

# ચારુસેટ હોસ્પિટલ, ચાંગા

વર્લ્ડ ક્લાસ મલ્ટી સ્પેશિયાલિટી હોસ્પિટલ

Body profile

તારીખ / Date

9/3/24

રજીસ્ટ્રેશન નંબર / Registration Number

CH - 2024 - 0053967

દર્દીનું નામ / Patient's Name

Amarjit Kumar Deepak

સંપર્ક નંબર / Contact Number

હેલ્થ લાઇન

એપોઇન્ટમેન્ટ માટે સંપર્ક

+91-2697-265502/504

+91-95379 27873

૨૪ કલાક ઈમરજન્સી સંપર્ક

+91-2697-265500

+91-75748 38111



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



Dr. Jainish

Date & Time : 9/3/24

Registration No. : CH-24-0053967

Name : Amarjitkumar Deepak Contact No. : (M) \_\_\_\_\_

Age : 40 Sex : m (O) \_\_\_\_\_

Address : \_\_\_\_\_

B.P. : 120/80 mm Hg Pulse 60/min SpO<sub>2</sub> : 99% and

BMI : \_\_\_\_\_ Height : \_\_\_\_\_ Weight : \_\_\_\_\_

## OPD-INITIAL ASSESSMENT FORM

Chief Complaints : Health checkup

## CASE ANALYSIS

Past History : N/A

Present History : \_\_\_\_\_

G/E Vitals : \_\_\_\_\_

Systemic Examination : \_\_\_\_\_

### FAMILY HISTORY :

- Diabetes
- IHD
- Hypertension
- Others (Specify) : \_\_\_\_\_

### PATIENT'S MEDICAL/OTHER HISTORY :

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

HABBITs :  Smoking  Alcohol  Tobacco  Others (Specify) : \_\_\_\_\_

# DENTAL REGISTRATION FORM



Date & Time : 9/3/24  
Registration No. : CH-24-0053967

Name : Amarjitkumar Deepak  
Age : 40  
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) :

- Jaundice  
 Hepatitis C  
 Hepatitis B  
 Food Allergy  
 Drug Allergy

## સંમતિ પત્રક

હું ..... ડૉક્ટરને મારી સારવાર કરવાની મંજૂરી આપું છું. આ સારવારનો પૂરેપૂરો ખર્ચો, ફાયદા-ગેરફાયદા, દવાની કે ઇન્જેક્શનની 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 ચાર્જેડ હોસ્પિટલ જવાબદાર નથી. તથા સારવારની ડિપોઝીટ પેટે અપાયેલ રકમ મેળવવા માટે હકકદાર 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 : Caries & Exl.

Treatment Plan : \_\_\_\_\_

Date : 9/3/24  
Time : \_\_\_\_\_

Name of Doctor : Dr. Masluwabi  
Signature : \_\_\_\_\_

Reg. No. : CH-24-0053967

Date : 9/3/24

Patient's Name : Amangitkumar Deepak Age : 40

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 /

routine eye Stickness / Swelling / Irritation / Burning / F. B. Sensation / Photophobia /

check up Diplopia / Squinting / Blackout / Floaters / Flashes / Injury /

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 :**

V/A with PH RE 6/6 LE 6/6

IOP 18mmHg 12mmHg

OWN GLASS : - -


AR : -0.50 / -0.50 x 97° -0.75 x 91°

**GLASS PRESCRIPTION**

	R. E. V/A			L. E. V/A		
		CYL.	AXIS	SPH.	CYL.	AXIS
Dis	-	-0.50	90°	-	-0.75	91°
Nr.	<del>_____</del>			<del>_____</del>		
Comp	<del>_____</del>			<del>_____</del>		

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

Remark : \_\_\_\_\_  
Signature : [Signature]

Patient Name :	AMARJITKUMAR . DEEPAK	Sample No. :	SAMPLE-0107749 
Patient ID :	CH-2024-0053967	Visit No. :	OPD/2024/03/0000434
Age/Sex :	40y/Male	Call. Date :	09-Mar-2024 09:29
Referred By :	RIPAL PATEL	S. Coll. Date :	09-Mar-2024 15:14
Ward :	-	Report Date :	09-Mar-2024 15:14

## PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	109.5 mg/dl [NORMAL]	100 - 140

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

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

DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR	INVESTIGATION
09-03-2024	AMARJITKUMAR. DEEPAK	40	F	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 & splenic 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 evidence of normal size & parenchymel echotexture.

No evidence of ascitis or abnormal bowel loops seen.

## COMMENTS:

No abnormality detected.



