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

OPD ASSESSMENT FORM

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Name Mrs. Ketki P Shirsat **Age.Sex** 38/F **MR.No.** 5151515

Doctor Dr. Krunal Gajjar **Date** 22/03/24

Ht : 159cm **Wt. :** 67.1kg **Temp :** (N) **Pulse :** 89 B/m **BP :** 120/73 mmHg

SPO2 : 96% **Post of walk SPO2 :**

Chief Complaints :

Not - Any.

Drug / Food Allergy :

NO.

Prior Medication Reviewed : Yes ☐ **No** ☐

On examination :

PR } NAD.
CVS }

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

→ Tab. Hbline
1-0-0 × (02) months.

Investigation advised :

— stool Obt.
— S. Ferritin.
— S. Iron - Profile.

K. Gajjar.

Dr. Krunal Gajjar
M.B.B.S., M.D. (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No.
SUNSHINE GLOBAL HOSPITAL
SURAT.

Follow Up : **Date :** **Signature**

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

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

NABH ACCREDITED — PATIENT SAFETY & QUALITY OF CARE

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OPD ASSESSMENT FORM

Name Mrs Ketaki P Shrisat **Age.Sex** 38 / F **MR.No.** 5151515

Doctor Dr. Hardik Shroff **Date** 22/03/2024

Ht : ______ **Wt. :** ______ **Temp :** ______ **Pulse :** ______ **BP :** ______

SPO2 : ______ **Post of walk SPO2 :** ______

Chief Complaints :

No. complaint

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ **No** ☐

On examination : BE Ant. Seg NAD

V v (6/6P / 6/6P N/6 Fundii (Central) BE NAD

Past History :

Provisional Diagnosis :

Nil ophthalmic

Nutritional Assessment :

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

Treatment and further Advices :
(Write in Capital Letters)

℞

Investigation advised :

Dr. Hardik Shroff
DOMS, DNB (Ophthalmology)
Reg. No. G-28902
SUNSHINE GLOBAL HOSPITAL
Piplod, SURAT.

Follow Up : SOS **Date :** ______

Signature

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

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GYNAECOLOGICAL CONSULTATION

MR. NO. S151515
Name : Mrs. Ketaki Prashant Shirgat
Date : 22/03/2014
Age : 38 Ht. : 156cm Wt. : 67.1kg B.P. : 120/73mm of Hg

Clinical Evaluation / History / Presenting Complain:

Routine.

F.H. D.M.
H.T.

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 કોઈએ બ્રેસ્ટ કેન્સર છે ?	☐	☑
8. Did anyone in you family suffer from any other cancer ? કુટુંબમાં કોઈને કોઈ પણ પ્રકારનું કેન્સર હતું ?	☐	☑

Obstetric History :

1. Menstrual History : Menarche at .... 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

   2-3 / 28-5

   Last menstrual Period (LMP): 3 days

2. Obstetric History :
   Gravida .... Pare .... Abortion ....- Live ....2.
   Married life with cohabitation..............
   Children M: 12y F: 14y Last Delivery: Yrs back
   Any bad Obstetric event / history Yes / No
   If yes Describe:

2 FTND

History of Contraception & Family Planning: —

Examination

a. Breast Examination - Right NAD Left NAD

b. Per abdomen examination

NAD

c. Local examination Vulva NAD Vagina NAD

d. Per Speculum Examination

Not Done

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

5151515

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ECHO CARDIOGRAPHIC REPORT

Patient's Name : Mrs. Kotaki shirsat Date : 20/03/24 10:15 AM

Sex : F Age : 38 Ref. by Dr. : _____ Done by Dr. Saravendoctring

LV Size : (N)

LVEF : 62 % (VISUAL)

DIASTOLIC DYSFUNCTION : No

LVH : No

RWMA : ANTERIOR WALL
ANTERIOR SEPTUM
IVS
LV APEX
POSTERIOR WALL
LATERAL WALL
INFERIOR WALL

| No RWMA

MITRAL VALVE : | (N)

PULMONARY VALVE :

AORTIC VALVE

TRICUSPID VALVE | (N)

PAH : —

PASP : 10 mmHg

RA :

LA :

RV : | (N)

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 regional IPE

2D Echo for Health checkupplan

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MR No.	: **S151515**	**Collection Date**	: 22/03/2024 9:07AM
Patient Name	: **Mrs. Ketaki Prashant Shirsat**	**Age**	: 38 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 22/03/2024 11:18AM

