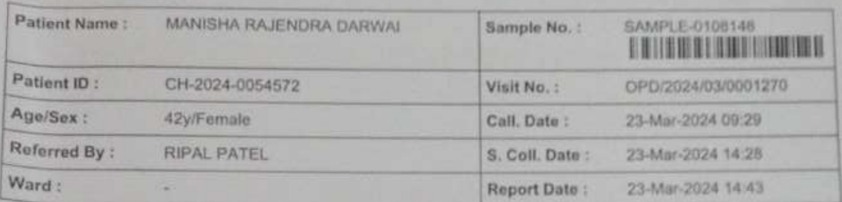
DARWAI 42Y/F CHEST PA

Ref. By. DR. H/C

HOSPITAL , CHANGA .



CHARUSAT HOSPITAL

Patient Name :	MANISHA RAJENDRA DARWAI	Sample No. :	SAMPLE-0108146
Patient ID :	CH-2024-0054572	Visit No. :	OPD/2024/03/0001270
Age/Sex :	42y/Female	Call. Date :	23-Mar-2024 09:29
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 14:28
Ward :	-	Report Date :	23-Mar-2024 14:43

PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	97.2 mg/dl [LOW]	100 - 140

DR. NAITIK BHATIA
CONSULTANT PATHOLOGIST
(M.B.B.S,D.C.P)

DR. KETAN KAPADIA
CONSULTANT PATHOLOGIST
(M.B.B.S,M.D)

CHARUSAT HOSPITAL

DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR	INVESTIGATION
23-03-2024	MANISHA DARWAI	42	F	BODY PROFILE	x-ray

X-ray CHEST PA view.

No evidence of abnormality seen involving both lungs.Costophrenic sinuses are clear.

Hilar shadows show evidence of normal size , position & opacity.

Aortic shadow show evidence of normal position & Size.Cardiac size & position is normal.

Domes of diaphragm & bony cage show no evidence of abnormality.

COMMENTS:

NO ABNORMALITY DETECTED

Thanks for reference
DR KIRTI C THAKKAR
M.B.B.S,D.M.R.D

CHARUSAT Campus, Changa, District Anand 388 421 (Guj) India. Ph # +91-2697-265500/02/04 • Mobile : 95379 27873 / 75748 38111
Web : www.ch-rf.org / www.charusathospital.org • E-mail : chrf@charusat.ac.in

CHARUSAT

DATE	PATIENT NAME	AGE IN YEARS	SEX	REF...
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

USG OF THE ABDOMEN/ PELVIS WAS

The liver is normal in size and echotexture
The intra hepatic biliary radicles are norm
The gall bladder is well distended with no

The pancreas reveals a normal echopattern
neoplasm. The spleen reveals a normal son

Both kidneys are normal in size and echote
medullary differentiation is noted. No evide

No free fluid or lymphadenopathy is seen.
The urinary bladder is well distended with n

The uterus is anterverted, normal size.
The endometrium is in the midline. No focal
Both the ovaries are nomal in size and shape

No adnexal abnormality is seen.
No free fluid is seen in the pouch of douglas.
Size in CM.

Right Kidney	Left Kidney
9.8x2.96	9.77x4.94

IMPRESSION :

NO ABNORMALITY DETECTED.

Thanks for reference
DR KIRTI C THAKKAR
M.B.B.S,D.M.R.D

CHARUSAT HOSP

USG OF THE ABDOMEN/ PELVIS WAS PERFORMED

The liver is normal in size and echotexture. No focal solid or cystic lesions are seen. The intra hepatic biliary radicles are normal. The portal vein and CBD are normal. The gall bladder is well distended with no calculi or polyp. The wall is not thickened.

The pancreas reveals a normal echopattern, with no focal calcification or a neoplasm. The spleen reveals a normal sonographic features.

Both kidneys are normal in size and echotexture. Evidence of good cortico medullary differentiation is noted. No evidence of any calculi or hydronephrosis.

No free fluid or lymphadenopathy is seen.
The urinary bladder is well distended with no calculi or polyps.

The uterus is anterverted, normal size.
The endometrium is in the midline. No focal myoma is seen.
Both the ovaries are nomal in size and shape. No focal solid or cystic lesion is seen.

No adnexal abnormality is seen.
No free fluid is seen in the pouch of douglas.

Size in CM.

Right Kidney	Left Kidney
9.8x2.96	9.77x4.94

IMPRESSION :

NO ABNORMALITY DETECTED.

