



NAME - MRS. SHIKHA SARITA GUPTA

AGE - 39 yrs, F

DATE - 23.03.24

Sub - Physical Examination

Height - 156 cm

Weight - 49 kg

BP - 100/70 mmHg

SPO₂ - 100% (R.A)

Pulse - 71 b/m

BMI - 20.1 kg/m²



PATIENT NAME & ADDRESS

MRS. SHIKHA SARITA GUPTA

PATHOLOGY



DESUN
HOSPITAL
A NABH HOSPITAL

Desun More, E.M. Bypass, Kasta Golpark, Kolkata-700 107, Ph: 71 222 000, Fax: 2443 9003
Email: desun@desunhospital.com, Website: www.desunhospital.com
(A unit of P. N. Memorial Neurocentre & Research Institute Ltd.)

DRAWN : 23-03-2024
11:24 Hrs.

RECEIVED : 23-03-2024
14:54 Hrs.

REPORTED : 23-03-2024
16:14 Hrs.

OPD/IPD DOC NO SD01/OPD/BILL/2023-24/OP40505353

PATIENT CODE SD01/PAT/1000164618



2331470600

REFERRING DOCTOR

ACCESSION NO DHHI-1/2023-24/0009946

AGE 39 Yrs 11 Mths

SEX Female

Results relate only to the samples tested

TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Glucose - Fasting			
Glucose - Fasting Specimen : Plasma Flouride Methodology : Hexokinase	83	Adult: 74 - 106 Children 60 - 100	mg/dL
Uric Acid			
Uric Acid Specimen : Serum Methodology : Uricase Peroxidase	4.1	Male : 3.5 - 7.2 Female : 2.6 - 6.0	mg/dL
Creatinine			
Creatinine Specimen : Serum Methodology : Jaffe Method	0.69	Male (<50 years) : 0.84 - 1.25 Male (>50 years) : 0.81 - 1.44 Female: 0.66 - 1.09 Neonate: 0.5 - 1.2 Infant: 0.4 - 0.7 Child: 0.5 - 1.2	mg/dL
LFT (Liver Function Test)			
Total Bilirubin Specimen : Serum Methodology : Diazotization	0.40	Adults: 0.3 - 1.2 Children 0-1 day 1.4 - 8.7 1-2 days 3.4 - 11.5 3-5 days 1.5 - 12.0	mg/dL
Direct Bilirubin Specimen : Serum Methodology : Diazotization	0.06	Adults and Children: < 0.2	mg/dL
Indirect Bilirubin Methodology : Calculated Value	0.34		mg/dL
Total Protein Specimen : Serum Methodology : Biuret	7.8	Adult : 6.6 - 8.3 Children (1 - 18 y) : 5.7 - 8.0 Newborns (1 - 30 d) : 4.1 - 6.3	g/dL
Albumin Specimen : Serum Methodology : Bromocresol Green (BCG)	4.7	Adults: 3.5 - 5.2 Newborn (0 - 4 day) : 2.8 - 4.4	g/dL
Globulin Methodology : Calculated Value	3.1	1.8 - 3.6	g/dL



23032024171218

Dr. Prerana Mondal
MD (Path), WBMC-70606
Consultant Pathologist

PATIENT NAME & ADDRESS

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LFT (Liver Function Test)

Aspartate Aminotransferase (SGOT) (AST)

23

Male (Adult): <50
Female (Adult): <35
Newborn: 25 - 75
Infant: 15 - 60

U/L

Specimen : Serum

Methodology : IFCC (UV without P5P)

Alanine Aminotransferase (SGPT) (ALT)

19

Male(Adult): <50
Female(Adult): <35
Newborn/Infant: 13 - 45

U/L

Specimen : Serum

Methodology : IFCC (UV without P5P)

Alkaline Phosphatase (ALP)

87

75 - 316

U/L

Specimen : Serum

Methodology : IFCC (PNPP, AMP buffer)



Dr. Prerana Mondal

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PATHOLOGY



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Glucose - PP (Post Prandial)

Glucose - Post Prandial

95

70.0 - 140.0

mg/dL

Specimen : Plasma Flouride

Methodology : Hexokinase

** Sample Drawn : 23.03.2024 14:45 Hrs.

Received : 23.03.2024 15:18 Hrs.