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

DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR	INVESTIGATION
09-03-2024	AMARJITKUMAR. DEEPAK	40	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

09-03-2024 09:56:22 AM

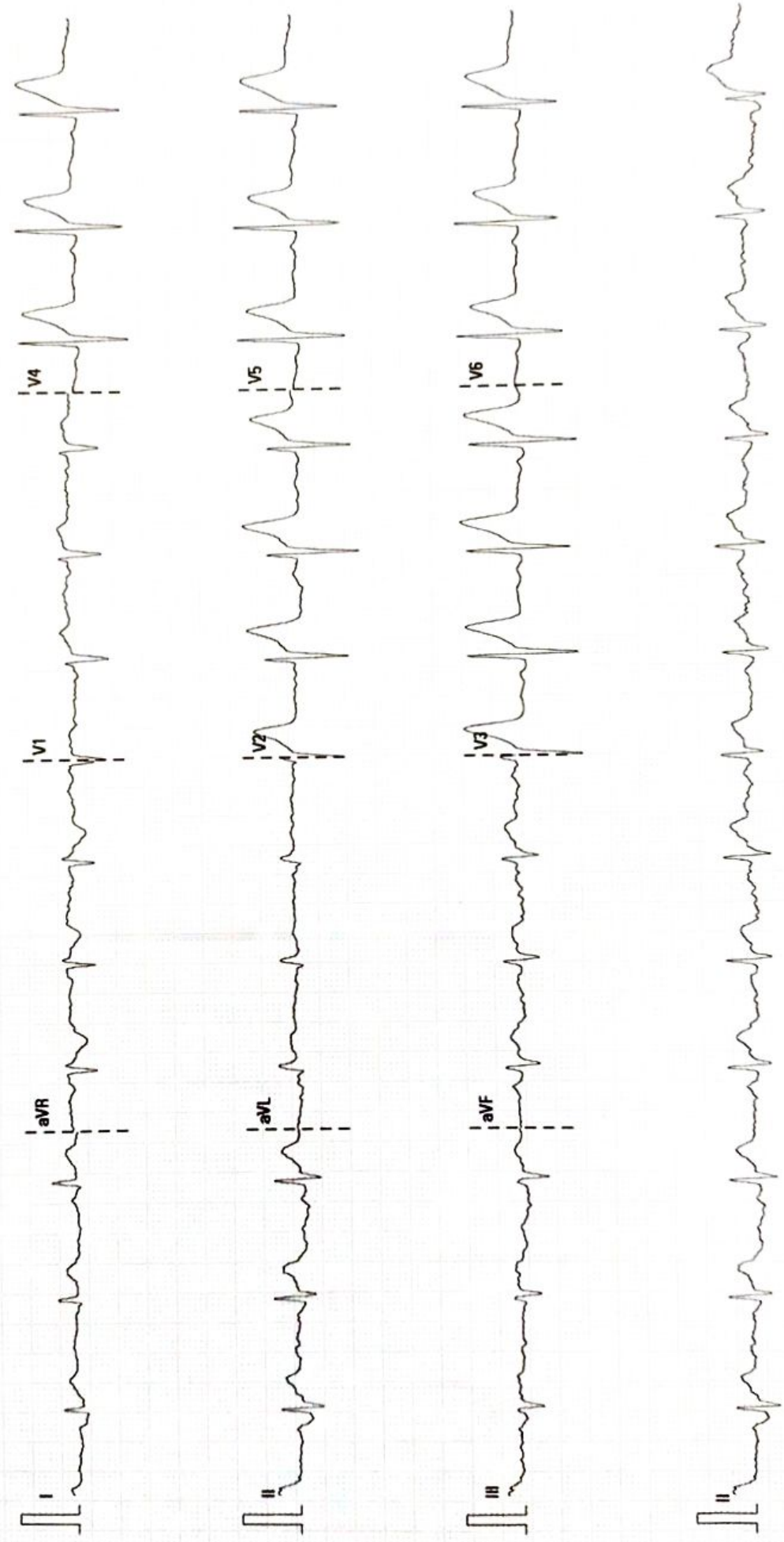
ID: 0053967  
Name: Deepak, Amarjitkumar.  
Age: 40 Years  
Gender: Male

Vent. Rate 82 bpm  
PR Interval 136 ms  
QRS Duration 82 ms  
QT/QTc Interval 320/359 ms  
P/QRS/T Axes 59/5/49 deg  
QTc Hodges


**\*\*\* CONSIDER ACUTE STEMI**

Sinus rhythm  
Lateral ST elevation, CONSIDER ACUTE INFARCT

Unconfirmed Diagnosis





Patient Name : AMARJITKUMAR . DEEPAK	Sample No. : SAMPLE-0107737 
Patient ID : CH-2024-0053967	Visit No. : OPD/2024/03/0000434
Age/Sex : 40y/Male	Call. Date : 09-Mar-2024 09:29
Referred By : RIPAL PATEL	S. Coll. Date : 09-Mar-2024 09:54
Ward : -	Report Date : 09-Mar-2024 11:00

### Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	13.4 gm/dl [LOW]	[M : 14-18, F : 12-16 ]

### WBC

Investigation	Result	Normal Value
R.B.C Count :	4.31 mill./c.mm [LOW]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	7210 /c.mm [NORMAL]	4000 - 10000

