



### OPD ASSESSMENT FORM



Name Mr. Arvind Rajput Age.Sex 39/M MR.No. S146 243

Doctor Dr. Hardik Shroff Date 25/11/28

Ht : \_\_\_\_\_ Wt : \_\_\_\_\_ Temp : \_\_\_\_\_ Pulse : \_\_\_\_\_ BP : \_\_\_\_\_

SPO2 : \_\_\_\_\_ Post of walk SPO2 : \_\_\_\_\_

Chief Complaints :

Drug / Food Allergy :

*No complain*

Prior Medication Reviewed : Yes  No

On examination :

*BE - Ant. seg MAD*

Past History :

*Vn K<sup>Gr</sup> G<sup>6</sup> d16 fundii (Overhead) BE-MAD*

Provisional Diagnosis :

*MM opthalmic*

Nutritional Assessment :

- Obese
- Well nourished
- Mild- moderate nourished
- Severely mal-nourished

Treatment and further Advices :  
(Write in Capital Letters)

R<sub>x</sub>

Investigation advised :

*Dr. Hardik Shroff*

Follow Up : Yes Date : \_\_\_\_\_

SUNSHINE GLOBAL HOSPITAL  
Pipava, surat.  
Signature

In case of emergency Please report to Emergency Department of Hospital OR  
Call : 75748 49465, 0261-4111000



OPD ASSESSMENT FORM



Name Mr. Arvind Rajpoot Age.Sex 39/M MR.No. S14G243

Doctor Dr. Umang Desai Date 25/11/2023

Ht : \_\_\_\_\_ Wt. : \_\_\_\_\_ Temp : \_\_\_\_\_ Pulse : \_\_\_\_\_ BP : \_\_\_\_\_

SPO2 : \_\_\_\_\_ Post of walk SPO2 : \_\_\_\_\_

Chief Complaints :

Drug / Food Allergy :

- Routine dental check up

Prior Medication Reviewed : Yes  No

On examination :

Past History :

- stain calculus

Provisional Diagnosis :

Nutritional Assessment :

- Obese
- Well nourished
- Mild- moderate nourished
- Severely mal-nourished

Treatment and further Advices :  
(Write in Capital Letters)

Investigation advised :

Rx  
1) scaling

Follow Up : \_\_\_\_\_ Date : \_\_\_\_\_

U. Desai

Signature

In case of emergency Please report to Emergency Department of Hospital OR  
Call : 75748 49465, 0261-4111000




<b>MR No.</b> : S146243	<b>Collection Date</b> : 25/11/2023 11:53AM
<b>Patient Name</b> : Mr. Arvind Singh Rajpoot	<b>Age</b> : 39 Y <b>Sex</b> : Male
<b>Ref By</b> : Dr. Hospital A Doctor	<b>Report Date</b> : 25/11/2023 12:24 PM

**HAEMATOLOGY**

Parameter	Result	Units	Normal Range
<b>CBC with ESR</b>			
HAEMOGLOBIN	15.2	gm/dl	13.0 - 17.0
PCV	45.2	%	40 - 50
RBC COUNT	5.35	mill/cmm	4.5 - 5.5
MCV	84.5	fl	76 - 96
MCH	28.4	pg	26 - 32
MCHC	33.6	%	32 - 36
RDW	13.8	%	11 - 15
PLATELET COUNT	1.90	lacs/cmm	1.5 - 4.5
WBC COUNT	7780	/cmm	4000 - 11000
ESR	04	mm/hr	0 - 10
<b>DIFFERENTIAL WBC COUNT</b>			
NEUTROPHIL	46	%	40 - 70
LYMPHOCYTES	36	%	20 - 40
EOSINOPHILS	11	%	1 - 6
MONOCYTES	07	%	2 - 11
BASOPHILS	00	%	0 - 2
<b>PERIPHERAL SMEAR</b>			
RBC MORPHOLOGY	Normochromic Normocytic		
WBC MORPHOLOGY	Eosinophilia		
PLATELET ON SMEAR	Adequate		
HEMOPARASITES	Not Seen		

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

  
**Dr. Shobha Choksi**  
**MD, DCP (Pathology)**  
**Reg. No.: G-9074**

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25/11/2023 12:25PM  
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<b>Ref By</b> : Dr. Hospital A Doctor	<b>Report Date</b> : 25/11/2023 12:18 PM

**HAEMATOLOGY**

<b>Parameter</b>	<b>Result</b>	<b>Normal Range</b>
<b>BLOOD GROUP &amp; RH FACTOR</b>		
BLOOD GROUP	"B"	
RH FACTOR	POSITIVE	

**BIOCHEMISTRY**

<b>FASTING BLOOD SUGAR (FBS)</b>			
FASTING BLOOD GLUCOSE (Hexokinase)	99	mg/dl	74 - 110
FASTING URINE GLUCOSE	Absent		
FASTING URINE KETONE	Absent		


**CLINICAL CHEMISTRY**

<b>THYROID FUNCTION TEST [TFT]</b>			
TOTAL T3 (CLIA)	1.27	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	9.57	ug/dl	5.1 - 14.0
TSH (CLIA)	3.06	uIU/ml	0.2 - 4.5

Note:-

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (freeT4). Additionally the hypothalamic tripeptide, thyrotropin releasing hormone (TSH) directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy also stimulate the thyroid gland to synthesize and secrete T3 and T4.

