Apollo
TOUCHING LIVES

MEDICAL SUMMARY

Apollo Clinic
VASHI

NAME:	Mrs. Rita Sehgal	UHID:	
AGE:	55	DATE OF HEALTHCHECK:	30/12/2024
GENDER:	F		

HEIGHT:	149 cm.	MARITAL STATUS:	M.
WEIGHT:	58.7 kg	NO OF CHILDREN:	1
BMI:	26.4		

C/O:

K/C/O:

PRESENT MEDICATION: - NAD

P/M/H: GERD - DCA 2023

P/S/H:

ALLERGY:

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

ALCOHOL: } NAD

TOBACCO/PAN:

FAMILY HISTORY FATHER: } NAD

MOTHER:

O/E:

LYMPHADENOPATHY:

BP: 110/60 mmHg PULSE: 70/min

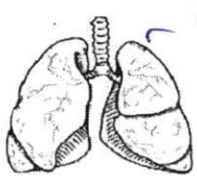
PALLOR/ICTERUS/CYNOSIS/CLUBBING: } NAD

TEMPERATURE: N SCARS:

OEDEMA:

S/E:

RS: - AE-B E



P/A: - NAD

CVS: S1 S2 A

Extremities & Spine: - NAD

CNS: Conscious, Oriented

ENT:

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: Rita Sehgal	Age: 55y	Date of Health check-up: 30/03/2024

Findings and Recommendation:

Findings:-

Mammography Rpt (P)

Thyroid deranged (P)

Recommendation:-

- Repeat Thyroid
- S4 rf

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 : 30/3/24

Name : Mrs Rita Age : 55 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 N6 Left Eye N6

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	+0.50					+0.5				
Near	+2.75					+2.75				

Presbyopia Pres

Colour Vision : NAD

Anterior Segment Examination : NAD / BC

Pupils : _____

Fundus : _____

Intraocular Pressure : 12 mm Hg

Diagnosis : _____

Advice : _____

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

Dr. _____
(Consultant Ophthalmologist)

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

Apollo Clinic, Licensee : **M/s. Indira Health & Lifestyle Pvt. Ltd.,** "The Emerald", Plot No. 195/B, Sector 12, Besides Neel Siddhi Towers, Vashi, Navi Mumbai - 400703. **Tel.:** (91-22) 2788 1322 / 23 / 24 82914 90000 Email: apolloclinicvashi@gmail.com

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DENTAL CHECKUP

Name:	Rita Sehgal.	**MR NO:**	
Age/Gender :	55/F	**Date:**	30/3/24

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 - 1200.

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Name : Mrs Rita Sehgal Age : 55 Sex : F UHID No. : Date : 30/03/2024

55 years / P,4 (LSCS)

postmenopausal : 8 years.

G/C fair

Afebrile

P - 72/min

No complaints

P/A - soft NT

P/S - Cx } healthy
VS }

(PAP smear taken)

Dr.

Apollo Clinic
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Apollo
TOUCHING LIVES

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

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MC-2364
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Apollo Clinic VASHI

Name	: Mrs. Rita Sehgal	Gender	: Female	Age	: 55 Years
UHID	: FVAH 11206.	Bill No	:	Lab No	: V-3622-23
Ref. by	: SELF	Sample Col.Dt	: 30/03/2024 08:33		
Barcode No	: 4100	Reported On	: 30/03/2024 15:20		

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)			
Haemoglobin(Colorimetric method)	12.6	g/dl	11.5 - 15
RBC Count (Impedance)	**3.92**	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	38.9	%	35 - 55
MCV:(Calculated)	**99.2**	fl	78 - 98
MCH:(Calculated)	32.2	pg	26 - 34
MCHC:(Calculated)	32.4	gm/dl	30 - 36
RDW-CV:	12	%	10 - 16
Total Leucocyte count(Impedance)	5720	/cumm.	4000 - 10500
Neutrophils:	54	%	40 - 75
Lymphocytes:	40	%	20 - 40
Eosinophils:	04	%	0 - 6
Monocytes:	02	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.48	Lakhs/c.mm	1.5 - 4.5
MPV	8.8	fl	6.0 - 11.0
ESR(Westergren Method)	15	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Macrocytosis(Mild)		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

Vasanti Gondal
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:	**:B:**
Rh Type:	**Positive**
Method :	Matrix gel card method (forward and reverse)
------	----------

Dilpreetkaur S Singh
Entered By

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	96	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 :	86	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		

Pooja Surve
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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin :	5.6	%	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 :	114.02	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

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LIPID PROFILE - Serum			
S. Cholesterol(Oxidase)	190	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	81	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	16.2	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	60.2	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	113.6	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	**3.2**		3.5 - 5
Ratio of LDL/HDL	**1.9**		2.5 - 3.5

Alsaba Shaikh
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LFT(Liver Function Tests)-Serum

