

Health Check up Booking Request(43E1475)

1 message

19 October 2024 at 12:59

Medsave <it@medsave.in>  
To: healthcareshridurga@gmail.com  
Cc: customercare@mediwheel.in



011-41195959

Dear Shri Durga Healthcare

We have received a booking request with the following details. Provide your confirmation by clicking on the Yes button.

**You confirm this booking?**      Yes      No

**Name** : Sunita Arora

**Proposal No** : 117298630

**Branch Code** : 117

**Contact Details** : 9810797869

**Location** : D63, Har Gyan Singh Arya Marg, South Extension I, Block D,  
New Delhi, Delhi 110049

**Appointment Date** : 22-10-2024

Member Information		
Booked Member Name	Age	Gender
Sunita Arora	61 year	Female

**Included Test -**

- BST Only fasting or Only PGBS
- ECG
- FMR

Thanks,  
Medsave  
Team



  
भारत सरकार  
GOVERNMENT OF INDIA

  
सुनीता अरोड़ा  
Sunila Arora  
जन्म तिथि/DOB: 04/09/1963  
शहरी/ FEMALE  
Mobile No: 9810797869  
4247 4657 9523  
VID - 9173 1418 2232 9427



मेरा आधार, मेरी पहचान

*Sunila Arora*

*Dr. PREETI DHIMAN*  
M.B.B.S





**IDENTIFICATION & DECLARATION FORMAT**

To,  
LIC of India  
Branch Office

117

Proposal No

: 117298630

Name of Life to be assured:

Sanita Arora

The Life to be assured was identified on the basis of:

Adhar

I have satisfied myself with regard to the identity of the Life to be assured before conducting tests / examination for which report/s are enclosed.

I hereby declare that the person examined has signed (affixed his/her thumb impression) in the space earmarked below, in my presence and I am not related to him/her or the Agent or the Development Officer.

Dated at M on the 22/10/24 day of 2024 at 10:15 a.m./p.m.

Signature of the Pathologist/Doctor  
(Name & Rubber stamp) Qualification:

*DR. PREETI DHIMAN  
M.B.B.S*

Signature of the Cardiologist (if LA has undergone CTMT / ECG)  
Name & Rubber stamp) Qualification

Signature of the Radiologist (if LA has undergone X-ray or scanning  
Name & Rubber stamp) Qualification

Sanita Arora

The examinations /tests were done with my consent and I was fasting for more than 12 hrs before the tests

Signature of the Life to be Assured

Name.....

Reports enclosed.

- 1..... PMR
- 2..... ECG
- 3..... FBS
- 4.....
- 5.....







**MEDICAL EXAMINER'S REPORT**  
Form No LIC03-001 (Revised 2020)

Branch Code: 0/17  
 Proposal/ Policy No: 117298630  
 MSP name/code: 0018  
 Date & Time of Examination: 22/10/24  
 Medical Diary No & Page No: 15, 15A

Mobile No of the Proposer/Life to be assured: \_\_\_\_\_  
 Identity Proof verified: Aadhaar ID Proof No. 9523  
 ( In Case of Aadhaar Card , please mention only last four digits)

[ Note: Mobile number and identity proof details to be filled in above . For Physical MER, Identity Proof is to be verified and stamped.]

For Tele/ Video MER, consent given below is to be recorded either through email or audio/video message. For Physical Examination the below consent is to be obtained before examination.

"I would like to inform that this call with/ visit to Dr. P. Prasad..... (Name of the Medical Examiner) is for conducting your Medical Examination through Tele/ Video/ Physical Examination on behalf of LIC of India".

Sumita Arora  
 Signature/ Thumb impression of Life to be assured  
 (In case of Physical Examination)

1	Full name of the life to be assured: <u>Sumita Arora</u>		
2	Date of Birth: <u>4/1/63</u>	Age: <u>61</u>	Gender: <u>Female</u>
3	Height (In cms): <u>153</u>	Weight ( in kgs): <u>57.5</u>	
4	Required only in case of Physical MER		
	Pulse: <u>66</u>	Blood Pressure (2 readings): 1. Systolic <u>140</u> Diastolic <u>80</u> 2. Systolic <u>140</u> Diastolic <u>80</u>	

ASCERTAIN THE FOLLOWING FROM THE PERSON BEING EXAMINED

If answer/s to any of the following questions is Yes, please give full details and ask life to be assured to submit copies of all treatment papers, investigation reports, histopathology report, discharge card, follow up reports etc. along with the proposal form to the Corporation

5 a. Whether receiving or ever received any **treatment/ medication** including alternate medicine like ayurveda, homeopathy etc ?  
 b. Undergone any **surgery / hospitalized** for any medical condition / disability / injury due to accident?  
 c. Whether visited the doctor any time in the last 5 years ?  
 If answer to any of the questions 5(a) to (c) ) is yes -  
 i. Date of surgery/accident/injury/hospitalisation  
 ii. Nature and cause  
 iii. Name of Medicine  
 iv. Degree of impairment if any  
 v. Whether unconscious due to accident, if yes, give duration

/ NO

6 In the last 5 years, if advised to undergo an X-ray/ CT scan / MRI / ECG / TMT / Blood test / Sputum/Throat swab test or any other investigatory or **diagnostic tests**?  
 Please specify date , reason ,advised by whom & findings.

