CHARUSAT HOSPITAL

Patient Name :	DIPAKKUMAR CHHOTABHAI VALAND	**Sample No. :**	SAMPLE-0106903
Patient ID :	CH-2024-0053596	**Visit No. :**	OPD/2024/02/0000528
Age/Sex :	52y/Male	**Coll. Date :**	10-Feb-2024 09:40
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 15:55

PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	98.0 mg/dl [LOW]	100 - 140
Post Prandial Urine Sugar (2Hrs) :	Absent	

HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	102.0 mg/dl	
Hb A 1c	5.2 %	> 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 contrl than blood glucose determination.
This Reaction is irreversible & therefore remains unaffected glucose & Haemoglobin. Long term complicabons of diabetes such as Retinopathy (Eye-complications) nephropathy(Kidney-complications) & neuropathy(never complications) are potensally serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.

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

CHARUSAT HOSPITAL

Dr. Jwinish sir

Date & Time : 10-02-24

Registration No. : CH-2024-0053596

Name : Dipakkumar C. Valand Contact No. : (M) _____

Age : 52 Sex : M (O) _____

Address : _____

B.P. : 110/80 mm Hg Pulse : 90/min SpO$_2$: 99 on RA

BMI : _____ Height : 158 cm Weight : 70kg

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : Heel ulcer c/o

CASE ANALYSIS

Past History : NA

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) : _____

CHRF/OPD/5083

CHARUSAT HOSPITAL

DENTAL REGISTRATION FORM

Date & Time : 10-02-24

Registration No. : CH-2024-005396

Name : Dipukkumar c Valand

Age : 52

Sex : M

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 ..... ડૉક્ટરને 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 ડૉક્ટરને 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 ડૉક્ટર કે ચારુસેટ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની ડિપોઝીટ પેટે આપાયેલ રકમ મેળવવા માટે હકદાર 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 : Gen. cervical abrasion

