1. HbA1c is important test for the assessment of long term blood glucose control (also called glycemic control).
2. HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of long term glycemic control than blood glucose determination.
3. 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.
4. Long term complications of diabetes such as retinopathy,nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.
5. 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.

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

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

06/03/2024 11:05AM

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MR No.	**: S150657**	**Collection Date**	**:** 06/03/2024 9:20AM
Patient Name	**: Mrs. Madhuri Kanuri**	**Age**	**:** 42 Y **Sex** : Female
Ref By	**:** Dr. Hospital A Doctor	**Report Date**	**:** 06/03/2024 11:06AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	**253**	mg/dl	50 - 200
HDL CHOLESTEROL Direct	**39**	mg/dl	40 - 60
LDL CHOLESTEROL Direct	**169.4**	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	**220**	mg/dl	50 - 150
VLDL Calc	**44**	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	**6.49**		0 - 5
LDL / HDL RATIO	**4.34**		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 *******

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MR No.	: **S150657**	**Collection Date**	: 06/03/2024 9:20AM
Patient Name	: **Mrs. Madhuri Kanuri**	**Age**	: 42 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 06/03/2024 11:08AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	**167**	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.8	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.3	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.5	mg/dl	0.0 - 0.8
SGPT (IFCC)	37	U/L	5 - 41
SGOT (IFCC)	32	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.6	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.8	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.8	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	1.71	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	0.6	mg/dl	0.5 - 1.2
BUN [BLOOD UREA NITROGEN]			
BUN	8.4	mg/dl	8 - 23

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

Dr. Shobha Choksi
MD, DCP (Pathology)
Reg. No.: G-9074

06/03/2024 11:08AM

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MR No.	**: S150657**	**Collection Date**	**: 06/03/2024 9:20AM**
Patient Name	**: Mrs. Madhuri Kanuri**	**Age**	**: 42 Y Sex : Female**
Ref By	: Dr. Hospital A Doctor	**Report Date**	**: 06/03/2024 11:06AM**

CLINICAL CHEMISTRY

Parameter	Result	Units	Normal Range
THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.17	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	8.54	ug/dl	5.1 - 14.0
TSH (CLIA)	1.99	uIU/ml	0.2 - 4.5

te:-

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechnism 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 whiled in secondary and tertiary hypothyroidism . TSH levels are low.

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

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MR No.	: **S150657**		**Collection Date**	: 06/03/2024 9:20AM	
Patient Name	: **Mrs. Madhuri Kanuri**		**Age**	: 42 Y	**Sex** : Female
Ref By	: Dr. Hospital A Doctor		**Report Date**	: 06/03/2024 11:10AM	

CLINICAL PATHOLOGY

Parameter	Result		Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION			
TYPE OF SPECIMEN - URINE	Random		
PHYSICAL EXAMINATION			
QUANTITY	**05**	ml	
COLOUR	Pale Yellow		
APPEARANCE	Sl.Turbid		
REACTION (pH)	6.0		
SPECIFIC GRAVITY	1.030		
CHEMICAL EXAMINATION			
PROTEIN	Absent		
GLUCOSE	Absent		
KETONE	Absent		
BILE SALT	Absent		
BILE PIGMENT	Absent		
OCCULT BLOOD	Absent		
NITRITE	Absent		
MICROSCOPIC EXAMINATION			
PUS CELLS	3-4	/hpf	
EPITHELIAL CELLS	12-15	/hpf	
RBC	Absent	/hpf	
CASTS	Absent		
CRYSTALS	Absent		
BACTERIA	Absent		
YEAST CELLS	Absent		

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

B

Dr. Shobha Choksi
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PAT. NAME: Madhuri Kanuri	Date : 06/03/2024
REF. DOCTOR : Hosp. Dr.	AGE : 42 Yrs / F
INV. : USG Whole Abdomen	MR NO. : S150657

Findings:

Liver is enlarge in size (16.9 cm), shape and shows moderate increase in parenchymal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is partially distended. A hyperechoic lesions with posterior acoustic shadowing is noted within the lumen – suggestive of GB calculus (26 mm). No e/o GB wall thickening / pericholecystic fluid. No e/o sludge or mass lesion is seen.
CBD and Portal Vein appears normal is size and calibre.