Quantification of TSH significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated whiled in secondary and tertiary hypothyroidism . TSH levels are low.

  
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MR No. : S146243	Collection Date : 25/11/2023 11:53AM
Patient Name : Mr. Arvind Singh Rajpoot	Age : 39 Y Sex : Male
Ref By : Dr. Hospital A Doctor	Report Date : 25/11/2023 12:19 PM

**BIOCHEMISTRY**

Parameter	Result	Units	Normal Range
<b>HBA1C [GLYCOSYLATED HEAMOGLOBIN]</b>			
HbA1C	5.7	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	116.89	mg/dl	

The test is done on Cobas Integra 400plus-Turbidimetric Inhibition ImmunoAssay  
 Note:- Criteria for the diagnosis of diabetes HbA1c  $\geq 6.5\%$   
 1. HbA1c is important test for the assessment of long term blood glucose control (also called glycemic control).  
 2. HbA1C reflects mean glucose concentration over past 6-8 weeks and provides a much better indication of long term glycemic control than blood glucose determination.  
 3. HbA1C is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.  
 4. Long term complications of diabetes such as retinopathy, nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.  
 5. Genetic Variants (Hb-S trait, Hb-C trait) elevated fetal haemoglobin & chemically modified derivatives of haemoglobin (eg carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1C measurement.

**SERUM URIC ACID**

SERUM URIC ACID (Uricase)	6.5	mg/dl	3.4 - 7.0
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\*\*\*\*\* End Report \*\*\*\*\*

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<b>Ref By</b> : Dr. Hospital A Doctor	<b>Report Date</b> : 25/11/2023 12:21 PM

**BIOCHEMISTRY**

Parameter	Result	Units	Normal Range
<b>LIPID PROFILE</b>			
SERUM CHOLESTEROL CHOD PAP	<b>206</b>	mg/dl	50 - 200
HDL CHOLESTEROL Direct	43	mg/dl	40 - 60
LDL CHOLESTEROL Direct	<b>135.6</b>	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	139	mg/dl	50 - 150
VLDL Calc	27.8	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	4.79		0 - 5
LDL / HDL RATIO	<b>3.15</b>		0 - 3

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment.
- Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Details on test interpretation available from the lab.

TEST	NEAR OPTIMAL (Moderate Risk)	BORDER LINE (Risk)	HIGH (Risk)	VERY HIGH
CHOLESTROL	160-199	200-239	240-279	280
HDL	50-59	40-49	< 40	
LDL	100-129	130-159	160-190	>190
TRIGLYCERIDES	150-169	170-199	240-499	>500
CHO/HDL RATIO	3.3-4.4	4.4-11.0	>11.0	
LDL/HDL RATIO	0.5-3.0	3.0-6.0	>6.0	

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

*SC*  
**Dr. Shobha Choksi**  
**MD, DCP (Pathology)**

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<b>Ref By</b> : Dr. Hospital A Doctor	<b>Report Date</b> : 25/11/2023 12:22 PM

**BIOCHEMISTRY**

Parameter	Result	Units	Normal Range
<b>LIVER FUNCTION TEST</b>			
ALKALINE PHOSPHATASE (IFCC)	68	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.9	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.3	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.6	mg/dl	0.0 - 0.8
SGPT (IFCC)	22	U/L	5 - 41
SGOT (IFCC)	19	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.7	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	5.0	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.7	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	1.85	gm/dl	1.5 - 2.5
<b>SERUM CREATININE</b>			
SERUM CREATININE (JAFPE)	0.9	mg/dl	0.5 - 1.2
<b>BUN [BLOOD UREA NITROGEN]</b>			
BUN	10.1	mg/dl	8 - 23
<b>ALBUMIN-CREATININE RATIO</b>			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	5.6	mg/L	
URINE CREATININE (JAFPE)	131.1	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	4.27	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

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

**Dr. Shobha Choksi**  
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<b>Patient Name</b> : Mr. Arvind Singh Rajpoot	<b>Age</b> : 39 Y <b>Sex</b> : Male
<b>Ref By</b> : Dr. Hospital A Doctor	<b>Report Date</b> : 25/11/2023 12:26 PM