Treatment Plan : _____

Date : 10/2/24

Time : _____

Name of Doctor Dr. Mashwadi

Signature : _____

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
10-02-2024	DIPAKKUMAR C VALAND	M	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
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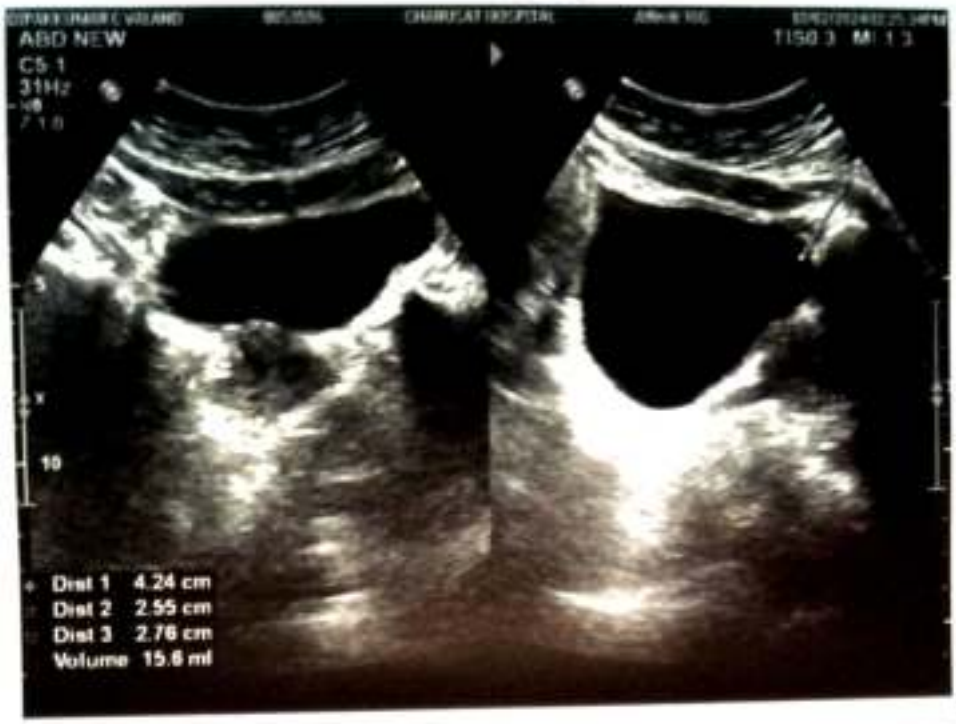
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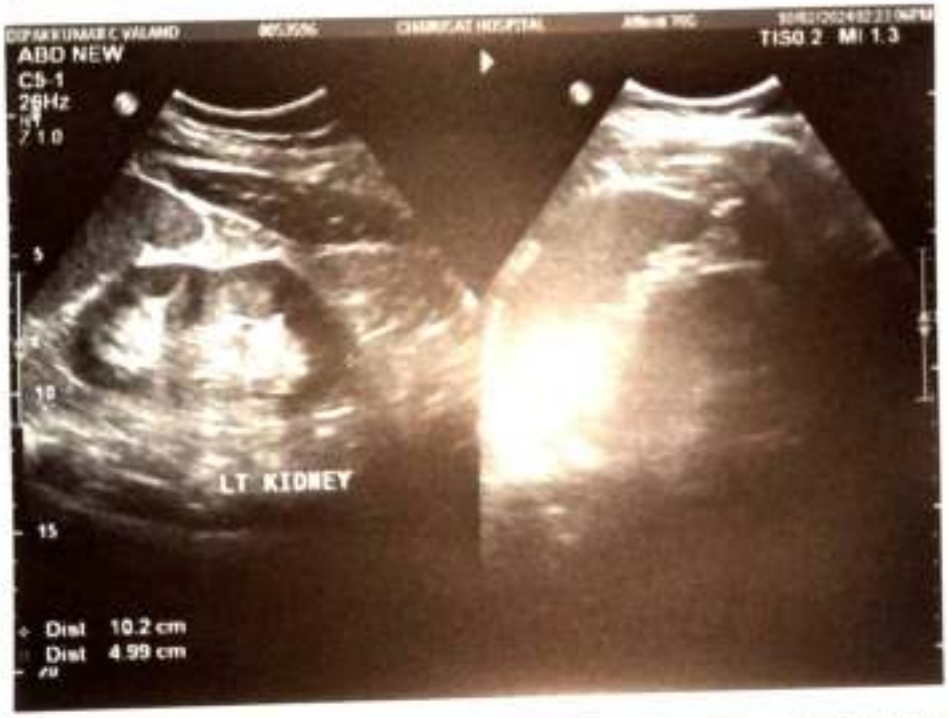
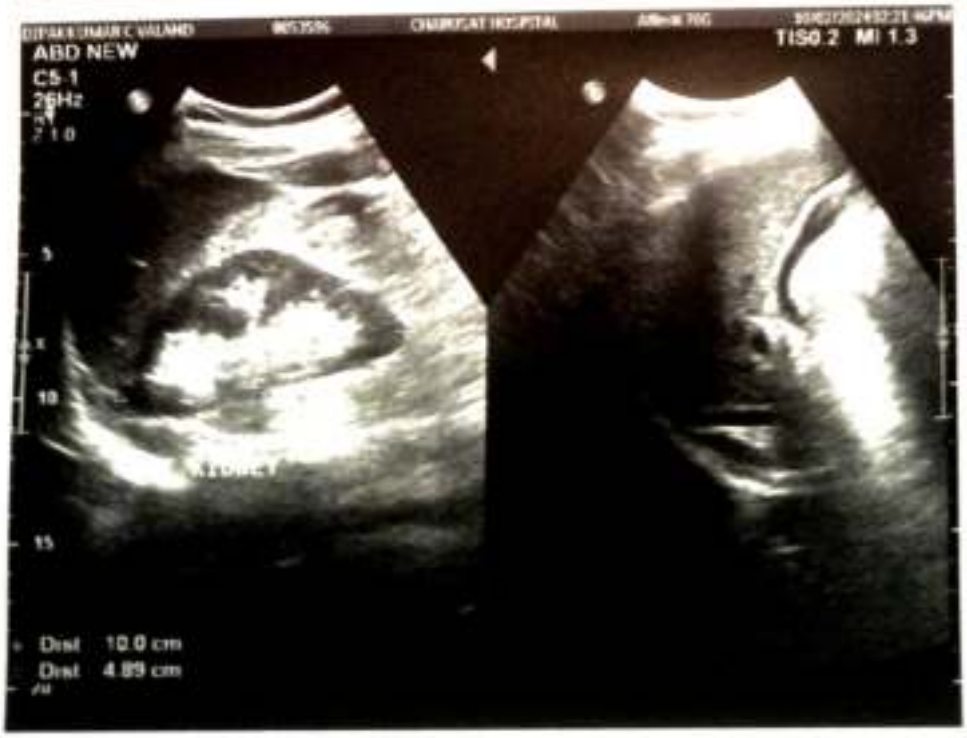
C5-1
31Hz
TIS0 3 MI 1.3
Dist 1 4.24 cm
Dist 2 2.55 cm
Dist 3 2.76 cm
Volume 15.6 ml


ABD NEW
C5-1
26Hz
TIS0 2 MI 1.3
LT KIDNEY
Dist 10.2 cm
Dist 4.99 cm


ABD NEW
C5-1
26Hz
TIS0 2 MI 1.3
Dist 10.0 cm
Dist 4.89 cm

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
10-02-2024	DIPAKKUMAR C VALAND	M	BODY PROFILE	UM-TOTAL ABDOMEN USG

USG ABDOMEN report.

