



MEDICAL CERTIFICATE

I, Dr. ADITYA SONDANKAR do hereby certify that I have carefully examined
Sri./Smt. MADHAV K. KULKARNI (whose signature is given below), son / daughter
of Mr. KESHAV KULKARNI is physically fit / unfit to join school / organization / undergo
professional education.

Signature of Candidate / Guardian:

Signature of Doctor: [Signature] Registration No: MMC 2009083017

Place: Medicover Hospital,
Bhosari, Pune.

Date: 14/6/24

DR. ADITYA VINOD SONDANKAR
MBBS DNB MEDICINE
MASTERCLASS IN DIABETES
FSCED
REG MMC 2009083017

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

OPD Nursing Assessment - Adult

Name: madhav Kulkarni Date of Birth : _____ Age/Sex: 37 UMR No.: 24141

Assessment :

Height: 172 cms Weight: 85.8 kg. BMI: _____ Respiration: _____ /min Pulse H/R : 67 /min
 BP: 138/90 mmHG Temperature : _____ °F/°C SpO2 97 % BSL _____

Chief Complaints : _____
Health checkup

Tick Appropriate :

- Interpreter Needed Yes No
- Nutritional Status: Weight Loss/Gain in Last 3 Months Yes No
- If Weight Loss / Gain-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 Surgeries 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
<u>Bashmy</u>	<u>029981</u>	<u>Bashmy</u>	<u>12/6/24</u>

