Apollo TOUCHING LIVES

Apollo Clinic VASHI

MEDICAL SUMMARY

NAME:	Ms-Pooja More	UHID:	
AGE:	31	DATE OF HEALTHCHECK:	24/12/2024
GENDER:	F		

HEIGHT:	162	MARITAL STATUS:	M
WEIGHT:	71.5	NO OF CHILDREN:	1.
BMI:	27.2		

C/O:

K/C/O:

PRESENT MEDICATION: - NO

P/M/H: - NO

P/S/H: - NO.

ALLERGY: - NO.

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

ALCOHOL:

TOBACCO/PAN: } NAD

FAMILY HISTORY FATHER: -

MOTHER: - } NAD.

O/E:

LYMPHADENOPATHY:

PALLOR/ICTERUS/CYNOSIS/CLUBBING: } NAD

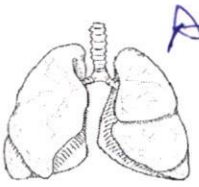
OEDEMA:

BP: 100/80 PULSE: - 68/min

TEMPERATURE: N SCARS: -

S/E:

RS: AE3G



P/A: - NAD

CVS: S1S2+

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:				

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: Mrs. Pooja Rupesh More Age: 31 Date of Health check-up: 24/02/2024.

Findings and Recommendation:

Findings:-

Eczema

Recommendation:-

Sos Cardiologist opinion

Signature:

Consultant –

DR. ANIRBAN DASGUPTA
MBBS, D.N.B MEDICINE
DIPLOMA CARDIOLOGY
MMC- 2005/02/0920

Apollo

Apollo Clinic VASHI

OPHTHALMIC EVALUATION

UHID No.: _____ Date : 24/12/24

Name : Miss Pooja 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 : NAD

Anterior Segment Examination : NAD (BE)

Pupils : _____

Fundus : _____

Intraocular Pressure : 14mmHg (BE)

Diagnosis : _____

Advice : _____

Re-Check on Alts (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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DENTAL CHECKUP

Name: Pooja More	**MR NO:**
Age/Gender : 31/F	**Date:** 24/2/24

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: _____

- Scaling & polishing - 700
- Start using floss

DR. AQSA SHAIKH
B. D. S
Reg. No: A 42611

Aqsa

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Name : Mrs Pooja More Age : 31 Sex : F UHID No. : Date : 24/2/2024

31 years / married / P, 4 (FNND)

No complains.

LMP - 10/2/2024.

O/E

GC Fair

Afebrile

P 88/m.

PA - soft NT.

P/S. Cx } healthy
Vy }
(PAP smear taken).

Dr. _____

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

Apollo TOUCHING LIVES

Apollo Clinic VASHI

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

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Email: apolloclinicvashi@gmail.com

Apollo Clinic VASHI

Name	: Mrs. Pooja Rupesh More	Gender	: Female	Age	: 31 Years
UHID	: FVAH 10731.	Bill No	:	Lab No	: V-3201-23
Ref. by	: SELF	Sample Col.Dt	: 24/02/2024 08:45		
Barcode No	: 9879	Reported On	: 24/02/2024 15:06		

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)			
Haemoglobin(Colorimetric method)	12.8	g/dl	11.5 - 15
RBC Count (Impedance)	4.12	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	38.3	%	35 - 55
MCV:(Calculated)	93	fl	78 - 98
MCH:(Calculated)	31	pg	26 - 34
MCHC:(Calculated)	33.3	gm/dl	30 - 36
RDW-CV:	12.7	%	10 - 16
Total Leucocyte count(Impedance)	5230	/cumm.	4000 - 10500
Neutrophils:	56	%	40 - 75
Lymphocytes:	39	%	20 - 40
Eosinophils:	03	%	0 - 6
Monocytes:	02	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.86	Lakhs/c.mm	1.5 - 4.5
MPV	9.1	fl	6.0 - 11.0
ESR(Westergren Method)	20	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.		

Neha More
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 :	Matrix gel card method (forward and reverse)
------	----------

Sheetal Nakate
Entered By

Ms Kaveri Gaonkar
Verified By

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

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin :	5.1	%	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 :	99.67	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

Neha More
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Name	: Mrs. Pooja Rupesh More	Gender	: Female	Age	: 31 Years
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Ref. by	: SELF	Sample Col.Dt	: 24/02/2024 08:45		
Barcode No	: 9879	Reported On	: 24/02/2024 15:06		

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	95	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 :	90	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		

Vasanti Gondal
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LIPID PROFILE - Serum			
S. Cholesterol(Oxidase)	172	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	135	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	27	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	40.5	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	104.5	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4.2		3.5 - 5
Ratio of LDL/HDL	2.6		2.5 - 3.5

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Barcode No	: 9879	Reported On	: 24/02/2024 15:06		

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.24	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.36	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.88	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.51		0.9 - 2
S.Total Bilirubin (DPD):	0.32	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.11	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.21	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	19	U/L	5 - 32
S.ALT (SGPT) (IFCC Kinetic with P5P):	20	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	94	U/L	35 - 105
S.GGT(IFCC Kinetic):	18	U/L	07 - 32

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	17.7	mg/dl	10.0 - 45.0
BUN (Calculated)	8.26	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.57	mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	14.49		9:1 - 23:1
S.Uric Acid(Uricase Method)	3.4	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)	1.86	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	124.7	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	2.78	□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	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Slightly Hazy		Clear
SEDIMENT	Absent		Absent
CHEMICAL EXAMINATION(Strip Method)			
REACTION(PH)	6.0		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	**3 - 4 / hpf**		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	**8 - 10 / hpf**		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

Anushka Chavan
Entered By

Ms Kaveri Gaonkar
Verified By

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

End of Report
Results are to be correlated clinically

Pooja, More
10731

Female

31 Years

24.02.2024 8:58:03
Apollo Clinic
1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703.