Reported : 23.03.2024 16:14 Hr



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Lipid Profile			
Cholesterol - Total Specimen : Serum Methodology : CHOD-POD * CLINICAL CORRELATION REQUESTED. * VALUE RECHECKED.	* 217	<200 : Desirable 200 - 239 : Borderline High >=240 : High	mg/dL
Cholesterol - HDL Specimen : Serum Methodology : Direct Enzymatic Colorimetric	54	40.0 - 59.0	mg/dL
Cholesterol - LDL Methodology : Calculated Value	142	> 160.0 : High Risk 130.0 - 160.0 : Borderline High <= 130.0 : Desirable	mg/dL
Cholesterol - VLDL Methodology : Calculated Value	21	< 40.0	mg/dL
Triglyceride Specimen : Serum Methodology : GPO POD	105	Normal : <150 Borderline high : 150 - 199 High : 200 - 499 Very high : >=500	mg/dL



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Lipid Profile

Cholesterol - Total/HDL ratio
 Methodology : Calculated Value

4.02

3.4 : 1/2 Average Risk
 5.0 : Average Risk
 9.6 : 2 x Average Risk
 23.4 : 3 x Average Risk

ratio

Cholesterol - HDL/LDL ratio
 Methodology : Calculated Value

0.38



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count)			
Haemoglobin (Hb) Specimen : Whole Blood - EDTA Methodology : Colorimetry * CLINICAL CORRELATION REQUESTED. * VALUE RECHECKED.	* 10.5	12.0 - 15.0	gm %
RBC Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	4.50	3.8 - 4.8	million/cmm
Packed Cell Volume (Hematocrit) (PCV) Specimen : Whole Blood - EDTA Methodology : Pulse height detection	33.8	36.0 - 46.0	%
Mean Cell Volume (MCV) Specimen : Whole Blood - EDTA Methodology : Calculated Value	75.2	83 - 101	fL
Mean Cell Haemoglobin (MCH) Specimen : Whole Blood - EDTA Methodology : Calculated Value	23.4	27 - 32	pg
Mean Cell Haemoglobin Concentration (MCHC) Specimen : Whole Blood - EDTA Methodology : Calculated Value	31.1	31.5 - 34.5	g/dL
Platelet Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	2.96	1.5 - 4.1	lakh/cmm
Total Count			
WBC Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	6.4	4 - 10	thou/cmm
Differential Count (Microscopy)			
Neutrophil	70	40 - 80	%
Lymphocyte	24	20 - 40	%
Monocyte	02	2 - 8	%
Eosinophil	04	1 - 6	%



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count)			
Basophil	00	<1 - 2	%
<i>Peripheral Blood Smear (Microscopy)</i>			
RBC	Microcytic hypochromic.		
WBC	Normal morphology. No immature cell seen.		
Erythrocyte Sedimentation Rate (ESR)	35	<=15	mm / hr
Specimen : Whole Blood - EDTA			
Methodology : Westergren			



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Results relate only to the samples tested

TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
--------------------	---------	-------------------------------	-------

ABO Group & RH Type

ABO Blood Group

A

Methodology : Tube Agglutination / Slide method

Rh Typing

POSITIVE

Specimen : Whole Blood - EDTA

Methodology : Tube Agglutination / Slide method

Note : Following factors are responsible for discrepancies in ABO Grouping:

1. Patients may fail to express ABO antigens on red cells due to diseases like Leukaemia & lymphoma.
2. Acquired B antigen can occur due to Infections; gram negative septicaemia, carcinoma colon, Blood Group chimera i.e. an individual with two population of cells which may occur as a result of either Bone marrow transplantation or Transfusion of group 'O' blood to 'A' or 'B' patient.
3. Rouleaux formation: It occurs in patients with abnormal Albumin/globulin concentration or in cord blood samples due to Whartons Jelly contamination.
4. Acquired antibodies i.e.
 Anti -A1 in A2 persons
 Anti -H in Bombay phenotype
 Cold auto - antibodies
 Unexpected allo-antibodies.

