MEDICOVER HOSPITALS | KLE Belagavi

Place Label Here
Pt. Name :
UMR :
Age : Sex :
IP :
If lable not available, write Pt. Name, IP No., Sex, Date, Name of Treating Physician

OPD Nursing Assessment - Adult

Name: Milind Kalolikar Date of Birth : — Age/Sex: 50/M UMR No.: 20936

Assessment :

Height: 165 cms Weight: 72 kg. BMI: — Respiration: 20/min Pulse H/R : 68 /min

BP: 106/85 mmHG Temperature : — °F/°C SpO2 96 % BSL —

Chief Complaints : Health check up

Tick Appropriate :

Interpreter Needed ☐ Yes ☑ No

Nutritional Status: Weight Loss/Gain in Last 3 Months ☐ Yes ☑ No

If Weight Loss / ain-Dietary Referral ☐ Yes ☑ No

Psychological Assessment Agitated Anxious ☐ Yes ☑ No ☐ Normal

(If Agitated, Inform Physician) ☐ Irritable

Any Allergies Known Including Drugs : NO

Past History: Any Surgeris Explain : No

Any Other illness: Explain : No

Pain Score: Numerical Scales (1-10) — Location — Characteristics —

Need to be seen immediately by the Doctor — ☐ Yes ☑ No

Fall risk: Age 65Yrs. — Tremors — High Grade Fever — H/O Fall in last 3 months —

Cardiac Medicines — Seizure Medications — Fall Prevention Education Done —

Name of Nurse	ID No. of Nurse	Signature of Nurse	Date & Time
Nidhi	028002	N.	29/03/24

MEDICOVER HOSPITALS | KLE Pune

DEPARTMENT OF LABORATORY

Patient Name	: Mr. MILIND KALOLIKAR	**Age /Gender**	: 50 Y(s)/Male
Bill No/ UMR No	: PUBC20978/PUU20936	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:09 pm	**Report Date**	: 30-Mar-24 12:14 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals
CUE(COMPLETE URINE EXAMINATION)			
GENERAL EXAMINATION			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.005	1.010 - 1.030
PH		6.0	4.5 - 8.0
CHEMICAL EXAMINATION			
PROTEIN	Urine	ABSENT	ABSENT
GLUCOSE		ABSENT	ABSENT
BLOOD		ABSENT	ABSENT
LEUCOCYTES		NEGATIVE	NEGATIVE
UROBILINOGEN		NORMAL	NORMAL
KETONE		ABSENT	ABSENT
BILIRUBIN		NEGATIVE	NEGATIVE
NITRITE		NEGATIVE	NEGATIVE
MICROSCOPIC EXAMINATION			
PUS CELLS	Urine	0-1	0 - 5 /hpf
RBC		NIL	0 - 2 /hpf
EPITHELIAL CELLS		0-1	0 - 5 /hpf
CRYSTALS		NIL	ABSENT
CASTS		ABSENT	ABSENT
OTHERS		ABSENT	ABSENT

*** End Of Report ***

System Name : m

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MEDICOVER HOSPITALS | KLE Pune

DEPARTMENT OF LABORATORY

Patient Name	: Mr. MILIND KALOLIKAR	**Age /Gender**	: 50 Y(s)/Male
Bill No/ UMR No	: PUBC20978/PUU20936	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:33 pm	**Report Date**	: 30-Mar-24 12:14 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA Blood	14.4	13.1 - 17.2 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		6,430	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		195000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.90	4.5 - 6 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		40.7	40 - 50 %	Analogical integration
MCV		83.1	82 - 95 fl	Calculated
MCH		29.3	27 - 32 pg	Calculated
MCHC		35.3	32 - 36 g/dL	Calculated
RDW(cv)		12.3	11.5 - 14.0 %	Calculated
MPV		9.7	6 - 9.5 fl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	38.4	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		40.6	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		15.1	00 - 06 %	DHSS/Microscopy
MONOCYTES		5.3	00 - 10 %	DHSS/Microscopy
BASOPHILS		0.6	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA Blood	Normocytic Normochromic		
WBC morphology		Lymphocytic Predominance. Eosinophilia		
PLATELETS		Adequate On Smear		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" AB "		
RH TYPE		POSITIVE		SLIDE AGGLUTINATION
ESR		11	0 - 15 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