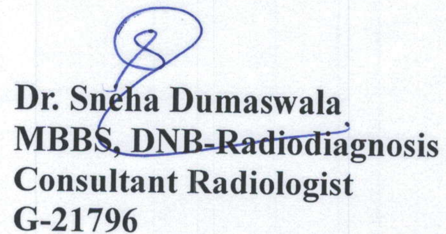
Pancreas appears normal in size and shows normal echopattern to the extent assessed.
Spleen appears normal in size, shape and homogenous echopattern.

Both kidneys appear normal in size, shape and echopattern. The corticomedullary differentiation is well maintained. No e/o hydronephrosis. Few non obstructing microliths are noted in both kidneys.

Aorta and para-aortic regions appears normal. No e/o any lymphadenopathy.
Urinary bladder is minimally distended
No e/o free fluid in abdomen / pelvis.

IMPRESSION:

- **Hepatomegaly with grade II fatty liver.**
- **Cholelithiasis.**
- **Bilateral non obstructing renal microliths.**



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

Transcribed By: Asha

Date & Time of report: 03/06/2024 – 12:30 PM

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Madhavi,

6/3/24

C Ginger, forte vag. tab.

૧ ગોળી રાતનાં અંદર રાખવી (6)

DR. BHAVNA DESAI
MD,DGO
REG. NO.-10538
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DOC. No.	SGHS/FMT/IPD009	DOI	14/06/2014	Rev. No.	0.0

GYNAECOLOGICAL CONSULTATION

MR. NO. S150657

Name : Mrs. Madhuri Kanuri

Age : 42/F Ht. : 157cm Wt. : 69.3 B.P. : 160/105 mmHg

Date : 06/03/24

Clinical Evaluation / History / Presenting Complain:

....

Routine

K/H : D.M.

....

Gynecological History :

	Yes	No
1. Have you ever noticed any bleeding between menstrual periods ? માસિક ના સમય સિવાય વચ્ચે અનીયમીત બ્લીડીંગ થાય છે ?	☐	☑
2. Are / were your periods Irregular ? પીરીયડ રેગ્યુલર છે ?	☐	☑
3 Are you pregnant now ? અત્યારે તમે પ્રેગનન્ટ છો ?	☐	☑
4 Have you had your change of life (Menopause)? મેનોપોઝ ની કોઈ લક્ષણ ની તકલીફ છે ?	☐	☑
5 Are / were you taking birth control piils? તમે ગર્ભનિરોધક ગોળીલો છે ?	☐	☑
6. Do you have a lump in your beast ? સ્તનમાં દુ:ખાવો / સોજો / ગાઠ છે ?	☐	☑
7. Did anyone in your family suffer from beast cancer ? કુટુંબમાં કોઇએ બ્રેસ્ટ કેન્સર છે ?	☐	☑
8. Did anyone in you family suffer from any other cancer ? કુટુંબમાં કોઇને કોઇ પણ પ્રકારનું કેન્સર હતું ?	☐	☑

Obstetric History :

1. Menstrual History : Menarche at 17 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): 2 days.

2. Obstetric History : N/o issue M.L. 3 yrs.

Gravida .... Pare .... Abortion .... Live ....

Married life with cohabitation....................................

Children M: F: Last Delivery: Yrs back

Any bad Obstetric event / history Yes / No

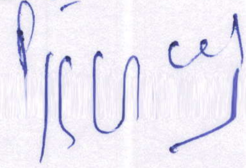
If yes Describe:

History of Contraception & Family Planning:

Examination

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

c. Local examination Vulva : NAD Vagina Vaginitis
d. Per Speculum Examination



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

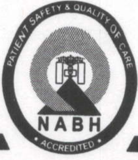
B. Therapeutic Advice

DR. BHAVNA DESAI
MD,DGO
REG. NO.-10538
SUNSHINE GLOBAL HOSPITAL
SURAT.