Thanks for reference

CHARUSAT HOSPITAL

Patient Name :	MANISHA RAJENDRA DARWAI	Sample No. :	SAMPLE-0108129
Patient ID :	CH-2024-0054572	Visit No. :	OPD/2024/03/0001270
Age/Sex :	42y/Female	Call. Date :	23-Mar-2024 09:29
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 10:08
Ward :	-	Report Date :	23-Mar-2024 13:34

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	11.5 gm/dl [LOW]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	4.14 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	5550 /c.mm [NORMAL]	4000 - 10000

Platelet count

Investigation	Result	Normal Value
Platelets	1.79 Lakh/cmm [NORMAL]	1.5 - 4.5

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	58 % [NORMAL]	40 - 70
Lymphocytes	35 % [NORMAL]	20 - 40
Eosinophils	01 % [NORMAL]	1 - 6
Monocytes	06 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	18.5 mg/dl [NORMAL]	15 - 40

S.Creatinine

CHARUSAT HOSPITAL

Patient Name :	MANISHA RAJENDRA DARWAI	Sample No. :	[illegible]
Patient ID :	CH-2024-0054572	Visit No. :	[illegible]
Age/Sex :	42y/Female	Coll. Date :	23-Mar-2024 [illegible]
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 [illegible]
Ward :	-	Report Date :	23-Mar-2024 [illegible]

Investigation	Result	Normal Value
Serum Creatinine	0.70 mg/dl [LOW]	Male : 0.9 to 1.5 mg/dl Female : 0.8 to 1.2 mg/dl

BUN

Investigation	Result	Normal Value
BUN :	09 [NORMAL]	8.0 to 23.0 (mg/dl)

URIC ACID

Investigation	Result	Normal Value
Serum Uric Acid	3.13 mg/dl [NORMAL]	Male : 2.5 to 7.5 Female : 1.5 to 6.0

ESR

Investigation	Result	Normal Value
ESR - After One Hour	10 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

Blood Group

Investigation	Result	Normal Value
ABO :	A	
Rh :	Positive	

FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar :	87.8 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	125.5 mg/dl	

CHARUSAT HOSPITAL

Patient Name :	MANISHA RAJENDRA DARWAI	Sample No. :	SAMPLE-0108129
Patient ID :	CH-2024-0054572	Visit No. :	OPD/2024/03/0001270
Age/Sex :	42y/Female	Call. Date :	23-Mar-2024 09:29
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 10:08
Ward :	-	Report Date :	23-Mar-2024 13:34

Hb A 1c	6.0 %	> 8 : Action Suggested 7-8 : Good Control < 7 : Goal 6-7 : Near Normal Glycemia < 6 : Non-diabetic Level

Comments

Hb A1C also know asGlycosylated Haemoglobin is the most important test for the assessment of longterm Blood glucose control (also called glycemic control).
Hb A1C reflects mean glucose concentration over past 69-8 week and provides a much better indicationn of longterm glycemic contril than blood glucose determination.
This Reaction is irreverdible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications).
nephropathy(Kidney-complications) & neuropathy(never complications) are potentially serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.

TSH

Investigation	Result	Normal Value
TSH :	3.19 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3

Investigation	Result	Normal Value
T3-Triodothyronine :	1.43 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

T4

Investigation	Result	Normal Value
T4-thyroxine :	75.8 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

LIPID PROFILE

Investigation	Result	Normal Value

CHARUSAT HOSPITAL

Patient Name :	MANISHA RAJENDRA DARWAI	Sample No. :	SAMPLE-0108129
Patient ID :	CH-2024-0054572	Visit No. :	OPD/2024/03/0001270
Age/Sex :	42y/Female	Coll. Date :	23-Mar-2024 09:29
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 10:08
Ward :	-	Report Date :	23-Mar-2024 13:34

Investigation	Result	Normal Value
Serum Cholesterol (Chol) :	124.9 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	62.8 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	56.2 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	43.72 mg/dl	
VLDL :	24.98 mg/dl [NORMAL]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	0.78 - [NORMAL]	< 3.5
TC / HDL Ratio :	2.22 - [LOW]	4.0 to 6.0
LDL (DIRECT) :	65.6 mg/dl [Optimal]	< 100.0 (Optimal), 100.0 to 120.0 (Near Optimal), 130.0 to 159.0 (Border line high), 160.0 to 189.0 (High), > 190.0 (Very high)

LIVER FUNCTION TEST

Investigation	Result	Normal Value
Total Bilirubin :	1.20 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.30 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	12.2 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	10.2 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	48.4 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0

CHARUSAT HOSPITAL

Patient Name :	[illegible]	Sample No :	[illegible]
Patient ID :	[illegible]	Visit No :	[illegible]
Age/Sex :	[illegible]	Coll. Date :	[illegible]
Referred By :	[illegible]	R. Coll. Date :	[illegible]
Ward :	[illegible]	Report Date :	[illegible]