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	**7.9**	gm/dl	12.0 - 15.0
PCV	**30.1**	%	36 - 46
RBC COUNT	4.06	mill/cmm	4.0 - 5.0
MCV	**74.1**	fl	76 - 96
MCH	**19.5**	pg	26 - 32
MCHC	**26.2**	%	32 - 36
RDW	**19.9**	%	11 - 15
PLATELET COUNT	**5.15**	lacs/cmm	1.5 - 4.5
WBC COUNT	7030	/cmm	4000 - 11000
ESR	**32**	mm/hr	0 - 15
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	52	%	40 - 70
LYMPHOCYTES	29	%	20 - 40
EOSINOPHILS	**13**	%	1 - 6
MONOCYTES	06	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Hypochromasia(+), Microcytosis(+), Anisopcikilocytosis(+)		
WBC MORPHOLOGY	Eosinophilia		
PLATELET ON SMEAR	Increased		
HEMOPARASITES	Not Seen		

SYSMEX XN-550

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

Dr. Shobha Choksi
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MR No.	: **S151515**	**Collection Date**	: 22/03/2024 9:07AM
Patient Name	: **Mrs. Ketaki Prashant Shirsat**	**Age**	: 38 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 22/03/2024 11:12AM

HAEMATOLOGY

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

BIOCHEMISTRY

SERUM URIC ACID			
SERUM URIC ACID (Uricase)	3.2	mg/dl	2.4 - 5.7
FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	109	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		

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

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MR No.	: **S151515**	**Collection Date**	: 22/03/2024 9:07AM
Patient Name	: **Mrs. Ketaki Prashant Shirsat**	**Age**	: 38 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 22/03/2024 11:12AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	6.0	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**125.5**	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 *******

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MR No.	: **S151515**	**Collection Date**	: 22/03/2024 9:07AM
Patient Name	: **Mrs. Ketaki Prashant Shirsat**	**Age**	: 38 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 22/03/2024 11:13AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	154	mg/dl	50 - 200
HDL CHOLESTEROL Direct	47	mg/dl	40 - 60
LDL CHOLESTEROL Direct	92.9	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	69	mg/dl	50 - 150
VLDL Calc	13.8	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	3.28		0 - 5
LDL / HDL RATIO	1.98		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.	: **S151515**	**Collection Date**	: 22/03/2024 9:07AM
Patient Name	: **Mrs. Ketaki Prashant Shirsat**	**Age**	: 38 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 22/03/2024 11:14AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	59	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.3	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.1	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.2	mg/dl	0.0 - 0.8
SGPT (IFCC)	07	U/L	5 - 41
SGOT (IFCC)	14	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.4	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.2	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	3.2	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	**1.31**	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	0.5	mg/dl	0.5 - 1.2
BUN [BLOOD UREA NITROGEN]			
BUN	**7.4**	mg/dl	8 - 23
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	**13.2**	mg/L	
URINE CREATININE (JAFFE)	**94.9**	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	13.9	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

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

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MR No.	: **S151515**	**Collection Date**	: 22/03/2024 9:07AM
Patient Name	: **Mrs. Ketaki Prashant Shirsat**	**Age**	: 38 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 22/03/2024 11:15AM

CLINICAL CHEMISTRY

Parameter	Result	Units	Normal Range
THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.39	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	8.77	ug/dl	5.1 - 14.0
TSH (CLIA)	1.88	uIU/ml	0.2 - 4.5

Note:-

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.	: **S151515**	**Collection Date**	: 22/03/2024 9:07AM
Patient Name	: **Mrs. Ketaki Prashant Shirsat**	**Age**	: 38 Y **Sex** : Female
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 22/03/2024 11:19AM

CLINICAL PATHOLOGY

Parameter	Result	Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION		
TYPE OF SPECIMEN - URINE	Random	
PHYSICAL EXAMINATION		
QUANTITY	**10**	ml
COLOUR	Pale Yellow	
APPEARANCE	Sl.Turbid	
REACTION (pH)	7.5	
SPECIFIC GRAVITY	1.010	
CHEMICAL EXAMINATION		
PROTEIN	Present(Trace)	
GLUCOSE	Absent	
KETONE	Absent	
BILE SALT	Absent	
BILE PIGMENT	Absent	
OCCULT BLOOD	Presetn(+)	
NITRITE	Absent	
MICROSCOPIC EXAMINATION		
PUS CELLS	3-4	/hpf
EPITHELIAL CELLS	12-15	/hpf
RBC	3-4	/hpf
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

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

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PAT. NAME : Ketaki Shirsat	**Date** : 22/03/2024
REF. DOCTOR : Hosp. Dr.	**AGE** : 38 Yrs / F
INV. : USG Whole Abdomen	**MR NO.** : S151515

Findings:

Liver is normal in size, shape and shows normal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is distended and appears normal. No e/o calculus, 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 any calculus or hydronephrosis is seen.

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

IMPRESSION:

- **No significant abnormality seen.**

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

Transcribed By: Asha

Date & Time of report: 03/22/2024 – 11:29 AM

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PAT. NAME : Ketaki Shirsat	**Date** : 22/03/2024
REF. DOCTOR : Hosp. Dr.	**AGE** : 38 Yrs / F
INV. : Radiograph of Chest PA	**MR NO.** : S151515

Clinical Details: HC

Observation:

- Both the lung fields appears normal.
- Both costophrenic angles appear clear.
- Both the hila appears normal.
- Trachea appears in midline.
- Cardiac size and other mediastinal shadows appears normal.
- Both domes of diaphragm appear normal.
- Bony thorax appears normal.