System Name : m

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. MILIND KALOLIKAR	Age /Gender	: 50 Y(s)/Male
Bill No/ UMR No	: PUBC20978/PUU20936	Referred By	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:40 pm	Report Date	: 30-Mar-24 12:14 pm

Parameters	Specimen	Result	Biological Reference In	Method

System Name : m

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MEDICOVER HOSPITALS | KLE Pune

DEPARTMENT OF LABORATORY

Patient Name	: Mr. MILIND KALOLIKAR	Age /Gender	: 50 Y(s)/Male
Bill No/ UMR No	: PUBC20978/PUU20936	Referred By	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:39 pm	Report Date	: 30-Mar-24 12:14 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.8	Normal < 5.7 Pre diabetic 5.7 - 6.5 Diabetic > 6.5 : 5.7 - 6.5	TINIA
SERUM CREATININE		0.95	0.8 - 1.3 mg/dL	Jaffe
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.85	0.1 - 1.2 mg/dL	Colorimetric diazo method
DIRECT BILIRUBIN		0.35	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.5	<= 1.0 mg/dL	
SGPT (ALT)		13.6	<= 41 U/L	Enzymatic
SGOT (AST)		19.1	<= 40 U/L	Enzymatic
ALKALINE PHOSPHATASE (ALP)		71	40 - 129 U/L	PNPP
TOTAL PROTEINS		6.91	6.4 - 8.3 g/dL	Method : Biuret method
SERUM ALBUMIN		4.66	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.25	1.8 - 3.6 g/dL	
A/G RATIO		2.07	1.1 - 2.2	
GAMMA GLUTAMYL TRANSFERASE(GGT)		16	10 - 71 U/L	Enzymatic colorimetric assay (IFCC)
LIPID PROFILE				
TOTAL CHOLESTEROL		189.9	Borderline High : 200 - 240 mg/dL High risk : > 240 mg/dL Desirable: : < 200 mg/dL	Enzymatic, Colorimetric Method
HDL CHOLESTEROL		46.8	Major risk factor for heart disease : : < 40 mg/dL Negative risk factor for heart disease : : > 60 mg/dL	Homogeneous enzymatic colorimetric assay
LDL CHOLESTEROL		127.04	Optimal : - < 100 mg/dL Near Optimal : 100 - 129 mg/dL Borderline High : 130 - 159 mg/dL High : 160 - 189 mg/dL Very High : - > 190 mg/dL	
VLDL		16.06	6 - 38 mg/dl	

System Name : m

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. MILIND KALOLIKAR	Age /Gender	: 50 Y(s)/Male
Bill No/ UMR No	: PUBC20978/PUU20936	Referred By	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:37 pm	Report Date	: 30-Mar-24 12:14 pm

Parameters	Specimen	Result	Biological Reference In	Method
SERUM TRYGLYCERIDES		80.3	Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL Normal : < 150 mg/dL	Enzymatic colorimetric test
CHO/HDL RATIO		4.06	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.71	2.5 - 3.5	
COMMENT		10-12 hours fasting is mandatory for Lipid profile parameters. If not ,Values may not be accurate.		
FBS (FASTING BLOOD SUGAR)				
FASTING BLOOD GLUCOSE		98.4	Normal Range : 70 - 99 mg/dL Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase
PPBS (POST PRANDIAL BLOOD SUGAR)				
PPBS (POST PRANDIAL BLOOD SUGAR)		92.6	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		1.19	0.8 - 2.0 ng/mL	Method : ECLIA
T4		9.08	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.31	0.27 - 4.2 uIU/mL	Method : ECLIA
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		10.7	7.0 - 21.0 mg/dL	Calculatead
SERUM URIC ACID		5.4	3.4 - 7.0 mg/dL	Enzymatic colorimetric test
PSA (PROSTATE SPECIFIC ANTIGEN).				
PROSTATE SPECIFIC ANTIGEN (PSA)		0.926	0 - 4.0 ng/mL	Method : ECLIA

*** End Of Report ***

System Name : m

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. MILIND KALOLIKAR	Age /Gender	: 50 Y(s)/Male
Bill No/ UMR No	: PUBC20978/PUU20936	Referred By	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:39 pm	Report Date	: 30-Mar-24 12:14 pm

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PATHOLOGIST
Pathology

Test results related only to the item tested.