Total Protein (TP) :	[illegible] gm/dl	[illegible]
Albumin (ALB) :	[illegible] gm/dl	[illegible]
Indirect Bilirubin (BIL) :	[illegible]	[illegible]
Globulin :	[illegible] gm/dl	[illegible]
A/G Ratio :	[illegible]	

URINE R & M

Investigation	Result	Normal Value
Physical Examination :		
Quantity :	20 ml	
Colour :	Pale Yellow	
Appearance :	Clear	
Odour :	[illegible]	
Reaction :	Acidic	
Specific Gravity :	[illegible]	
Chemical Examination :		
Albumin :	Absent	
Sugar :	Absent	
Bile Salts :	Absent	
Bile Pigments :	Absent	
Acetone :	Absent	
Urobilinogen :	Absent	
Microscopic Examination :		
Pus Cells :	[illegible]	
RBCs :	Absent	
Epithelial cells :	[illegible]	

CHARUSAT HOSPITAL

Patient Name :	MANISHA RAJENDRA DARWAI	Sample No. :	SAMPLE-0108129
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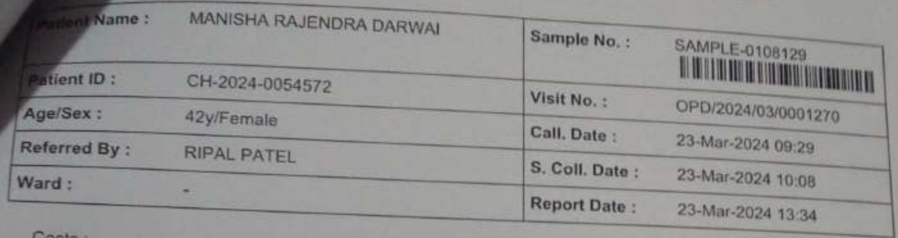
Ward :	-	Report Date :	23-Mar-2024 13:34

Casts : Absent -

Crystals : Absent -



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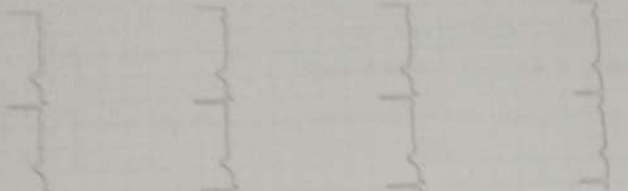


CHARUSAT HOSPITAL

Care with compassion...

CHARUSAT HEALTHCARE & RESEARCH FOUNDATION

CHARUSAT Campus.Changa.District ANAND 388421 (GUJ) India. Ph No. +91-2697-265502

Receipt

Receipt No. : 2024/03/0019081 Patient ID : CH-2024-0054572
Visit : OPD/2024/03/0001270 (OPD) Bill No. : OPD/2024/03/0014904
Name : MANISHA RAJENDRA DARWAI
Pay Mode : Cash

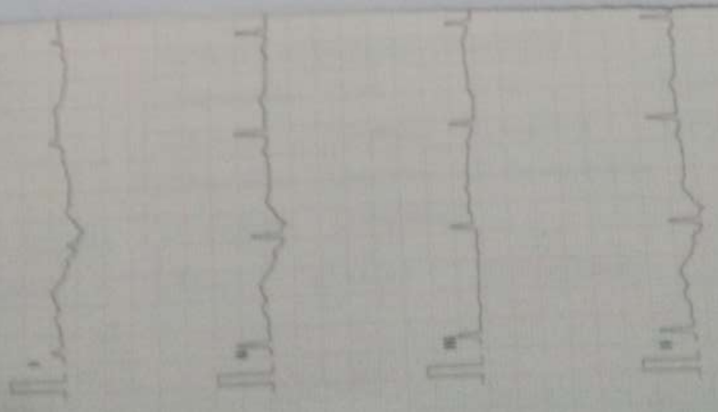
Date : 23-Mar-2024 14:03

Sr	Particulars	Amount(Rs)
1	Advance Patient Payment	400.0
	Total	400.0

(Four Hundred Only)

Generated By : (KRUNAL VYAS)