----- End of Report -----



233032024171218

Dr. Prerana Mondal
 MD (Path), WBMC-70606
 Consultant Pathologist

PATIENT NAME & ADDRESS

MRS. SHIKHA SARITA GUPTA

PATHOLOGY



DESUN

REFERENCE LAB

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 A Unit of Desun Healthcare & Research Institute Ltd.
 5-16, Phase-III, K. I. Estate, E. M. Bypass, Kolkata-700 107, India
 Phone No. : 033 40016355, 033 48006439
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 Website : www.desunpathology.com

BED NO : OPD

DRAWN : 23-03-2024
11:24 Hrs.RECEIVED : 23-03-2024
12:09 Hrs.REPORTED : 23-03-2024
15:51 Hrs.

PATIENT CODE 164618

OPD/IPD DOC NO OP40505353



2331470600

REFERRING DOCTOR

ACCESSION NO DHHI-3/2023-24/0018541

AGE 39 Yrs 11 Mths

SEX Female

TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
<i>Results relate only to the samples tested</i>			
Thyroid Profile - 1 (T3, T4, TSH)			
Triiodothyronine (T3) Specimen : Serum Methodology : Electrochemiluminescence	1.06	0.80 - 2.00	ng/mL
Thyroxine (T4) Specimen : Serum Methodology : Electrochemiluminescence	8.04	5.10 - 14.10	µg/dL
Thyroid Stimulating Hormone (TSH) Specimen : Serum Methodology : Electrochemiluminescence	4.09	Non-Pregnant : 0.27 - 4.20 Pregnant 1st Trimester : 0.10 - 2.5 2nd Trimester : 0.20 - 3.0 3rd Trimester : 0.30 - 3.0	µIU/mL

----- End of Report -----

Dr. Jayati Gupta

Ph.D (Bio.Chem)

PATIENT NAME & ADDRESS

MRS. SHIKHA SARITA GUPTA

CARDIOLOGY

DESUN
HOSPITAL
A NABH HOSPITAL

Desun More, E.M. Bypass, Kasba Golpark, Kolkata-700 107, Ph: 71 222 000, Fax: 2443 9003

REPORT DATE: 23.03.2024 Email: desun@desunhospital.com Website: www.desunhospital.com

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REGISTRATION NO. : 23.03.2024

OPD/BILL NO. : SD01/OPD/BILL/2023-24/OP40505353

REGISTERING DOCTOR :

REGISTRATION NO. : R/DHHI-1/2023-24/0015447

PATIENT CODE : SD01/PAT/1000164618

AGE : 39 Yrs 11 Mths

SEX : F

REPORT OF ELECTROCARDIOGRAM

Standardization : 10 mm/mv.
 Rhythm : Regular/Sinus.
 Rate : 72 bpm
 QRS Axis : Normal.
 QRS : Normal.
 QTC : Normal.
 'P' Wave : Normal.
 P.R : Normal.
 QRS Complex : Normal.
 'Q' Wave : Absent.
 ST Segment : Isoelectric.
 'T' Wave : ↓ V1
 'U' Wave : Absent.
IMPRESSION : **SINUS RHYTHM.**