Yes Routine Blood Test

7 Suffering or ever suffered from **Novel Coronavirus (Covid-19)** or experienced any of the symptoms (for more than 5 days) such as any fever, Cough, Shortness of breath, Malaise (flu-like tiredness), Rhinorrhea (mucus discharge from the nose), Sore throat, Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhoea, Chills, Repeated shaking with chills, Muscle pain, Headache, Loss of taste or smell within last 14 days.  
 If yes provide all investigation and treatment reports

/ NO

Dr. P. Prasad  
 MBBS





8	a. Suffering from <b>Hypertension</b> (high blood pressure) or <b>diabetes</b> or blood sugar levels higher than normal or history of sugar /albumin in urine? b. Since when, any follow up and date and value of last checked blood pressure and sugar levels? c. Whether on medication? please give name of the prescribed medicine and dosage d. Whether developed any complications due to diabetes? e. Whether suffering from any other <b>endocrine disorders</b> such as <b>thyroid disorder</b> etc.? f. Any weight gain or weight loss in last 12 months (other than by diet control or exercise)?	NO NO NO NO YES Last 3 years Thyroiding D NO
9	a. Any history of chest pain, <b>heart attack</b> , palpitations and breathlessness on exertion or irregular heartbeat? b. Whether suffering from <b>high cholesterol</b> ? c. Whether on medication for any heart ailment/ high cholesterol? Please state name of the prescribed medicine and dosage. d. Whether undergone Surgery such as CABG, open heart surgery or PTCA?	NO
10	Suffering or ever suffered from any disease related to <b>kidney</b> such as kidney failure, kidney or ureteral stones, blood or pus in urine or prostate?	NO
11	Suffering or ever suffered from any <b>Liver disorders</b> like cirrhosis, hepatitis, jaundice, or disorder of the Spleen or from any <b>lung related</b> or respiratory disorders such as Asthma, bronchitis, wheezing, tuberculosis breathing difficulties etc.?	NO
12	Suffering or ever suffered from any <b>Blood disorder</b> like anaemia, thalassemia or any Circulatory disorder?	NO
13	Suffering or ever suffered from any form of <b>cancer</b> , leukaemia, tumor, cyst or growth of any kind or enlarged lymph nodes?	NO
14	Suffering or ever suffered from Epilepsy, <b>nervous disorder</b> , multiple sclerosis, tremors, numbness, paralysis, brain stroke?	NO
15	Suffering or ever suffered from any <b>physical impairment</b> /disability /amputation or any congenital disease/abnormality or disorder of back, neck, muscle, joints, bones, arthritis or gout?	NO
16	Suffering or ever suffered from Hernia or <b>disorder of the Stomach</b> / intestines, colitis, indigestion, Peptic ulcer, piles, or any other disease of the gall bladder or pancreas?	NO
17	a. Suffering from Depression/Stress/ Anxiety/ Psychosis or any other Mental / <b>psychiatric disorder</b> ? b. Whether on treatment or ever taken any treatment, if yes, please give details of treatment, prescribed medicine and dosages	NO NO
18	Is there any <b>abnormality</b> of Eyes (partial/total blindness), Ears (deafness/ discharge from the ears), Nose, Throat or Mouth, teeth, swelling of gums / tongue, tobacco stains or signs of oral cancer?	NO
19	Whether person being examined and/ or his/her spouse/partner tested positive or is/ are under treatment for <b>HIV /AIDS/ Sexually transmitted diseases</b> (e.g. syphilis, gonorrhoea, etc.)	NO
20	Ascertain if any other condition / disease / adverse habit (such as <b>smoking/ tobacco chewing/ consumption of alcohol/drugs</b> etc) which is relevant in assessment of medical risk of examinee.	NO

Proponents only  
Whether pregnant? If so duration  
Whether consulted a pregnancy investigation, treatment for a gynaecological cyst or any disease of the breast or taken / taking any treatment for

FROM MEDICAL EXAMINER'S OFFICE  
WHETHER LIFE TO BE ASSURED AND PHYSICAL FITNESS



Dr. PREETI DHIMAN  
M.B.B.S.