For, Changa



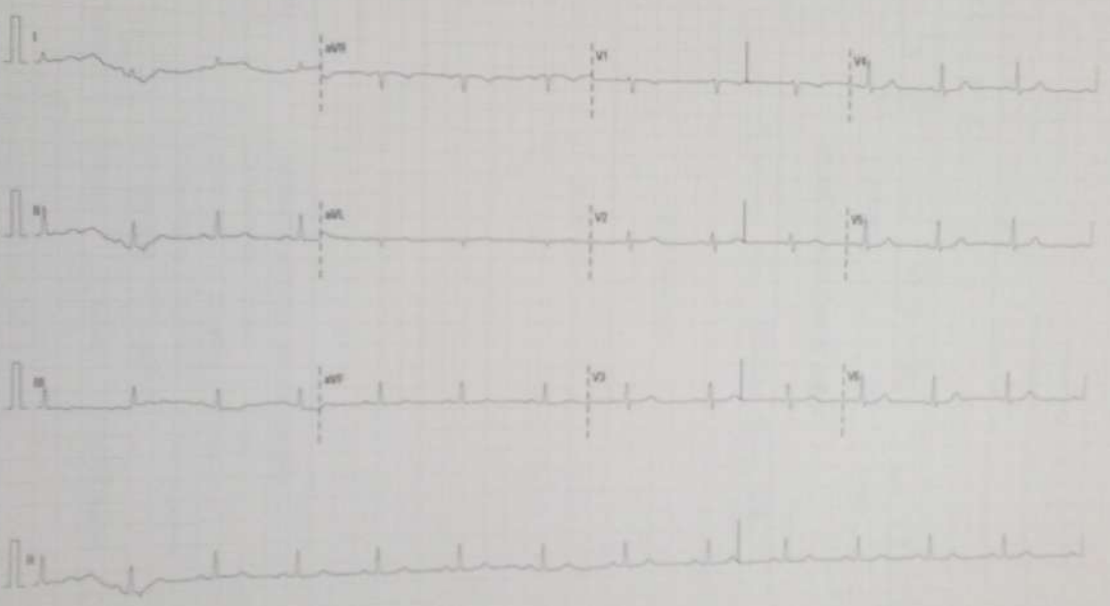
ID: 0054572
Name: Dorwa, Manisha
Age: 42 Years
Gender: Female

23-03-2024 09:[illegible] M

Vent. Rate	79 bpm	Sinus rhythm
PR Interval	134 ms	
QRS Duration	70 ms	
QT/QTc Interval	346/379 ms	
P/QRS/T Axes	57/71/42 deg	

QTc:Hodges

Unconfirmed Diagnosis



25 mm/s 10 mm/mV 50 Hz ~ BSR 25 Hz CHARUSAT HOSPITAL

LALITABEN P.D. PATEL OPD SERVICES
REGISTRATION FORM (OPD)

Dr. Jainish

Date & Time : 23/3/24

Registration No. :

Name : Manisha D. Desai

Age : 42 Sex : F

Address :

B.P. :

Pulse :

Weight :

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : Came for Health check up

CASE ANALYSIS

Past History : NAD

Present History :

G/E Vitals :

Systemic Examination :

FAMILY HISTORY :

- ☐ Diabetes
- ☐ IHD
- ☐ Hypertension
- ☐ Others (Specify) :

PATIENT'S MEDICAL/OTHER HISTORY :

- ☐ Hypertension ☐ IHD ☐ T.B. ☐ Jaundice
- ☐ Epilepsy ☐ Asthma ☐ Hepatitis B ☐ Hepatitis C
- ☐ Food Allergy ☐ AIDS/HIV ☐ Bleeding Disorder
- ☐ Drug Allergy ☐ Pregnancy

HABBITS : ☐ Smoking ☐ Alcohol ☐ Tobacco ☐ Others (Specify) :

CHARUSAT HOSPITAL

DENTAL REGISTRATION FORM

Date & Time : 23/3/24
Registration No. : CH-2024-0054572

Name : Manisha Dorwai
Age : 42
Sex : F

Contact No. :
Emergency Contact No. :
Address :

OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine checkup.

Family History :

- ☐ Diabetes
- ☐ Hypertension
- ☐ IHD
- ☐ Others (Specify) :

Habits : ☐ Tobacco

- ☐ Hypertension
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Bleeding Disorder
- ☐ Smoking

Medical/Other History :

- ☐ IHD
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Pregnancy
- ☐ Other (Specify) :
- ☐ T.B.
- ☐ Hepatitis B
- ☐ Food Allergy
- ☐ Others (Specify) :
- ☐ Jaundice
- ☐ Hepatitis C
- ☐ Drug Allergy

સંમતિ પત્રક

હું .... ડોક્ટરને મારી સારવાર કરવાની મંજૂરી આપુ છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ફાયદા-ગેરફાયદા, દવાની કે ઇંજેક્શનની આડ અસર અને સારવારની સફળતા, નિષ્ફળતા વિશે મને તથા મારા સંબંધીઓને સમજૂતી આપેલ છે. મેં ડોક્ટરને મારી શારીરિક સ્થિતિ તથા તેને લગતી દવા વિશે સંપૂર્ણ માહિતી આપેલ છે. જો કોઈપણ સંજોગોમાં સારવાર અધૂરી છોડીશ કે અનિયમિત રહીશ તો તેની નિષ્ફળતા માટે ડોક્ટર કે ચારુસેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની ડિપોઝીટ પેટે અપાયેલ રકમ મેળવવા માટે હક્કદાર રહીશ નહીં. આ સંમતિ હું સ્વેચ્છાએ કોઈપણ દબાણ વગર આપું છું.