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
S.Total Protein (Biuret method)	7.84	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.44	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.4	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.31		0.9 - 2
S.Total Bilirubin (DPD):	0.36	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.13	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.23	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):	12	U/L	5 - 33
S.Alk Phosphatase(pNPP-AMP Kinetic):	76	U/L	35 - 105
S.GGT(IFCC Kinetic):	13	U/L	07 - 32

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Ref. by	: SELF	Sample Col.Dt	: 30/03/2024 08:33		
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P

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	20.5	mg/dl	10.0 - 45.0
BUN (Calculated)	9.56	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.57	mg/dl	0.50 - 1.1
BUN / Creatinine Ratio	16.77		9:1 - 23:1
S.Uric Acid(Uricase Method)	4.9	mg/dl	2.4 - 5.7

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Name	: Mrs. Rita Sehgal	Gender	: Female	Age	: 55 Years
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
	Thyroid (T3,T4,TSH)- Serum		
Total T3 (Tri-iodo Thyronine) (ECLIA)	**1.22**	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	**58.89***	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	1.45	□IU/ml	Euthyroid :0.35 - 5.50 □IU/ml Hyperthyroid : < 0.35 □IU/ml Hypothyroid : > 5.50 □IU/ml
Remarks:	*** Rechecked & confirmed. Kindly Correlate Clinically**		
	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	Clear		Clear
SEDIMENT	Absent		Absent
CHEMICAL EXAMINATION(Strip Method)			
REACTION(PH)	6.5		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	Occasional		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	1 - 2 / hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

Anushka Chavan
Entered By

Ms Kaveri Gaonkar
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Chief Pathologist

End of Report
Results are to be correlated clinically

Rita, Sengal
11206

Female

55 Years

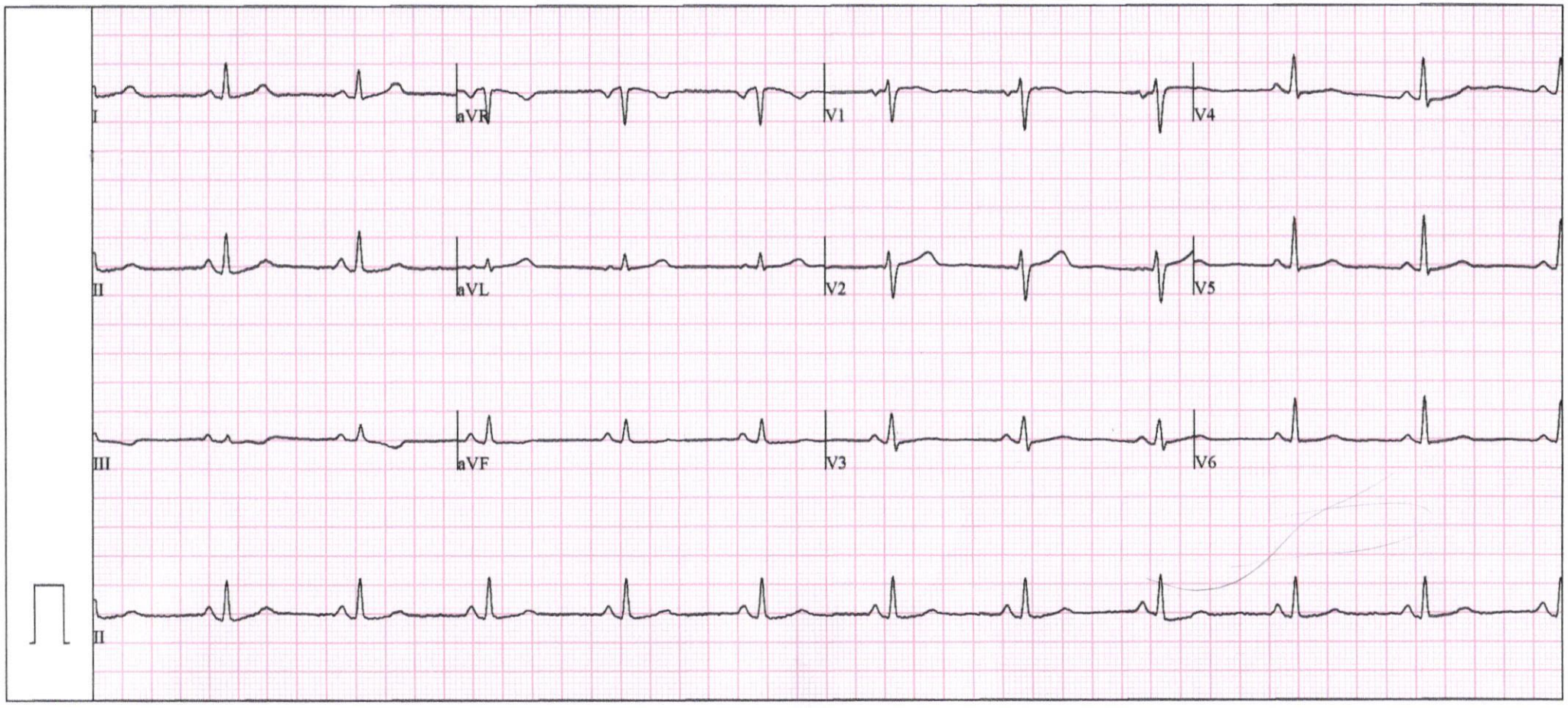
30.03.2024 9:12:53
Apollo Clinic
1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703.