**CLINICAL PATHOLOGY**

Parameter	Result	Normal Range
<b>URINE ROUTINE &amp; MICROSCOPIC EXAMINATION</b>		
TYPE OF SPECIMEN - URINE	Random	
<b>PHYSICAL EXAMINATION</b>		
QUANTITY	40	ml
COLOUR	Pale Yellow	
APPEARANCE	Clear	
REACTION (pH)	6.0	
SPECIFIC GRAVITY	1.030	
<b>CHEMICAL EXAMINATION</b>		
PROTEIN	Absent	
GLUCOSE	Absent	
KETONE	Absent	
BILE SALT	Absent	
BILE PIGMENT	Absent	
OCCULT BLOOD	Absent	
NITRITE	Absent	
<b>MICROSCOPIC EXAMINATION</b>		
PUS CELLS	2-3	/hpf
EPITHELIAL CELLS	1-2	/hpf
RBC	Absent	/hpf
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

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

**Dr. Shobha Choksi**  
MD, DCP (Pathology)

Reg. No.: G-9074

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PAT. NAME: Arvind Rajpoot	Date : 25/11/2023
REF. DOCTOR : Hosp. Dr.	AGE : 39 Yrs / M
INV. : USG Abdomen & Pelvis	MR NO. : S146243

**Findings:**

Liver is normal in size, shape and shows mild increase in parenchymal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is distended and appears normal. No e/o calculus, sludge or mass lesion is seen. CBD and Portal Vein appears normal in size and calibre.


Pancreas appears normal in size and shows normal echopattern to the extent assessed. Spleen appears normal in size, shape and homogenous echopattern.

Both kidneys appear normal in size, shape and echopattern. The corticomedullary differentiation is well maintained. No e/o any calculus or hydronephrosis is seen.

Aorta and para-aortic regions appears normal. No e/o any lymphadenopathy. Urinary bladder appears well distended and normal. Prostate appears normal in size, shape and echopattern. No e/o free fluid in abdomen / pelvis.

**IMPRESSION:**

- Grade I fatty liver.

  
**Dr. Sneha Dumaswala**  
MBBS, DNB-Radiodiagnosis  
Consultant Radiologist  
G-21796



PAT. NAME: Arvind Rajpoot	Date : 25/11/2023
REF. DOCTOR : Hosp. Dr.	AGE : 39 Yrs / M
INV. : Radiograph of Chest PA	MIR NO. : S146243

**Clinical Details:** HC

**Observation:**

- Both the lung fields appears normal.
- Both costophrenic angles appear clear.
- Both the hila appears normal.
- Trachea appears in midline.
- Cardiac size and other mediastinal shadows appears normal.
- Both domes of diaphragm appear normal.
- Bony thorax appears normal.

  
**Dr. Sneha Dumaswala**  
MBBS, DNB-Radiodiagnosis  
Consultant Radiologist  
G-21796

Transcribed By: Asha

Page: 1 out of 1  
Date & Time of report: 25/11/2023 - 11:38 AM

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ECHO CARDIOGRAPHIC REPORT



Patient's Name : Mr Anvindsingh Rastogi Date : 25/11/23 11:20 AM

Sex : M Age : 39 Ref. by Dr. : \_\_\_\_\_ Done by Dr. Sarvendra Singh

LV Size : (n)

LVEF : 68 % (VISUAL)

DIASTOLIC DYSFUNCTION : n

LVH : No

- RWMA : ANTERIOR WALL
- ANTERIOR SEPTUM
- IVS
- LV APEX
- POSTERIOR WALL
- LATERAL WALL
- INFERIOR WALL

No RWMA

MITRAL VALVE : | (n)

AORTIC VALVE  
TRICUSPID VALVE (n)

PAH : -

PASP : 8 mmHg

RA :  
RV : | (n)

LA :  
IVC : | (n)

IAS :  
IVS : | (n)

IVS (s)	cm	LV (s)	cm	PW (s)	cm	LVEF =	%
IVS (d)	cm	LV (d)	cm	PW (d)	cm	FS =	%

CONCLUSION :

No veg. or IPE



23-NOV-2023 13:04:19

DOB: 39 | M  
yr. MALE

Vent rd 66 BPM  
PR int: 127 ms  
QRS dur: 96 ms  
QT/QTc: 342/356 ms  
P-R-T axes: 18 46 8

SINUS RHYTHM  
POSSIBLE RIGHT VENTRICULAR CONDUCTION DELAY  
BORDERLINE ECG  
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS

Reviewed by Mr. Arvind Raypoat

39 | M

