CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	**Sample No. :**	SAMPLE-0106922
Patient ID :	CH-2024-0053592	**Visit No. :**	OPD/2024/02/0000520
Age/Sex :	37y/Male	**Call. Date :**	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 15:11
Ward :	-	**Report Date :**	10-Feb-2024 16:49

PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	94.2 mg/dl [LOW]	100 - 140

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

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

CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	Sample No. :	SAMPLE-0106904
Patient ID :	CH-2024-0053592	Visit No. :	OPD/2024/02/0000520
Age/Sex :	37y/Male	Call. Date :	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 09:56
Ward :	-	Report Date :	10-Feb-2024 15:37

HBA1C

Investigation	Result	Normal Value
Mean Blood Glucose	102 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 contril than blood glucose determination.
This Reaction is irreverdible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications).
nephropathy(Kidney-complications) & neuropathy(never complications) are potentially serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.

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

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

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
10-02-2024	PRATIK D SHAH	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.

COMMENTS:

No abnormality detected.

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

CHARUSAT HOSPITAL

DATE	PATIENT NAME	SEX	REFERRED BY DR	INVESTIGATION
10-02-2024	PRATIK D SHAH	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
DR KIRTI C THAKKAR
M.B.B.S,D.M.R.D

CHARUSAT HOSPITAL

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

DR. Pavan

Date & Time : 20 - 2 - 2024

Registration No. : CH - 2024 - 0053592

Name : Bantik. Dineshchandra. Singh Contact No. : (M) _____

Age : 37 Sex : M (O) _____

Address : _____

B.P. : 110/80 mmHg Pulse : 82 bpm SpO$_2$: 100 %

BMI : _____ Height : 170 cm Weight : 59.6 kg

OPD-INITIAL ASSESSMENT FORM

Chief Complaints : H/o ~~Cough~~ Cold 2 days

CASE ANALYSIS

Past History : _____

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) : _____

F/OPD/5083

Investigation/s Advised :

Provisional Diagnosis :

Allergy :

Nutritional Advice :

TREATMENT ADVISED

DATE	DOCTOR'S NOTE	REMARK
	Piles & Fissure T. Diosmine 264 1-0-1 T. Azithro 500 0-1-0. T. Rafiod D 1-0-0	

CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	Sample No. :	SAMPLE-0106904
Patient ID :	CH-2024-0053592	Visit No. :	OPD/2024/02/0000520
Age/Sex :	37y/Male	Call. Date :	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 09:56
Ward :	-	Report Date :	10-Feb-2024 11:53

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	12.9 gm/dl [LOW]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	4.33 mill./c.mm [LOW]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]
WBC :	4780 /c.mm [NORMAL]	4000 - 10000

Platelet count

Investigation	Result	Normal Value
Platelets	3.18 Lakh/cmm [NORMAL]	1.5 - 4.5

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	62 % [NORMAL]	40 - 70
Lymphocytes	28 % [NORMAL]	20 - 40
Eosinophils	02 % [NORMAL]	1 - 6
Monocytes	08 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	31.4 mg/dl [NORMAL]	15 - 40

S.Creatinine

CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	**Sample No. :**	SAMPLE-0106904
Patient ID :	CH-2024-0053592	**Visit No. :**	OPD/2024/02/0000520
Age/Sex :	37y/Male	**Call. Date :**	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 11:53

Investigation	Result	Normal Value
Serum Creatinine	1.12 mg/dl [NORMAL]	Male : 0.9 to 1.5 mg/dl Female : 0.8 to 1.2 mg/dl

BUN

Investigation	Result	Normal Value
BUN :	15 [NORMAL]	8.0 to 23.0 (mg/dl)

URIC ACID

Investigation	Result	Normal Value
Serum Uric Acid	7.87 mg/dl [HIGH]	Male : 2.5 to 7.0 Female : 1.5 to 6.0

ESR

Investigation	Result	Normal Value
ESR - After One Hour	14 mm [HIGH]	[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 :	88.9 mg/dl [NORMAL]	70 - 110
Fasting Urine Sugar :	Absent	