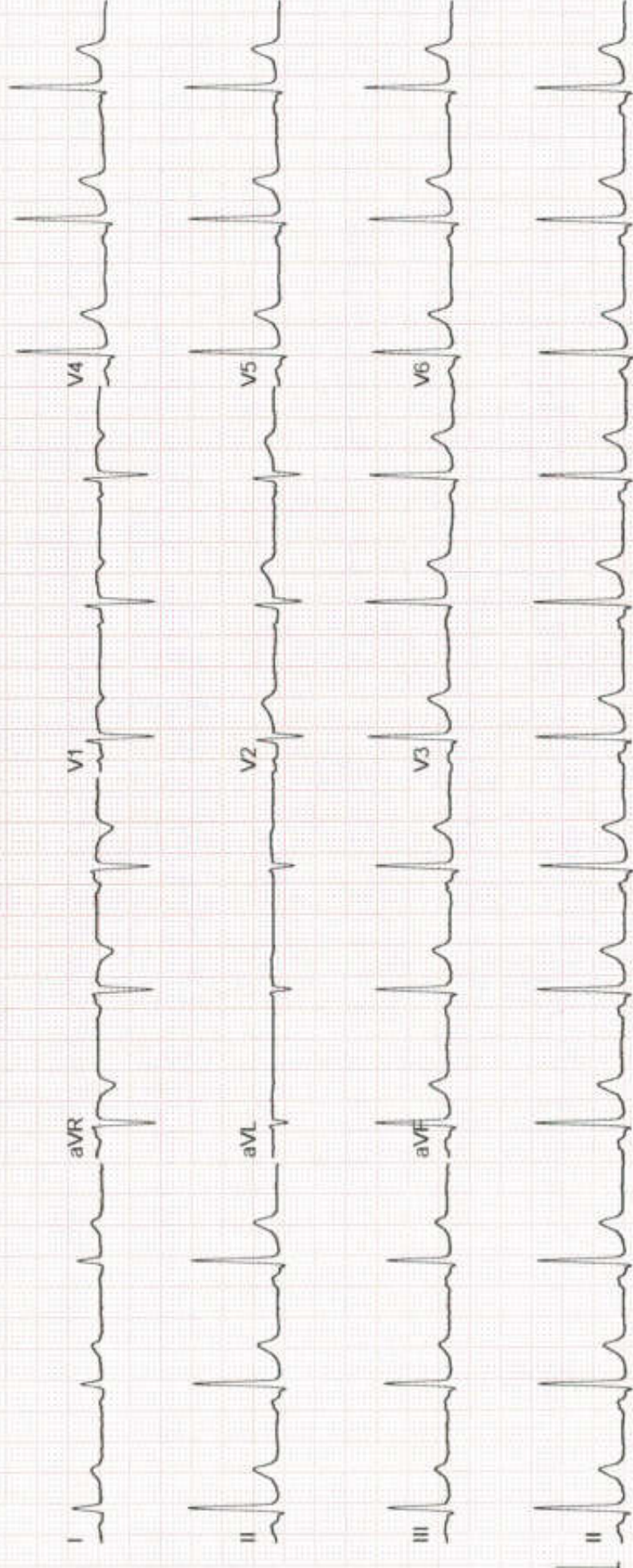
Dr. IMRAN AHMED KHAN

Reg No: 64336, MBBS
Dept. of Cardiac Science

Normal sinus rhythm
Normal ECG

QRS : 90 ms
QT / QTcBaz : 366 / 400 ms
PR : 136 ms
P : 102 ms
RR / PP : 836 / 833 ms
P / QRS / T : 69 / 74 / 60 degrees

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:



DESUN HOSPITAL & HEART INSTITUTE

Patient Details **Date:** 3/23/2024 **Time:** 1:37:27 PM
Name: SHIKHA SARITA GUPTA ID: 164618
Age: 39 y **Sex:** F **Height:** 156 cms **Weight:** 49 Kgs
Clinical History:

Medications:

Test Details

Protocol: Bruce **Pr.MHR:** 181 bpm **THR:** 162 (90 % of Pr.MHR) bpm
Total Exec. Time: 7 m 34 s **Max. HR:** 158 (87% of Pr.MHR)bpm **Max. Mets:** 10.20
Max. BP: 130 / 70 mmHg **Max. BP x HR:** 20540 mmHg/min **Min. BP x HR:** 5580 mmHg/min
Test Termination Criteria: TARGET HEART RATE ACHIEVED