66 bpm
-- / -- mmHg

NORMAL ECG

QRS :	76 ms	Normal sinus rhythm
QT / QTcBaz :	382 / 400 ms	Normal ECG
PR :	134 ms	
P :	118 ms	
RR / PP :	904 / 909 ms	
P / QRS / T :	50 / 45 / 10 degrees	

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



Unconfirmed

GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz 4x2.5x3_25_R1 1/1

Apollo Clinic
The Emerald, Plot No-195/B, Sector-12,
Neel Siddhi Towers, Vashi-400703

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: RITA, SEHGAL
Patient ID: 11206
Height:
Weight:

DOB: 12.10.1968
Age: 55yrs
Gender: Female
Race: Asian

Study Date: 30.03.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR.ANIRBAN DASGUPTA
Technician: Anita Gaikwad

Medications:
NIL

Medical History:
NIL

Reason for Exercise Test:
Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:07	0.00	0.00	69	100/70	
	STANDING	00:15	0.00	0.00	70		
	HYPERV.	00:15	0.00	0.00	71		
	WARM-UP	00:08	0.00	0.00	72		
EXERCISE	STAGE 1	03:00	1.70	10.00	121	110/80	
	STAGE 2	03:00	2.50	12.00	130	130/80	
	STAGE 3	00:40	3.40	14.00	141	140/90	
RECOVERY		01:06	0.00	0.00	101	160/90	

The patient exercised according to the BRUCE for 6:40 min:s, achieving a work level of Max. METS: 9.00. The resting heart rate of 70 bpm rose to a maximal heart rate of 144 bpm. This value represents 87 % of the maximal, age-predicted heart rate. The resting blood pressure of 100/70 mmHg , rose to a maximum blood pressure of 160/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions
TMT IS NEGATIVE FOR INDUCIBLE MYOCARDIAL ISCHAEMIA AT THE WORKLOAD ACHIEVED.

Physician-DR.ANIRBAN DASGUPTA

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Diploma Cardiology
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Apollo
TOUCHING LIVES

Apollo Clinic
VASHI

PATIENT'S NAME	MRS. RITA SEHGAL	AGE :- 55Y/F
UHID	11206	30 Mar 2024

X-RAY BILATERAL MAMMOGRAMS

Film screen mammography of the breasts was performed using low radiation dose. Medio-lateral oblique and cranio - caudal projections were obtained.

Indication: Screening mammogram.

Comparison: No previous mammogram is available for comparison.

Findings-

ACR C-Moderate dense scattered parenchyma in both breasts, which may obscure small masses, thereby limiting sensitivity of the mammogram.

Right breast:

Two small lucent lesions with rim calcification seen in upper and outer quadrant – most likely representing oil cysts.

No dominant mass, suspicious calcifications or architectural distortion is seen.

Left breast:

Two small lucent lesions with rim calcification seen in lower and inner quadrant – most likely representing oil cysts.

Two axillary lymph nodes are seen.

No dominant mass, suspicious calcifications or architectural distortion is seen.

IMPRESSION-

- **Two small lucent lesions with rim calcification in both the breast – most likely representing oil cysts (Benign) ACR BIRADS category 2.**
- **Left axillary lymphadenopathy.**

Recommendation: Routine screening follow up and regular self breast examinations.

DISCLAIMER: Not all breast abnormalities show up on mammography. The false negative rate of mammography is approximately 10%.The management of a palpable abnormality must be based on clinical grounds.If you detect a lump or any other change in your breast before your next screening mammogram, consult your doctor immediately.

Lexicon:ACR BIRADS category 1- negative for malignancy; ACR BIRADS category 2- benign finding; ACR BIRADS category 3- probably benign finding, 98 % benign and 2 % risk of malignancy; ACR BIRADS category 4a- low suspicion of malignancy, 2-10% risk of malignancy; ACR BIRADS category 4b- intermediate suspicion of malignancy, 10-50% risk of malignancy; ACR BIRADS category 4c- high suspicion of malignancy, 50-95 % risk of malignancy; ACR BIRADS category 5- highly suggestive of malignancy, > 95% risk of malignancy; ACR BIRADS category 6- biopsy proven malignancy.

Thanking you for the referral,
With regards,

DR. SIDDHI PATIL
Con. Radiologist

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.
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VASHI

PATIENT'S NAME	RITA SEHGAL	AGE :55 Y/F
UHID NO	11206	30 Mar 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

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PATIENT'S NAME	RITA SEHGAL	AGE :- 55Y/F
UHID	11206	30 Mar 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 10.2 x 4.3 cm. **LEFT KIDNEY** measures 10.0 x 4.4 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. ET measures 3.1 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.

DR. NITESH PATEL
DMRE (RADIOLOGIST)

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