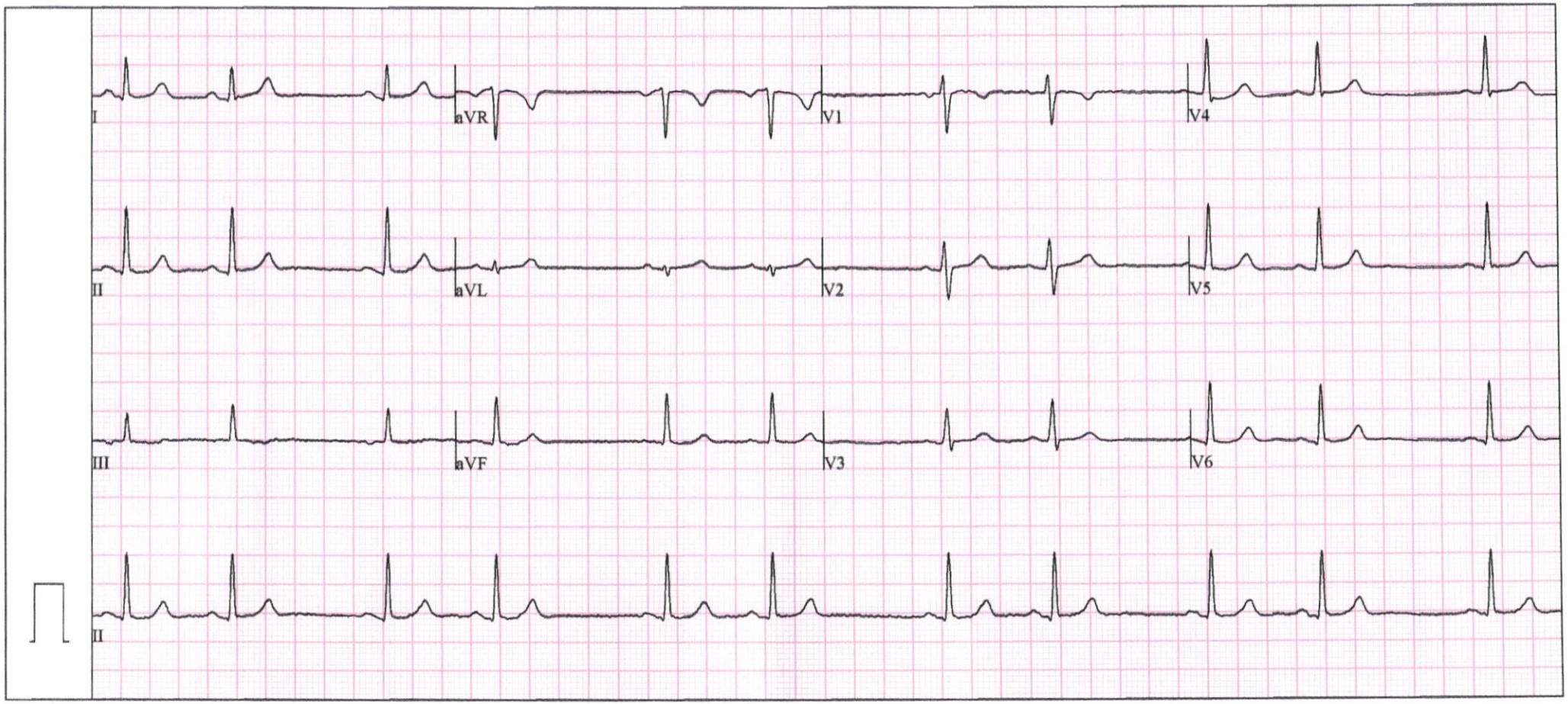
65 bpm
-- / -- mmHg

QRS :	70 ms
QT / QTcBaz :	366 / 380 ms
PR :	140 ms
P :	90 ms
RR / PP :	928 / 923 ms
P / QRS / T :	13 / 60 / 26 degrees

Sinus rhythm with premature atrial complexes in a pattern of bigeminy
Otherwise normal ECG

PAC a Bigemy

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

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VASHI

PATIENT'S NAME	POOJA R MORE	AGE :- 31Y/F
UHID	10731	DATE :- 24-02-24

2D Echo and Colour Doppler Report

Ectopic during study

All cardiac chambers are normal in dimension

No obvious resting regional wall motion abnormalities (RWMA)

Interatrial and Interventricular septum – Appears Normal

Valves – Structurally normal

Mild MR

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.

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Measurements

Aorta annulus	17 mm
Left Atrium	27 mm
LVID(Systole)	17 mm
LVID(Diastole)	37 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	POOJA R MORE	AGE :- 31Y/F
UHID NO	10731	24 Feb 2024

DIGITAL RADIOGRAPH OF CHEST (PA VIEW)

The lung fields are clear.

Heart and aorta appears normal.

Both hila appear normal.

Both costo-phrenic angles are clear.

Visualized bony thorax appears normal.

IMPRESSION: NO SIGNIFICANT ABNORMALITY IS DETECTED IN CURRENT RADIOGRAPH.

Clinico-haematological correlation is recommended.

Thanking you for the referral,
With regards,

DR. SIDDHI PATIL
Cons. Radiologist

Apollo
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PATIENT'S NAME	POOJA R MORE	AGE :- 31Y/F
UHID	10731	24 Feb 2024

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, shape and 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 10.7 x 3.8 cm. **LEFT KIDNEY** measures 12.0 x 4.2 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 7.2 x 4.9 x 4.0 cm; ET measures 6 mm.

Both ovaries are normal in size, shape and position.

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

IMPRESSION –

- **No significant abnormality detected.**

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

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