

MEDICAL SUMMARY

NAME:	Radhika Bhatt	UHID:	
AGE:	39 yrs	DATE OF HEALTHCHECK:	24/2/2024
GENDER:			

HEIGHT:	155	MARITAL STATUS:	M.
WEIGHT:	45.5	NO OF CHILDREN:	1.
BMI:	18.9		

C/O: Cold 1 day
 No fever cough
 Breathlessness
 P/M/H: - No

K/C/O:
 PRESENT MEDICATION: - No

P/S/H: - No

ALLERGY: - No

PHYSICAL ACTIVITY: Active / Moderate / Sedentary

H/A: SMOKING:

ALCOHOL:

TOBACCO/PAN:

FAMILY HISTORY FATHER: - DM

MOTHER: -

O/E:

BP: 100/70 PULSE: - 80/min

TEMPERATURE: - SCARS:

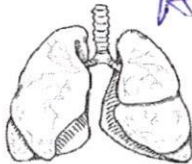
LYMPHADENOPATHY:

PALLOR/ICTERUS/CYNOSIS/CLUBBING:

OEDEMA:

S/E:

RS:



P/A:



CVS: -

Extremities & Spine: -

CNS:

Conscious, oriented

ENT:

Skin:

Vision:

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

• ANDHERI • COLABA • NASHIK • VASHI

Name: Radhica R. Bhatt Age: 39y Date of Health check-up: 21/04/2014

Findings and Recommendation:

Findings:-

- Hb 7+
- PC-68
- gwen in 1st lead

Recommendation:-

Cardiac catheter 805

Signature:

Consultant -



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

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 24/2/24

Name: Miss Rachika Age: 39 Gender: Male/Female

Without Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye 26 Left Eye 126

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	<u>075</u>	<u>050</u>	<u>90°</u>			<u>075</u>	<u>050</u>	<u>28</u>		
Near										

Colour Vision : NM

Anterior Segment Examination : NM / BC

Pupils : _____

Fundus : _____

Intraocular Pressure : 14 mmHg (2)

Diagnosis : _____

Advice : _____

Re-Check on 6 mths (This Prescription needs verification every year)

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

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: Radhika bhatt.	MR NO:
Age/Gender : 39/F	Date: 20/2/24.

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 ADVISED:

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 - 900.
 - Extraction 587

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



• ANDHERI • COLABA • NASHIK • VASHI

Name: Radhika Bhatt Age: 39 Sex: F UHID No.: _____ Date: 24/2/24

39 years / P, G (L&S)

No complains, willing for PAP smear

Umo - 1/2/2024

O/R

GCFair

Afebrile

P- 88/min

Sw inputs

PA - SyTM

Pls. Ex y healthy
(PAP smear taken)

Dr. _____



Apollo Clinic
VASHI

■ Consultation

■ Diagnostics

■ Health Check-Ups

■ Dentistry

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

Name : Mrs. Radhika Rajat Bhatt Gender : Female Age : 39 Years
 UHID : FVAH 10753. Bill No : Lab No : V-3242-23
 Ref. by : SELF Sample Col.Dt : 24/02/2024 10:45
 Barcode No : 9920 Reported On : 24/02/2024 18:07

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

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

Haemoglobin(Colorimetric method)	11.1	g/dl	11.5 - 15
RBC Count (Impedance)	4.63	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	34.8	%	35 - 55
MCV:(Calculated)	75.1	fl	78 - 98
MCH:(Calculated)	23.9	pg	26 - 34
MCHC:(Calculated)	31.8	gm/dl	30 - 36
RDW-CV:	17	%	10 - 16
Total Leucocyte count(Impedance)	9740	/cumm.	4000 - 10500
Neutrophils:	71	%	40 - 75
Lymphocytes:	22	%	20 - 40
Eosinophils:	03	%	0 - 6
Monocytes:	04	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	4.54	Lakhs/c.mm	1.5 - 4.5
MPV	7.6	fl	6.0 - 11.0
ESR(Westergren Method)	15	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Hypochromasia(Mild),Microcytosis(Mild),Anisocytosis(+)		
WBCs:	Normal		
Platelets	Increased		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