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Patient ID:	PUU20936	Patient Name:	MILIND KALOLIKAR
Age:	50 Years	Sex:	M
Accession Number:	PUR20936 AK	Modality:	DX
Referring Physician:	HC	Study:	CHEST
Study Date:	29-Mar-2024		

X RAY CHEST PA VIEW

FINDINGS : Chest PA view with no comparison study shows.

- Visualized lung fields are clear.
- No obvious consolidation is seen.
- There is no pleural effusion or pneumothorax seen.
- No pneumoperitoneum is seen.
- The cardiac silhouette appears within normal limits.
- The diaphragmatic shadow and mediastinal structures are within normal limits.
- Visualized osseous structures demonstrate no obvious abnormality.

IMPRESSION :

- **No radiographically evident acute cardiopulmonary process in the present study.**

Dr. Amaya Mahajan
Consultant Radiologist
MBBS DMRD DNB

Date: 29-Mar-2024 19:06:06

DEPARTMENT OF RADIOLOGY

Patient Name : Mr. Milind Kalolikar	**Age : 50 yrs / M**
Ref. By : Health check up	**OPD/IPD No: PUU: 20936**
Date of USG:29/03/2024	**Date of Reporting: 29/03/2024**

USG ABDOMEN AND PELVIS

CLINICAL DETAILS: Routine screening.

FINDINGS:

Liver : It is normal in size and shape. It measures 131 mm along maximum craniocaudal axis. It shows raised parenchymal echotexture in both the lobes. No obvious focal lesion is seen. No evidence of intrahepatic biliary radicle dilatation. Common bile duct appears undilated. The hepatic veins and inferior vena cava appears unremarkable. The portal vein appears unremarkable.

Gall Bladder : It is partially distended. No evidence of obvious intraluminal calculus/ mass seen. No evidence of obvious wall thickening or pericholic collection.

Pancreas : It is well visualised. The head, body and tail appears normal in size and shows homogenous echotexture. The pancreatic duct appears undilated.

Spleen : is normal in size & shape. It measures 118 mm along its maximum length. It shows normal parenchymal echotexture. No obvious focal lesion is noted.

Kidneys : Right kidney measures 93 x 35 mm in size & Left kidney measures 102 x 38 mm in size. They appear normal in size, shape, location and axis. They show normal parenchymal echotexture with well maintained corticomedullary differentiation. No evidence of hydronephrosis on either side.No or calculus is noted on either side. ***A simple cortical cyst measuring 16 x 15 mm noted in inter-polar region of right kidney.***

Urinary Bladder: It is well distended. It shows smooth outlines and internal mucosal regularity with normal wall thickness. No obvious intraluminal calculus/focal lesion is seen.

Prostate : It is normal in size and shows homogenous echotexture. It measures 15 cc in volume. No obvious focal lesions / calcification / abnormal vascularity.

Retro peritoneum isobscured by bowel gases. No obvious enlarged retro peritoneal or mesenteric lymph nodes noted. The visualised bowel loops appear unremarkable. No evidence of obvious bowel wall thickening. No ascites seen.

IMPRESSION:

1. **Grade I fatty infiltration of liver.**
2. **Right renal simple cortical cyst.**

Clinical/ lab parameter correlation/ further evaluation and follow up recommended.

Dr. Sunita Shewale
Consultant Radiologist

(Because of technical and technological limitation complete diagnosis cannot be assured on imaging sonography. Sonography has its limitation for evaluation of GIT lesion. Clinical correlation, consultation if required repeat imaging required in the event of controversies.)

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Date:- 29/03/24.

Name:- Mr. Milind Kalolikar.

Age/Sex:- 50/M.

S/B: Ophthalmologist: Dr Kirti Mane

Eye	UCVA	PGVA	Pinhole	NEAR	COLOR VISION
Right	6/9	6/6 (+1.00)	>6/6.	N6	WNL
Left	6/9	6/6. (+0.75)		+2.00	

Other findings:-

Squint } no

Nystagmus } no

Night blindness:-

Impression:- Within normal limits

Eye exam is .

for desired fitness for work.