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	2 : 47	1.0	0	0	108	120 / 60	-0.64 III	0.71 II
Standing	0 : 31	1.0	0	0	94	120 / 60	-0.64 III	0.71 V6
Hyperventilation	0 : 55	1.0	0	0	96	120 / 60	-0.32 III	1.06 V5
1	3 : 0	4.6	1.7	10	126	130 / 70	-0.85 III	1.42 V6
2	3 : 0	7.0	2.5	12	140	130 / 70	-1.06 III	1.24 V6
Peak Ex	1 : 34	10.2	3.4	14	158	130 / 70	-1.27 III	1.42 II
Recovery(1)	1 : 0	1.8	1	0	125	130 / 70	-0.96 III	1.95 II
Recovery(2)	1 : 0	1.0	0	0	109	130 / 70	-0.42 II	1.77 II
Recovery(3)	1 : 0	1.0	0	0	99	130 / 70	-0.64 aVF	1.06 V4
Recovery(4)	1 : 0	1.0	0	0	93	120 / 70	-0.64 II	0.71 V4
Recovery(5)	1 : 0	1.0	0	0	99	120 / 70	-0.53 II	0.53 II
Recovery(6)	1 : 0	1.0	0	0	98	110 / 60	-0.53 II	0.71 V6
Recovery(7)	0 : 3	1.0	0	0	98	110 / 60	-0.32 II	0.53 V6


Interpretation

- * Base line ECG shows within normal limits.
- * No chest pain or Significant ST- T changes noted.
- * Normal heart rate and blood pressure response.
- * Good exercise tolerance.
- * Bruce Protocol used.
- * THR achieved.
- * No significant arrhythmia detected during exercise & recovery.
- * No significant ST-T changes noted during exercise & recovery.
- * Stress test is NEGATIVE for provokable myocardial ischaemia.

*Please correlate clinically & further investigations are suggested if clinically indicated.

Ref. Doctor: SELF

(Summary Report edited by user)


DR. MIRAN AHMED KHAN
 REG. NO. 94336 (WBMC)
 DEPT. OF CARDIAC SCIENCE
 DESUN HOSPITAL

Doctor: DR I A KHAN

(c) Schiller Healthcare India Pvt. Ltd. V 4.12

PATIENT NAME & ADDRESS

RADIOLOGY

MRS. SHIKHA SARITA GUPTA



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PROCEDURE DONE ON : 23.03.2024
 OPD / IPD DOC NO : SD01/OPD/BILL/2023-24/OP40505353
 REFERRING DOCTOR :
 ACCESSION NO : R/DHHI-1/2023-24/0015458

REPORTED : 23.03.2024
 PATIENT CODE : SD01/PAT/1000164618
 AGE : 39 Yrs 11 Mths
 SEX : F

(US-13130) USG OF WHOLE ABDOMEN

LIVER

Shows normal homogeneous echotexture. Intrahepatic biliary ducts and hepatic vein tributaries are not dilated. No obvious focal lesion seen.

GALL BLADDER

Physiologically distended. Wall thickness is normal. No evidence of any intraluminal lesion seen.

C.B.D.

Normal for age. No obvious intraluminal lesion seen in visible parts.

PORTAL VEIN

Normal for age.

PANCREAS

Normal in size, shape and echotexture. No obvious focal lesion or intraparenchymal calcification seen. Main pancreatic duct is not dilated. No peripancreatic fluid collection seen.

SPLEEN

Spleen is normal in size, shape and echotexture. No focal lesion seen. Spleno-portal axis is normal.

KIDNEYS

Both the kidneys are normal in size, shape and axis. Cortical echotexture and cortico-medullary differentiation are normal in both sides. No evidence of any focal lesion seen in either kidneys. No hydronephrosis detected.

URETERS

Pelvi-ureteric junction and vesico-ureteric junctions are normal. No obvious intraluminal lesion seen in visible part.