Followup Date

Gynaecologist's Signature

DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1



OPD ASSESSMENT FORM

Name Mrs. Madhuri Kumari Age.Sex 42/F MR.No. S1506577

Doctor Dr Shailaja Desai Date 6/3/24

Ht : ________ Wt. : ________ Temp : ________ Pulse : ________ BP : ________

SPO2 : ________ Post of walk SPO2 : ________

Chief Complaints :

- Routine dental check up

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

- Root stump of 7|

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) Extraction of 7|

Investigation advised :

Dr. Shailaja Desai
B.D.S. (Dental Surgeon)
A-9793
Dental Surgeon
Sunshine Global Hospital, Surat

Signature

Follow Up : Date : ________

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

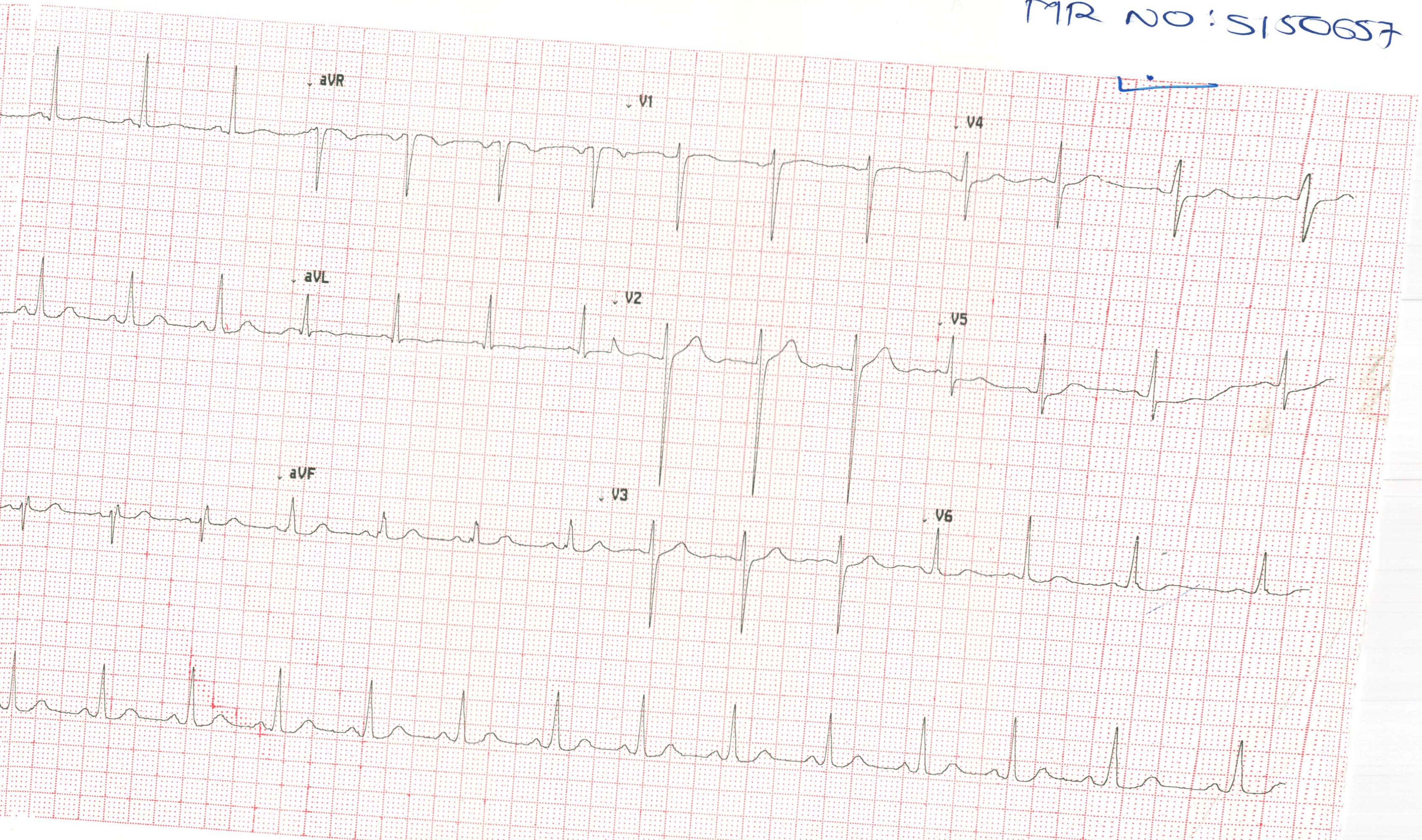
FEMALE

Vent rate:	4 BPM
PR int:	150 ms
QRS dur:	88 ms
QT/QTc:	352/393 ms
P-R-T axes:	46 25 70

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

Reviewed by ________________

Mrs. Madhuri Kumari
42/F
MR NO: S150657



Version 1.20.02 Sequence #20787 25mm/s 10mm/mV 0.05-40 Hz 50Hz