Age 35 years  
Height 155 cm  
Weight 55 kg

Male Proponents only	
Whether pregnant? If so duration.	NO
Suffering from any pregnancy related complications	NO
Whether consulted a gynaecologist or undergone any investigation, treatment for any gynaec ailment such as fibroid, cyst or any disease of the breasts, uterus, cervix or ovaries etc. or taken / taking any treatment for the same	NO

FROM MEDICAL EXAMINER'S OBSERVATION/ASSESSMENT WHETHER LIFE TO BE ASSURED APPEARS MENTALLY AND PHYSICALLY HEALTHY	Yes
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Declaration

You Mr/Ms Sunita Arora declare that you have fully understood the questions asked to you during the call / Physical Examination and have furnished complete, true and accurate information after fully understanding the same. We thank you for having taken the time to confirm the details. The information provided will be passed on to Life Insurance Corporation of India for further processing.

Sunita Arora

Signature/ Thumb impression of Life to be assured  
(In case of Physical Examination)

I hereby certify that I have assessed/ examined the above life to be assured on the \_\_\_ day of \_\_\_ 20\_\_\_ vide Video call / Tele call/ Physical Examination personally and recorded true and correct findings to the aforesaid questions as ascertained from the life to be assured.

Place:  
Date:  
Stamp:

ND

22/10/24

D. PRATI DHIMAN  
Signature of Medical Examiner  
Name & Code No:



**LIFE INSURANCE CORPORATION OF INDIA**

Zone \_\_\_\_\_ Division \_\_\_\_\_ Branch \_\_\_\_\_

Proposal No. \_\_\_\_\_

Agent/D.O. Code: \_\_\_\_\_

Full Name of Life to be assured: Shweta Arora

Age/Sex : 61/P

**ELECTROCARDIOGRAM**

**ANNEXURE- 1**

LIC03-002

**Instructions to the Cardiologist:**

- i. Please satisfy yourself about the identity of the examiners to guard against impersonation
- ii. The examinee and the person introducing him must sign in your presence. Do not use the form signed in advance. Also obtain signatures on ECG tracings.
- iii. The base line must be steady. The tracing must be pasted on a folder.
- iv. Rest ECG should be 12 leads along with Standardization slip, each lead with minimum of 3 complexes, long lead II. If L-III and AVF shows deep Q or T wave change, they should be recorded additionally in deep inspiration. If V1 shows a tall R-Wave, additional lead V4R be recorded.

**DECLARATION**

I hereby declare that the foregoing answers are given by me after fully understanding the questions. They are true and complete and no information has been withheld. I do agree that these will form part of the proposal dated \_\_\_\_\_ given by me to LIC of India.

Shweta Arora  
Signature or Thumb Impression of L.A.

Witness

**Note :** Cardiologist is requested to explain following questions to L.A. and to note the answers thereof.

- i. Have you ever had chest pain, palpitation, breathlessness at rest or exertion?  
Y/N
- ii. Are you suffering from heart disease, diabetes, high or low Blood Pressure or kidney disease? Y/N
- iii. Have you ever had Chest X-Ray, ECG, Blood Sugar, Cholesterol or any other test done? Y/N Yes

If the answer/s to any/all above questions is -Yes, submit all relevant papers with this form.

Dated at 20 on the day of 22/10/24 2024

Shweta Arora  
Signature of L.A.

Signature of the Cardiologist

Name & Address  
Qualification

Code No.

Clinical findings  
(A)





Height (Cms)	Weight (kgs)	Blood Pressure	Pulse Rate
153	57.5	140/80	66

(B) Cardiovascular System

NAD

Rest ECG Report:

Position	Sup	P Wave	NAD
Standardisation Imv	100	PR Interval	NAD
Mechanism	all	QRS Complexes	NAD
Voltage	all	Q-T Duration	NAD
Electrical Axis	all	S-T Segment	NAD
Auricular Rate	60	T-wave	NAD
Ventricular Rate	60	Q-Wave	NAD
Rhythm	sin		
Additional findings, if any.	no		

Conclusion:

WNL

Dated at

22/10/24

on the day of

20 24

Signature of the Cardiologist

Name & Address

Qualification

Code No.