Liver:show evidence of normal size,parenchymel echotexture & no evidence of focal solid or cystic mass lesion seen.Normal hepatic vasculature seen with no evidence of intrahepatic biliary dilatation seen.

Gall bladder is physiologically distended with no evidence of calculus or sludge.Thickness of gall bladder wall is normal with no evidence of pericholecystic fluid collection.
CBD,portal vein & spleenic vein size are normal.

Spleen size & parenchymel echotexture is normal with no focal mass lesion seen.
Pancreas show evidence of normal size & parenchymel echotexture with no evidence of focal mass lesion.

Aorta show normal caliber & no evidence of paraaortic mass lesion seen.

Right kidney show evidence of normal size,position,corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.
No evidence of focal solid or cystic mass lesion seen.

Left kidney show evidence of normal size,position,corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.
No evidence of focal solid or cystic mass lesion seen.

Bladder walls are normal & no evidence of stone or mass seen.
Prostate show evideance of normal size & parenchymel echotexture.
No evidence of ascitis or abnormal bowel loops seen.

Size cm app

Right Kidney	Left Kidney	Prostate Vol/Wt cc/gms
10X489	10.2X4.9	15.6

COMMENTS:

No abnormality detected.

Thanks for reference
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Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 12:20

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	17.0 gm/dl [NORMAL]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	4.78 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	6180 /c.mm [NORMAL]	4000 - 10000

Platelet count

Investigation	Result	Normal Value
Platelets	2.03 Lakh/cmm [NORMAL]	1.5 - 4.5

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	59 % [NORMAL]	40 - 70
Lymphocytes	34 % [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	17.0 mg/dl [NORMAL]	15 - 40

S.Creatinine

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Investigation	Result	Normal Value
Serum Creatinine	0.72 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	08 [NORMAL]	8.0 to 23.0 (mg/dl)

URIC ACID

Investigation	Result	Normal Value
Serum Uric Acid	5.36 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

ESR

Investigation	Result	Normal Value
ESR - After One Hour	04 mm [NORMAL]	[M : 3 - 5, F : 4 - 7]

Blood Group

Investigation	Result	Normal Value
ABO	B	
Rh	Positive	

FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar :	95.8 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

TSH

Investigation	Result	Normal Value
TSH :	1.98 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3

Investigation	Result	Normal Value

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Patient Name :	DIPAKKUMAR CHHOTABHAI VALAND	**Sample No. :**	SAMPLE-0106903
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T3-Triodothyronine :	1.53 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

T4

Investigation	Result	Normal Value
T4-thyroxine :	64.1 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

LIPID PROFILE

Investigation	Result	Normal Value
Serum Cholesterol (Chol) :	120.2 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	77.0 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	33.9 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	62.26 mg/dl	
VLDL :	24.04 mg/dl [NORMAL]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	1.84 - [NORMAL]	< 3.5
TC / HDL Ratio :	3.55 - [LOW]	4.0 to 6.0
LDL (DIRECT) :	83.3 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

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Patient Name :	DIPAKKUMAR CHHOTABHAI VALAND	**Sample No. :**	SAMPLE-0106903
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Total Bilirubin :	0.96 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.29 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	23.5 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	15.4 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	76.8 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP) :	7.39 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	4.26 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.67 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.13 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.4	

URINE R & M

Investigation	Result	Normal Value
Physical Examination :		
Quantity :	15 ml	
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Acidic -	
Specific Gravity :	1.025 -	
Chemical Examination :		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	

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Acetone :	Absent -
Urobilinogen :	Absent -

Microscopie Examination :

Pus Cells :	1-2 -
RBCs :	Absent -
Epithelial cells :	1-2 -
Casts :	Absent -
Crystals :	Absent -

PSA

Investigation	Result		Normal Value
PSA	0.937	ng/ml	0.0 - 4.0 ng/ml 4.0 - 10.0 ng/ml Gray Z 10.0 - 30.0 ng/ml suspi of malignancy Above 30 ng/ml Highly suspicious of malignan
FREE PSA	-	ng/ml	