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Verified By

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

End of Report
Results are to be correlated clinically



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NABL Accredited Laboratory

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

Apollo Clinic
VASHI

Name	: Mrs. Radhika Rajat Bhatt	Gender	: Female	Age	: 39 Years
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TEST

RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group:	:B:
Rh Type:	Positive
Method :	Matrix gel card method (forward and reverse)

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
	PLASMA GLUCOSE		
Fasting Plasma Glucose :	87	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LIPID PROFILE - Serum

S. Cholesterol(Oxidase)	168	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	72	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	14.4	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	46.7	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	106.9	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	3.6		3.5 - 5
Ratio of LDL/HDL	<u>2.3</u>		2.5 - 3.5

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.33	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.25	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.08	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.38		0.9 - 2
S.Total Bilirubin (DPD):	0.43	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.17	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.26	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):	89	U/L	35 - 105
S.GGT(IFCC Kinetic):	15	U/L	07 - 32

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	11.1 mg/dl	10.0 - 45.0
BUN (Calculated)	5.18 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.74 mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	Z	9:1 - 23:1
S.Uric Acid(Uricase Method)	3.1 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)	1.71	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	97.01	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	1.59	□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 hypothyroidism.
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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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	20	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	1.005		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	6 - 8 / hpf		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	18 - 20 / hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Present(Few)		Absent

Anushka Chavan
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Dr. Milind Patwardhan
M.D(Path)

Page 2 of Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

STOOL EXAMINATION

PHYSICAL EXAMINATION

COLOUR Brown
CONSISTENCY Semi Solid
MUCUS Absent Absent

CHEMICAL EXAMINATION

OCCULT BLOOD (Guaiac method) Absent Absent
PH(Litmus paper) Acidic Acidic/Alkaline

MICROSCOPIC EXAMINATION

PUS CELLS Absent 0 - 1
EPITHELIAL CELLS Absent Absent
RED BLOOD CELLS Nil /HPF Absent
FAT GLOBULES Absent Absent
VEGETABLE FIBRES Present Present
YEASTS Absent Absent
CYST Absent Absent
VEGETATIVE FORMS Absent Absent
OVA Absent Absent
LARVAE Absent Absent

Dilpreetkaur S Singh
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Chief Pathologist