ID: 2024061210314775
Name: mradhav kulkarni
Age: 37 Years
Gender: Male

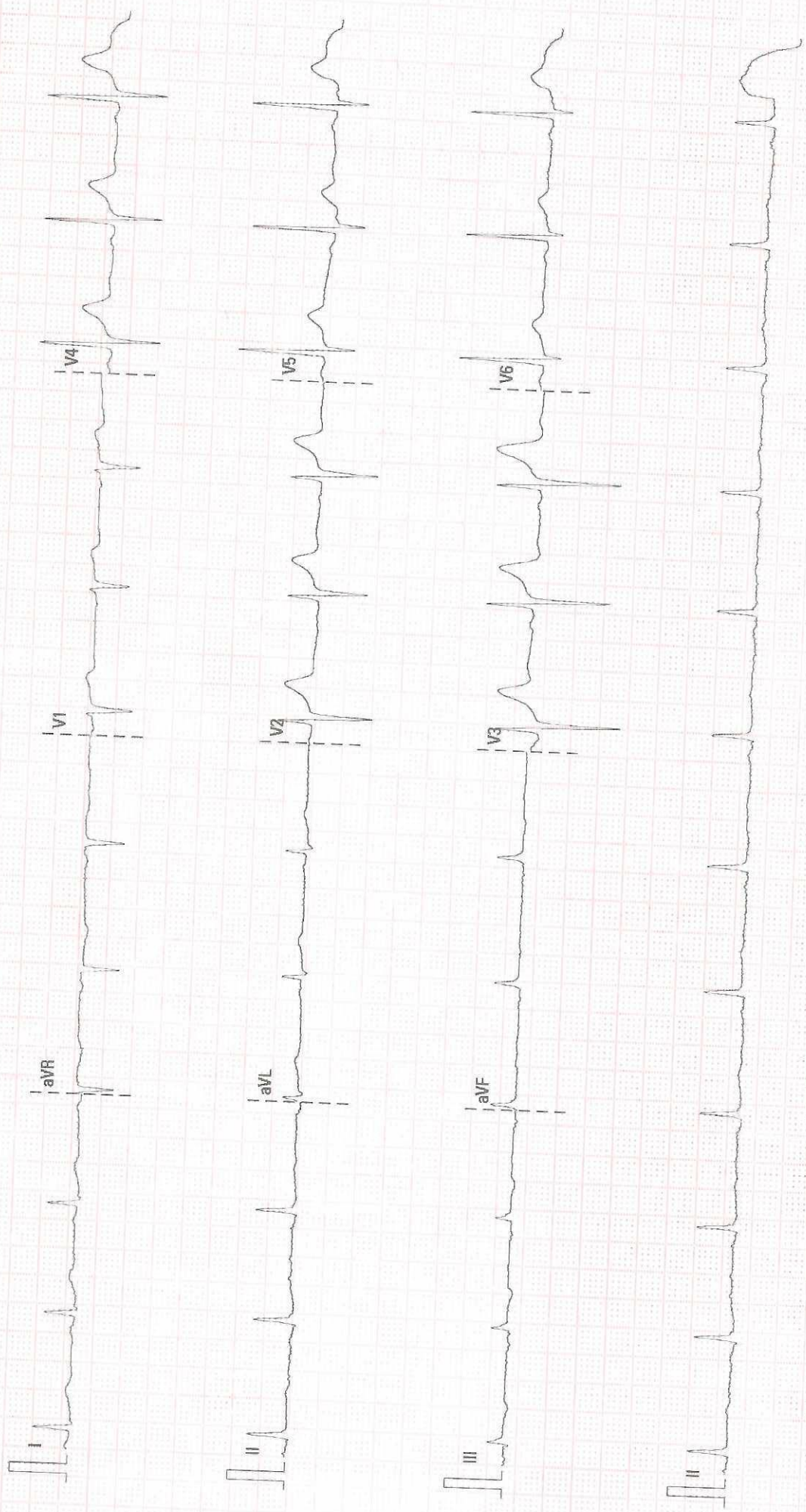
12-06-2024 10:32:09 AM

Vent. Rate
PR Interval
QRS Duration
QT/QTc Interval
P/QRS/T Axes
QTc:Hodges

71 bpm
140 ms
86 ms
380/399 ms
21/43/7 deg

Sinus rhythm
Normal ECG

Unconfirmed Diagnosis



25 mm/s
10 mm/mV
50 Hz
8DR 35 Hz

MEDICOVER KLE PUNE

02 10.00/V28.4.1

SN:FN-26035806



DEPARTMENT OF LABORATORY

Patient Name : Mr. MADHAV KESHAV KULKARNI **Age / Gender** : 37 Y(s)/Male
Bill No/ UMR No : PUBC24350/PUU24141 **Referred By** : Dr. GENERAL MEDICINE CONSULTANT
Received Dt : 12-Jun-24 10:05 am **Report Date** : 12-Jun-24 01:52 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
CUE(COMPLETE URINE EXAMINATION)			
<u>GENERAL EXAMINATION</u>			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.025	1.010 - 1.030
PH		5.0	4.5 - 8.0
<u>CHEMICAL EXAMINATION</u>			
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
<u>MICROSCOPIC EXAMINATION</u>			
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

*** End Of Report ***



DEPARTMENT OF LABORATORY

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Bill No/ UMR No : PUBC24350/PUU24141	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 12-Jun-24 10:05 am	Report Date : 12-Jun-24 01:52 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA Blood	15.0	13.2 - 17.3 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		5,710	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		222000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		5.28	4.5 - 6 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		44.1	40 - 50 %	Analogical integration
MCV		83.4	82 - 95 fl	Calculated
MCH		28.3	27 - 32 pg	Calculated
MCHC		33.9	32 - 36 g/dL	Calculated
RDW(cv)		13.0	11.5 - 14.0 %	Calculated
MPV		8.9	6 - 9.5 fl	Calculated
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	54.5	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		35.4	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		4.3	00 - 06 %	DHSS/Microscopy
MONOCYTES		4.9	00 - 10 %	DHSS/Microscopy
BASOPHILS		0.9	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA Blood	Normocytic Normochromic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate On Smear		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" A "		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		3	0 - 15 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

System Name : M



DEPARTMENT OF LABORATORY

Patient Name : Mr. MADHAV KESHAV KULKARNI	Age / Gender : 37 Y(s)/Male
Bill No/ UMR No : PUBC24350/PUU24141	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 12-Jun-24 10:05 am	Report Date : 12-Jun-24 04:22 pm

Parameters Specimen Result Biological Reference In Method



DEPARTMENT OF LABORATORY

Patient Name : Mr. MADHAV KESHAV KULKARNI
Age / Gender : 37 Y(s)/Male
Bill No/ UMR No : PUBC24350/PUU24141
Referred By : Dr. GENERAL MEDICINE CONSULTANT
Received Dt : 12-Jun-24 10:21 am
Report Date : 12-Jun-24 05:33 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
FBS (FASTING BLOOD SUGAR)				
FASTING BLOOD GLUCOSE		108.4	Normal Range : 70 - 99 mg/dL Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase
NOTE			Kindly correlate clinically. Repeat test with strict 10-12 hours fasting fresh sample, if indicated.	
SERUM CREATININE				
SGPT (ALT)		0.79	0.8 - 1.3 mg/dL	Jaffe
SERUM BILIRUBIN TOTAL		23.1	<= 41 U/L	Enzymatic
DIRECT BILIRUBIN		0.61	0.1 - 1.2 mg/dL	Colorimetric Diazo Method
INDIRECT BILIRUBIN		0.23	<= 0.20 mg/dL	Method: Diazo Method
0.38			<= 1.0 mg/dL	
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		6.1	7.0 - 21.0 mg/dL	Calculatead
PPBS (POST PRANDIAL BLOOD SUGAR)				
PPBS (POST PRANDIAL BLOOD SUGAR)		134.1	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase

*** End Of Report ***

Lab Incharge

Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PATHOLOGIST

Test results related only to the item tested.
No part of the report can be reproduced without written permission of the laboratory.

System Name : M



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Patient ID:	PUU24141	Patient Name:	MADHAV KULKARNI
Age:	37 Years	Sex:	M
Accession Number:	PUBC24350-PK	Modality:	DX
Referring Physician:	HC	Study:	CHEST
Study Date:	12-Jun-2024		

X RAY CHEST PA VIEW

FINDINGS : Chest PA view with no comparison study shows.

- **Prominent bronchovascular markings noted in bilateral lung fields.**
- Rest of the 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.**

Needs clinical correlation.

Dr. Madhuri Avhad (MBBS DMRD)
Consultant Radiologist
(typed & printed by sk)