તારીખ :
સમય :

દર્દી / સગાની સહી

CONSENT

I .... hereby request and authorize Doctor .... to perform the required dental treatment. Doctor has informed me and my relatives about the treatment plan in details with success and failure of the treatment with all expenditure, possible complications from medicines or local anesthesia. I have informed the Doctor about my medical history and drug history in details. If in any circumstances, I am irregular or leave the treatment in between, the doctor and CHARUSAT Hospital will not be responsible for the same and treatment charges will not be returned back.

I give my consent to proceed with my dental treatment.

Date :
Time :

Patient's / Relative's Sign.

Investigation Advised :

Final Diagnosis : Calculus

Treatment Plan : Scaling.

Date : 23/3/24
Time :

Name of Doctor : Dr. Bhashwati
Signature :

CHA/DENTAL/5016

OPHTHALMIC REGISTRATION FORM

Reg. No.: 0424-44592 (?)
Date: 23/3/24

Patient's Name: Manisha Dorwni Age: 62

Address:

Telephone No.: Mobile No.:

Referred by / Care of:

Profession: Banker

Type or work in daily routine: Driving / Watching TV / Computer / Reading /

History / Complain of: Diminution of vision / Pain / Watering / Redness / Earache / Headache / Itching / Stickiness / Swelling / Irritation / Burning / F. B. Sensation / Photophobia / Diplopia / Squinting / Blackout / Floaters / Flashes / Injury /

Routine checkup.

Eye involve: RE / LE / BE Duration:

Ophthalmic History: Surgery / Laser / PRK / DCR / Glaucoma / RP / Corneal Opacity / Injury / Amblyopia /

Treatment:

Any Surgery: Cataract / Glaucoma / ____ / RE / LE / BE

Family History: Glaucoma / RP / DM / — None —

SYSTEMIC: DM / HT / IHD / COPD / PROSTATE / ASTHMA / ALLERGY / SMOKING / ALCOHOL

— None —

EYE DETAILS:

	RE	LE
V/A with PH	6/6	6/6
IOP	10 mm Hg	9 mm Hg.
OWN GLASS:	near add only.	
AR:	-1.00 DSph.	+0.25/-0.25 x 90°

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
	SPH	CYL	AXIS	SPH.	CYL	AXIS
Dist	plano					
Nr						
Comp						

Bifocal / Distant / Near only / Constant / Progressive / Photocromatic

Remark:

Signature: [signature]

OPHTHALMIC REGISTRATION FORM

Reg. No. : CH2024-0045?2

Date : 23/3/24

Patient's Name : Manisha Dorwai Age : 42

Address :

Telephone No. : Mobile No. :

Referred by / Care of :

Profession : Banker

Type or work in daily routine : Driving / Watching TV / Computer / Reading /

History / Complain of : Diminution of Vision / Pain / Watering / Redness / Eyeache / Headache / Itching / Stickness / Swelling / Irritation / Burning / F. B. Sensation / Photophobia / Diplopia / Squinting / Blackout / Floaters / Flashes / Injury /

Routine check-up.

Eye Involve : RE / LE / BE Duration :

Ophthalmic History : Surgery / Laser / FFA / Oct / Glaucoma / RP / Corneal Opacity / Injury / Amblyopia / Treatment

Any Surgery : Cataract / Glaucoma / / RE / LE / BE

Family History : Glaucoma / RP / DM / — None —

SYSTEMIC : DM / HT / IHD / COPD / PROSTATE / WROID / ALLERGY / SMOKING / ALCOHOL

— None —

EYE DETAILS :

	RE	LE
V/A with PH	6/6.	6/6.
IOP	10 mm/Hg	9 mm/Hg.
OWN GLASS :	Near add only.	
AR :	-1.00 Dsph.	-0.25/-0.25 x 90°.

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	plano					
Nr.						
Comp						

Bifocal / Distant / Near only / Constant / Progressive / Photocromatic

CHRF/OPTH/5089

Remark :

Signature : [signature]