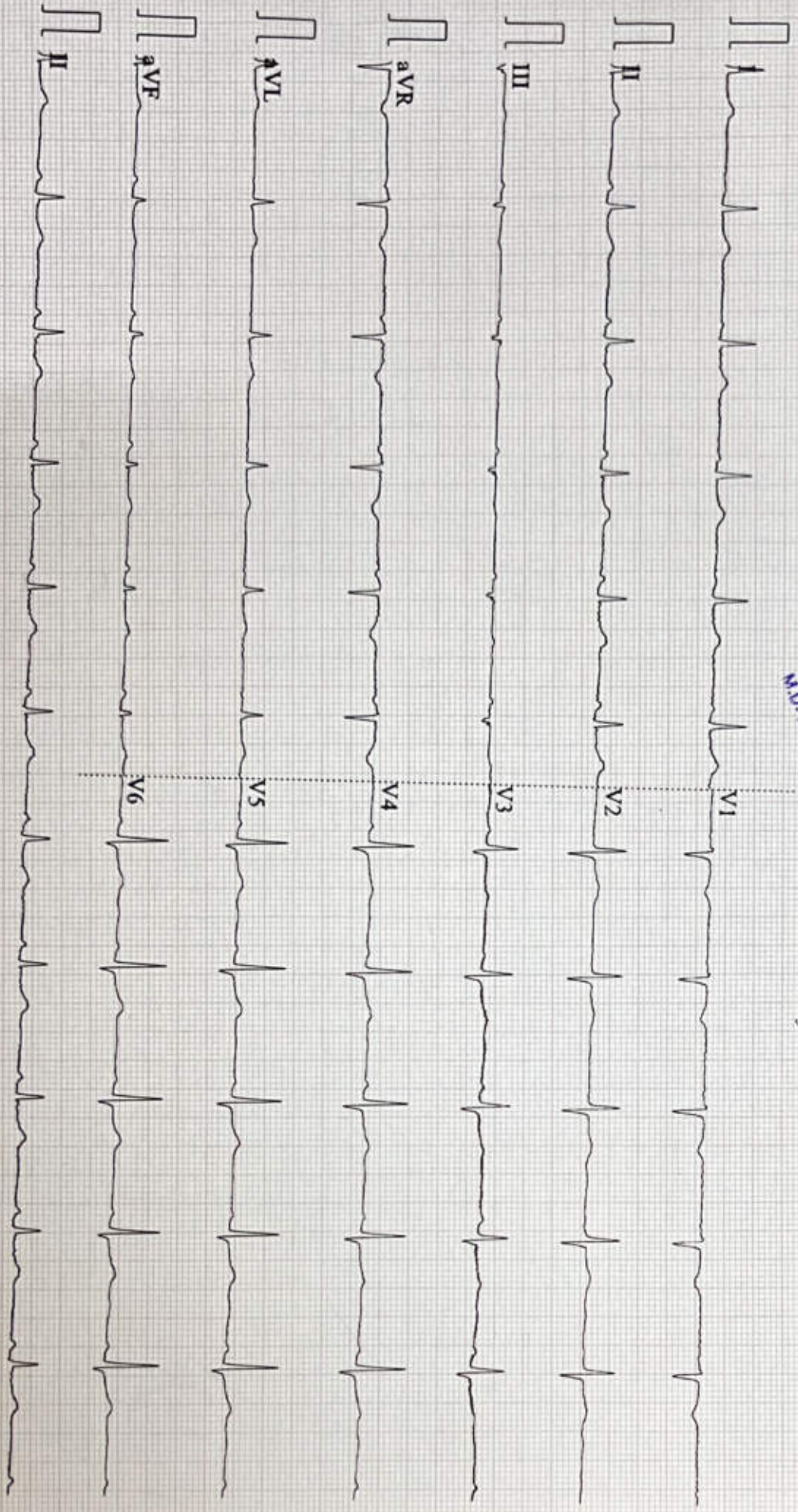




Diagnosis Information:

*Dr. Raj Kumar*  
M.D. (Medicine)  
Card. FNC  
Report Confirmed by:

*Sunita Arora*







# Shri Durga Health Care

Consultation : Computerized Pathological Lab ECG, CTMT, PFT

Name:	SUNITA ARORA	Sex:	FEMALE
Lab. No:	202401001	Age:	61
Date:	22/10/2024	Ref. By	LIC

## BIOCHEMISTRY

<u>Test Name</u>	<u>Value</u>	<u>Unit</u>	<u>Normal Value</u>
Blood Sugar PP	98	mg/dl	70-140

\*\*\*\*\*End of Report\*\*\*\*\*



# SDHC

D-63, Ground Floor, South Exn. Part-1, Near Barat Ghar, New Delhi-110049  
Mob : 9899994465 | E-mail : healthcareshridurga@gmail.com

Note Valid For Medico-legal Purposes

Home Sample Collection Facility Available | Timing : 8:00 am To 8: Pm (Sunday Open)



दुर्गा HEALTHCARE  
(CHAUDHARI DURGASINGH)  
HEALTHCARE PRIVATE LIMITED

DR. SUNIL KUMAR  
DR. ANITA KUMAR



DR. PREETI CHANAN



GPS Map Camera



**New Delhi, Delhi, India**  
H6cc+vj7, Har Gyan Singh Arya Marg, Arya Basti, Block D,  
New Delhi, Delhi 110003, India  
Lat 28.572162° Long 77.221588°  
22/10/24 10:37 AM GMT +05:30