URINARY BLADDER

Optimally distended, normal in shape and wall thickness. No evidence of any intraluminal lesion seen.

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 SEX : F

UTERUS

anteverted and anteflexed. Endometrial thickness is normal. Hypoechoic lesion noted in right posterior lateral wall of body of Uterus suggestive of fibroid, measuring (3.0 x 4.1 x 2.6) cm.

OVARIES

Normal in size, shape and echopattern. No focal cystic or solid lesion seen.

No adnexal or pelvic SOL seen.

Pouch of Douglas - Clear.

RETROPERITONEUM

No obvious sonological evidence of any retroperitoneal mass lesion or lymphadenopathy seen in visible part. Aorta and I.V.C. appear normal.

PERITONEUM

No free fluid seen in the peritoneal cavity. Mesenteric echogenicity appears normal.

LOWER PLEURAL SPACES

No free fluid seen.

R.I.F.

No obvious mass lesion / localised collection seen.

IMPRESSION:

* Fibroid in uterus.

Dr. DINESH JAIN

WBMC-70597

MD, DNB (Radiology), EDIR, FRCR

Patient Name:	SHIKHA SARITA GUPTA 39Y OPD	Study Date/Time:	23-03-2024 11:42 AM
Sex/Age/Modality:	O/39Y/CR	Report Date/Time:	23-03-2024 02:37 PM
Patient ID:	21001	Report:	CHEST PA
Ref. Physician:	DESUN HOSPITAL & HEART INSTITUTE, KOLKATA	Report ID:	1302719D1385

CHEST X-RAY PA VIEW

Both lung fields are clear.

Both hilar shadow appears normal.

C. P. angles are clear.

C-T ratio appears normal.

Bony thorax appears normal.

IMPRESSION: Normal study.

Clinical correlation and further investigation suggested.

Apurba Kumar Majhi

Dr. Apurba Kumar Majhi
MBBS, MD Radio-diagnosis
Consultant Radiologist
Reg no- WBMC-73132





NAME - Mrs. Shekha Sarita Gupta
AGE - 39Y, F
DATE - 23/03/24

Refraction Done.
Ach.

RE \rightarrow -0.75 DCyl \times 90 $^{\circ}$ \downarrow 6/6
LE \rightarrow -0.25 DCyl \times 90 $^{\circ}$ \downarrow 6/6

For constant use

Dr. Soumyadeep Majumdar
MBBS, MD
Reg. No. 68358-WBMC
Department of Ophthalmology
23/03/24





Name : Mrs. Shikha Sanita Gupta

Date : 23.03.24

U / Doctor : Dr. Snehamanti Bag

Age : 39Y Sex : F

Doctor's Prescription

Rx

c/o itching
in right ear
x 8 to 10 days

Known
allergic
rhinitis

c/o right
side throat
pain mainly
in the lower

Ears :-
- B/L TM Disturbance
Mild (right) (+)
R/L (A) (-)

Oral cavity
Candida (+)
Oral cavity
Candida (+)
Oral cavity
Candida (+)



→ Stop ear-picking

→ Blood for ESR,
Complete allergy profile

→ Xray C/S spine AP
Lateral

→ SUNFAZ SD cream
apply locally twice daily
B/L EAC x 10 days.

→ DUONASE nasal spray
1 puff twice daily
each nasal cavity
x 2 weeks

→ SOLSPRE nasal spray
1 puff twice daily
each nasal cavity x 2 weeks

→ Ref for dental
opinion

1.3.24
23-03-24



Dr. Sreemanti Bag
MBBS, MS
Reg. No. - 73853 WBMC
Department of ENT
Desun Hospital

To,
Desun Hospital
Kolkata

23/03/2024

I do here by declare that I have
not done dental & prosthodontic
work.

Patient name { Shikha Sarita Gupta }
Shikha Sarita Gupta
23rd March 2024
E.C. No. 79879
Bank of Baroda