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39 Years

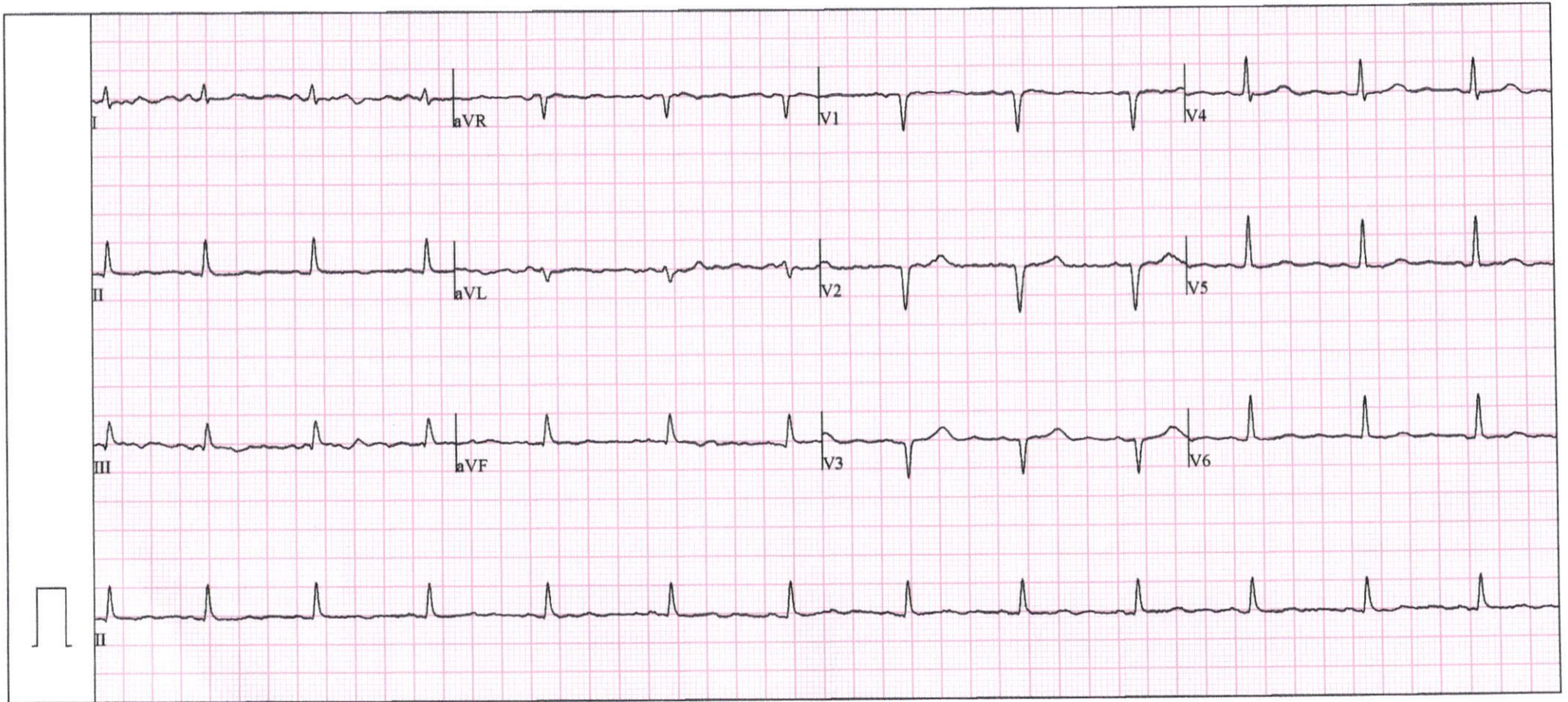
Female

QRS : 68 ms
QT / QTcBaz : 374 / 423 ms
PR : 128 ms
P : 76 ms
RR / PP : 780 / 779 ms
P / QRS / T : 22 / 76 / 89 degrees

Normal sinus rhythm
Septal infarct, age undetermined
Abnormal ECG

- 95 in Ant leads

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



PATIENT'S NAME	RADHIKA R BHATT	AGE :- 39Y/F
UHID	10753	DATE :- 24-02-24

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

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	25 mm
LVID(Systole)	16 mm
LVID(Diastole)	30 mm
IVS(Diastole)	10 mm
PW(Diastole)	10 mm
LV ejection fraction.	55-60%

Conclusion

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

Dasgupta

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

PATIENT'S NAME	RADHIKA R BHATT	AGE :- 39 Y/M
UHID	10753	DATE :- .26 Feb. 24

X-RAY CHEST PA VEIW

OBSERVATION:

Bilateral 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:

- No significant abnormality seen.



DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

PATIENT'S NAME	RADHIKA R BHATT	AGE :- 39/F
UHID	10753	24 Feb 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.

Gall Bladder is partially 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 9.6 x 3.5 cm. **Left Kidney** measures 10.4 x 4.2 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 8.4 x 3.3 x 3.2 cm in size. The endometrium measures 10.1 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 PATIL
Con. Radiologist



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Apollo Clinic
VASHI

Name : Mrs. Radhika Rajat Bhatt Gender : Female Age : 39 Years
UHID : FVAH 10753. Bill No : Lab No : V-3359-23
Ref. by : SELF Sample Col.Dt : 24/02/2024 15:10
Barcode No : 38 Reported On : 26/02/2024 14:18

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
	PLASMA GLUCOSE		
Post Prandial Plasma Glucose :	149	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

Alsaba Shaikh
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End of Report
Results are to be correlated clinically