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

Transcribed By: Asha

Date & Time of report: 22/03/2024 – 11:21 AM

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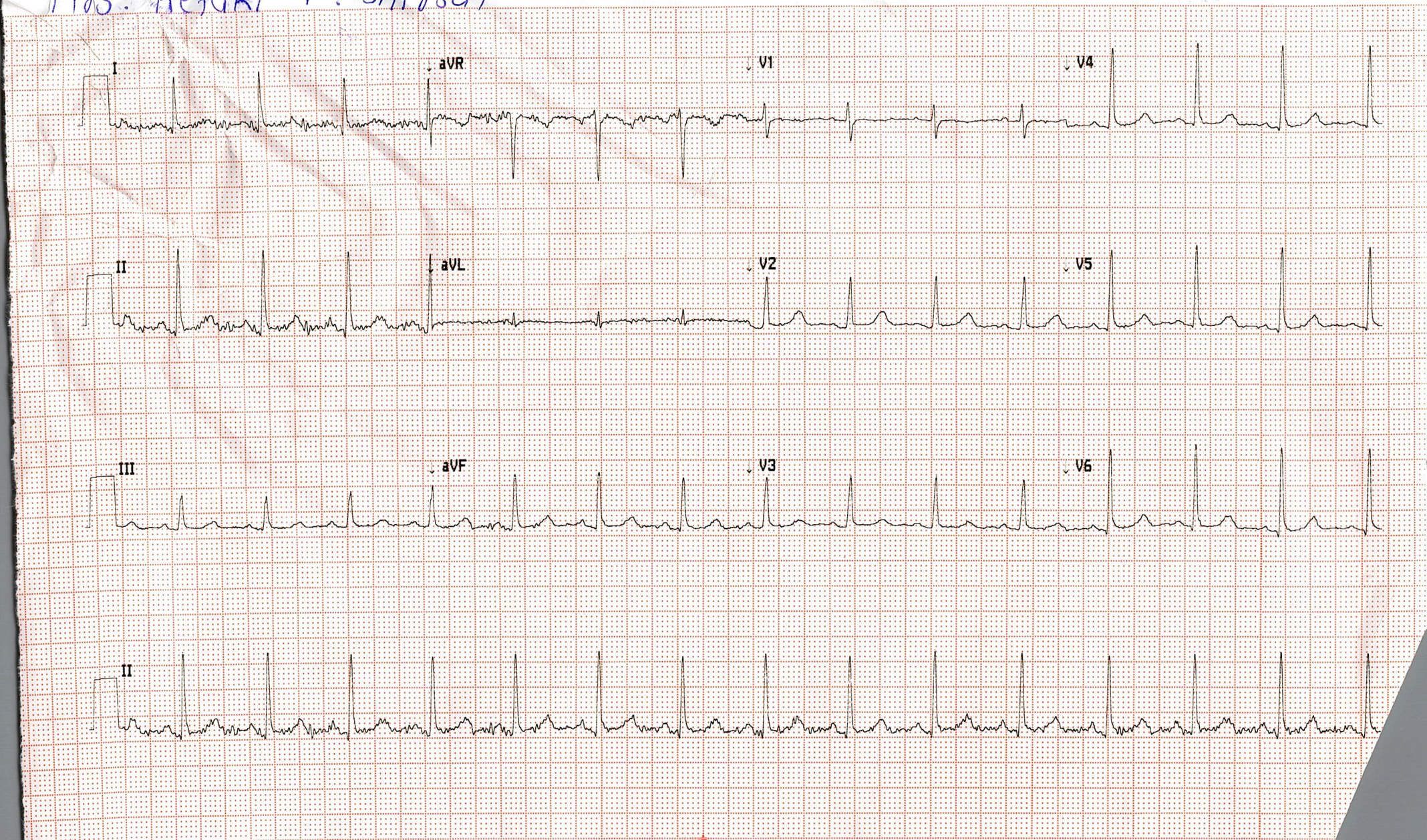
DOB:
0yr, FEMALE

Vent rate:	89 BPM
PR int:	159 ms
QRS dur:	86 ms
QT/QTc:	372/419 ms
P-R-T axes:	61 57 59

..PEDIATRIC ECG INTERPRETATION
SINUS BRADYCARDIA WITH PROLONGED PR FOR AGE
BORDERLINE ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 6 MONTHS

Reviewed by _____

Mrs. Ketuki P. Shirsat



Version 1.20.02 Sequence #21065 25mm/s 10mm/mV 0.05-40 Hz 50Hz