Dr K. Mane
9005705712708

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Mr. Milind Kalalikar

50/Male

H/o : ~~NAD~~ -

O/E :

8 | Impaction seen Adv OPG

~~upper~~ stain ++ calculi ++

- Scaling & Polishing

Dr. Roshani J. Kotian
B.D.S (NHDC)
Consultant General Dentist
Reg. : A-28340

Name: Milind Kalolikar
Age: 50 Years
Gender: Male

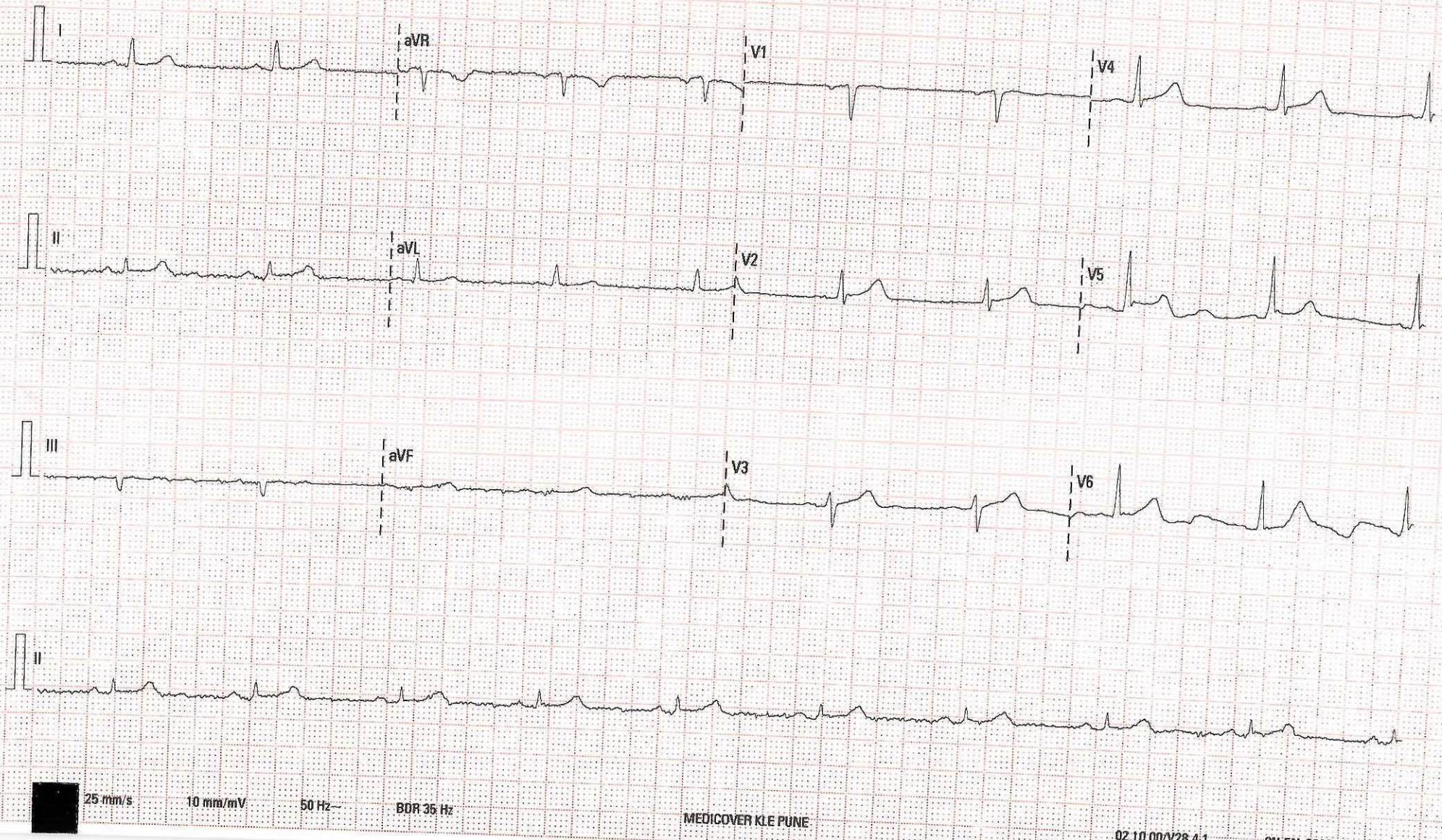
V Rate	57 bpm
PR Interval	160 ms
QRS Duration	86 ms
QT/QTc Interval	418/413 ms
P/QRS/T Axes	39/4/39 deg

QTc:Hodges

Sinus rhythm
Possible sequence error: V2,V3 omitted

Normal ECG

Unconfirmed Diagnosis



25 mm/s 10 mm/mV 50 Hz~ BDR 35 Hz

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02.10.00/V28.4.1 SN:FN-26035806