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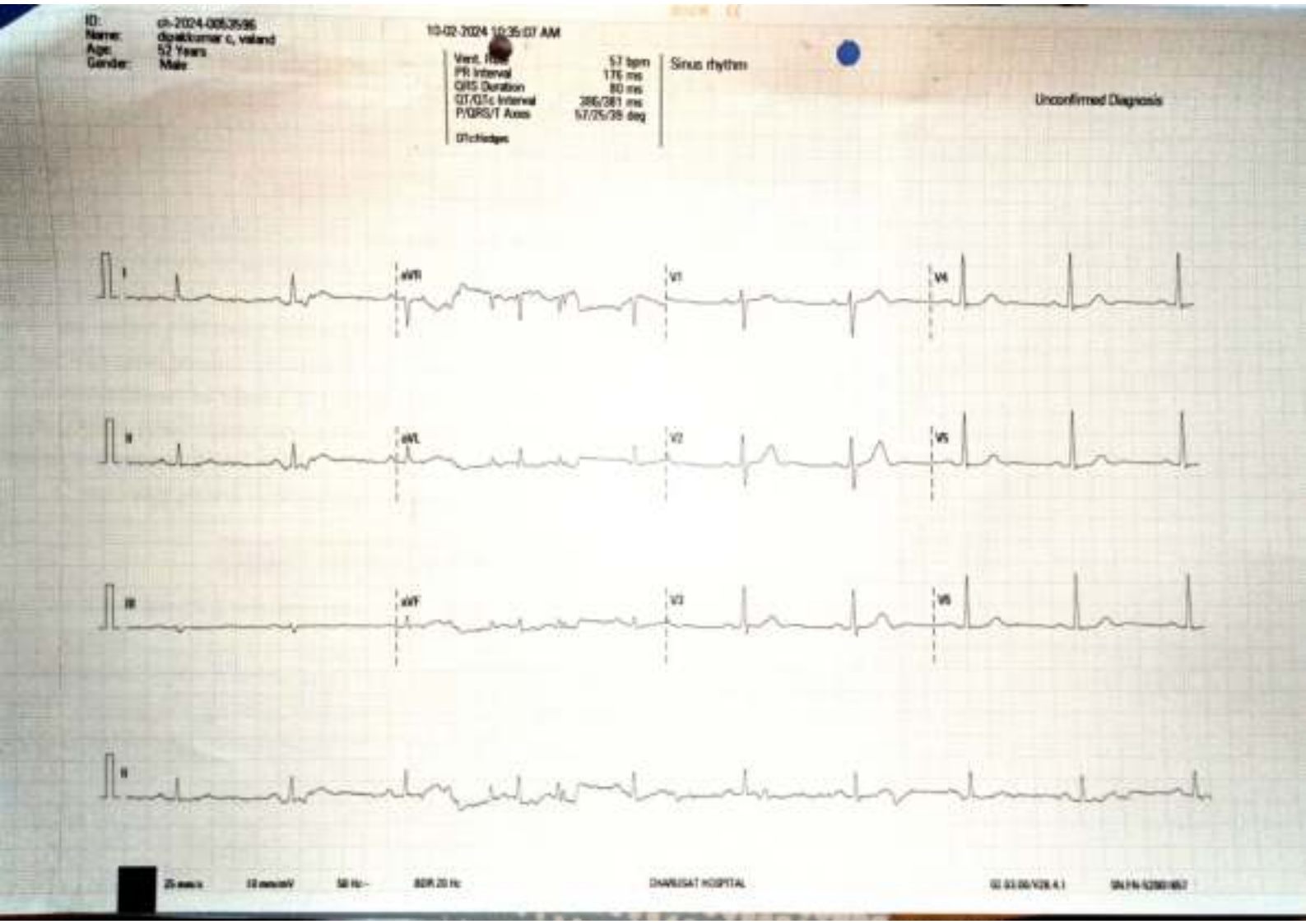
ID:
Name:
Age:
52 Years
Gender:
Male
10-02-2024 10:35:07 AM
Vent. Rate
PR Interval
QRS Duration
QT/QTc Interval
P/QRS/T Axes
57 bpm
176 ms
80 ms
386/381 ms
57/25/39 deg
Sinus rhythm
Unconfirmed Diagnosis
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
CHARUSAT HOSPITAL

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OPHTHALMIC REGISTRATION FORM

Reg. No. : CH-2024-0053596

Date : 10-02-24

Patient's Name : Dipak Kumar C. Vakani Age : 52/M

Address :

Telephone No. : Mobile No. :

Referred by / Care of :

Profession :

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 /

fourth eye checkup

Eye Involve : RE / LE / BE Duration :

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

Treatment

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

Family History : Glaucoma / RP / DM / -

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

NAD

EYE DETAILS :

	RE	LE
V/A with PH	6/6	6/6
IOP	14 mmHg	12 mmHg
OWN GLASS :	+2.50 Near Add	+2.50 near add
AR :	-0.50 x 100°	-0.50 x 58°

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	—	—	6/6		-0.50	58°
Nr. Add	+2.50	—	N6	+2.50	—	N6
Comp						

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

Remark :

Signature :