### Platelet count

Investigation	Result	Normal Value
Platelets	1.57 Lakh/cmm [NORMAL]	1.5 - 4.5


### WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	50 % [NORMAL]	40 - 70
Lymphocytes	43 % [HIGH]	20 - 40
Eosinophils	02 % [NORMAL]	1 - 6
Monocytes	05 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

### BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	20.2 mg/dl [NORMAL]	15 - 40

### S.Creatinine

Patient Name : AMARJITKUMAR . DEEPAK	Sample No. : SAMPLE-0107737 
Patient ID : CH-2024-0053967	Visit No. : OPD/2024/03/0000434
Age/Sex : 40y/Male	Call. Date : 09-Mar-2024 09:29
Referred By : RIPAL PATEL	S. Coll. Date : 09-Mar-2024 09:54
Ward : -	Report Date : 09-Mar-2024 11:00

Investigation	Result	Normal Value
Serum Creatinine	0.65 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	5.86 mg/dl [NORMAL]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

### ESR

Investigation	Result	Normal Value
ESR - After One Hour	18 mm [HIGH]	[M : 3 - 5, F : 4 - 7]

### Blood Group


Investigation	Result	Normal Value
ABO :	O	
Rh :	Positive	

### FASTING BLOOD GLUCOSE

Investigation	Result	Normal Value
Fasting Blood Sugar :	99.0 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

### HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	131.2 mg/dl	

Patient Name : AMARJITKUMAR . DEEPAK	Sample No. : SAMPLE-0107737 
Patient ID : CH-2024-0053967	Visit No. : OPD/2024/03/0000434
Age/Sex : 40y/Male	Call. Date : 09-Mar-2024 09:29
Referred By : RIPAL PATEL	S. Coll. Date : 09-Mar-2024 09:54
Ward : -	Report Date : 09-Mar-2024 11:00

Hb A 1c

6.2 %

> 8 : Action Suggested  
7-8 : Good Control  
< 7 : Goal  
6-7 : Near Normal Glycemia  
< 6 : Non-diabetic Level

Comments

Hb A1C also known as Glycosylated 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 6-8 week and provides a much better indication of longterm glycemic control than blood glucose determination.  
This Reaction is irreversible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications), nephropathy(Kidney-complications) & neuropathy(nerve 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 :	1.34 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

## T3


Investigation	Result	Normal Value
T3-Triiodothyronine :	1.16 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

## T4

Investigation	Result	Normal Value
T4-thyroxine :	60.3 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

## LIPID PROFILE


Investigation	Result	Normal Value
---------------	--------	--------------

Patient Name : AMARJITKUMAR . DEEPAK	Sample No. : SAMPLE-0107737 
Patient ID : CH-2024-0053967	Visit No. : OPD/2024/03/0000434
Age/Sex : 40y/Male	Call. Date : 09-Mar-2024 09:29
Referred By : RIPAL PATEL	S. Coll. Date : 09-Mar-2024 09:54
Ward : -	Report Date : 09-Mar-2024 11:00

Serum Cholesterol (Chol) :	183.8 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	121.2 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	38.0 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	109.04 mg/dl	
VLDL :	36.76 mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	2.87 - [NORMAL]	< 3.5
TC / HDL Ratio :	4.84 - [NORMAL]	4.0 to 6.0
LDL (DIRECT) :	143.0 mg/dl [Border line high]	< 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 :	0.56 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.17 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	42.4 IU/L [HIGH]	[0.0 - 40]
AST (SGOT) :	33.5 IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	130.4 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0

Patient Name :	AMARJITKUMAR . DEEPAK	Sample No. :	SAMPLE-0107737 
Patient ID :	CH-2024-0053967	Visit No. :	OPD/2024/03/0000434
Age/Sex :	40y/Male	Call. Date :	09-Mar-2024 09:29
Referred By :	RIPAL PATEL	S. Coll. Date :	09-Mar-2024 09:54
Ward :	-	Report Date :	09-Mar-2024 11:00

Total Protein (TP) :	7.5 gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	4.4 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.39 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.1 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.4	

## URINE R & M

Investigation	Result	Normal Value
<b>Physical Examination :</b>		
Quantity :	20 ml	
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Acidic -	
Specific Gravity :	1.025 -	
<b>Chemical Examination :</b>		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	
Acetone :	Absent -	
Urobilinogen :	Absent -	
<b>Microscopic Examination :</b>		
Pus Cells :	3-4 -	
RBCs :	Absent -	
Epithelial cells :	1-2 -	

Patient Name : AMARJITKUMAR . DEEPAK	Sample No. : SAMPLE-0107737 
Patient ID : CH-2024-0053967	Visit No. : OPD/2024/03/0000434
Age/Sex : 40y/Male	Call. Date : 09-Mar-2024 09:29
Referred By : RIPAL PATEL	S. Coll. Date : 09-Mar-2024 09:54
Ward : -	Report Date : 09-Mar-2024 11:00

Casts : Absent -

Crystals : Absent -

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

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