TSH

Investigation	Result	Normal Value
TSH :	0.507 uIU/ml [NORMAL]	0.34 to 4.5 (uIU/ml)

T3

Investigation	Result	Normal Value

CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	**Sample No. :**	SAMPLE-0106904
Patient ID :	CH-2024-0053592	**Visit No. :**	OPD/2024/02/0000520
Age/Sex :	37y/Male	**Call. Date :**	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 11:53

T3-Triodothyronine :	1.26 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

T4

Investigation	Result	Normal Value
T4-thyroxine :	87.2 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

LIPID PROFILE

Investigation	Result	Normal Value
Serum Cholesterol (Chol) :	192.6 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Boderline High > 240 mg/dl High
Serum Triglyceride :	88.2 mg/dl	<150 mg/dl Normal 150-199 mg/dl Boderline High 200-499 mg/dl High
S.HDL Cholesterol :	36.3 mg/dl	Men : >55, Wo : >65 Standread Risk Level Men : 35-55, Wo : 46-65 Risk Men : <35, Wo : <45
LDLC :	117.78 mg/dl	
VLDL :	38.52 mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	3.24 - [NORMAL]	< 3.5
TC / HDL Ratio :	5.31 - [NORMAL]	4.0 to 6.0
LDL (DIRECT) :	102.3 mg/dl [Near 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

CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	**Sample No. :**	SAMPLE-0106904
Patient ID :	CH-2024-0053592	**Visit No. :**	OPD/2024/02/0000520
Age/Sex :	37y/Male	**Call. Date :**	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 11:53

Total Bilirubin :	0.58	mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.18	mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	24.3	IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	12.1	IU/L [NORMAL]	<= 45.0
Alkaline Phosphatase (ALP) :	120.3	IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0
Total Protein (TP) :	7.26	gm/dl [NORMAL]	[Adult 6.0 to 7.8]
Albumin (ALB) :	3.98	gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.40	[NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.28	gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.2		

URINE R & M

Investigation	Result	Normal Value
Physical Examination :		
Quantity :	15 ml	
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Acidic -	
Specific Gravity :	1.020 -	
Chemical Examination :		
Albumin :	Absent -	
Sugar :	Absent -	
Bile Salts :	Absent -	
Bile Pigments :	Absent -	

CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	**Sample No. :**	SAMPLE-0106904
Patient ID :	CH-2024-0053592	**Visit No. :**	OPD/2024/02/0000520
Age/Sex :	37y/Male	**Coll. Date :**	10-Feb-2024 09:00
Referred By :	RIPAL PATEL	**S. Coll. Date :**	10-Feb-2024 09:56
Ward :	-	**Report Date :**	10-Feb-2024 11:53

Acetone :	Absent	-
Urobilinogen :	Absent	-
Microscopie Examination :		
Pus Cells :	2-3	-
RBCs :	Absent	-
Epithelial cells :	1-2	-
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)

CHARUSAT HOSPITAL

Patient Name :	PRATIK DINESHCHANDRA SHAH	Sample No. :	SAMPLE-0106916
Patient ID :	CH-2024-0053592	Visit No. :	OPD/2024/02/0000520
Age/Sex :	37y/Male	Call. Date :	10-Feb-2024 11:54
Referred By :	RIPAL PATEL	S. Coll. Date :	10-Feb-2024 12:19
Ward :	-	Report Date :	10-Feb-2024 12:19

HIV

Investigation	Result	Normal Value
HIV 1-2 :		
HIV 1 & 2	Negative -	
Comments	Test Result Align Can not be used to diagnose HIV 1 & 2 interaction. A Negative Test Result does not Preciuse the Possibillity of exposure to or infection with HIV. This may usuallu happen during initial phase of about 3 months after exposure and in immunocompromised but infected person, kindly contact the lab if required. Test results may also vary according to the sensitivity and specificity of the kit. IN CASE OF POSITIVE RESULTS CONFORMATORY TESTS ARE ADVISED.	

CALCIUM TOTAL

Investigation	Result	Normal Value
S.Calcium Total :	8.9 mg/dl [NORMAL]	8.4 to 10.4 (mg/dl)

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

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

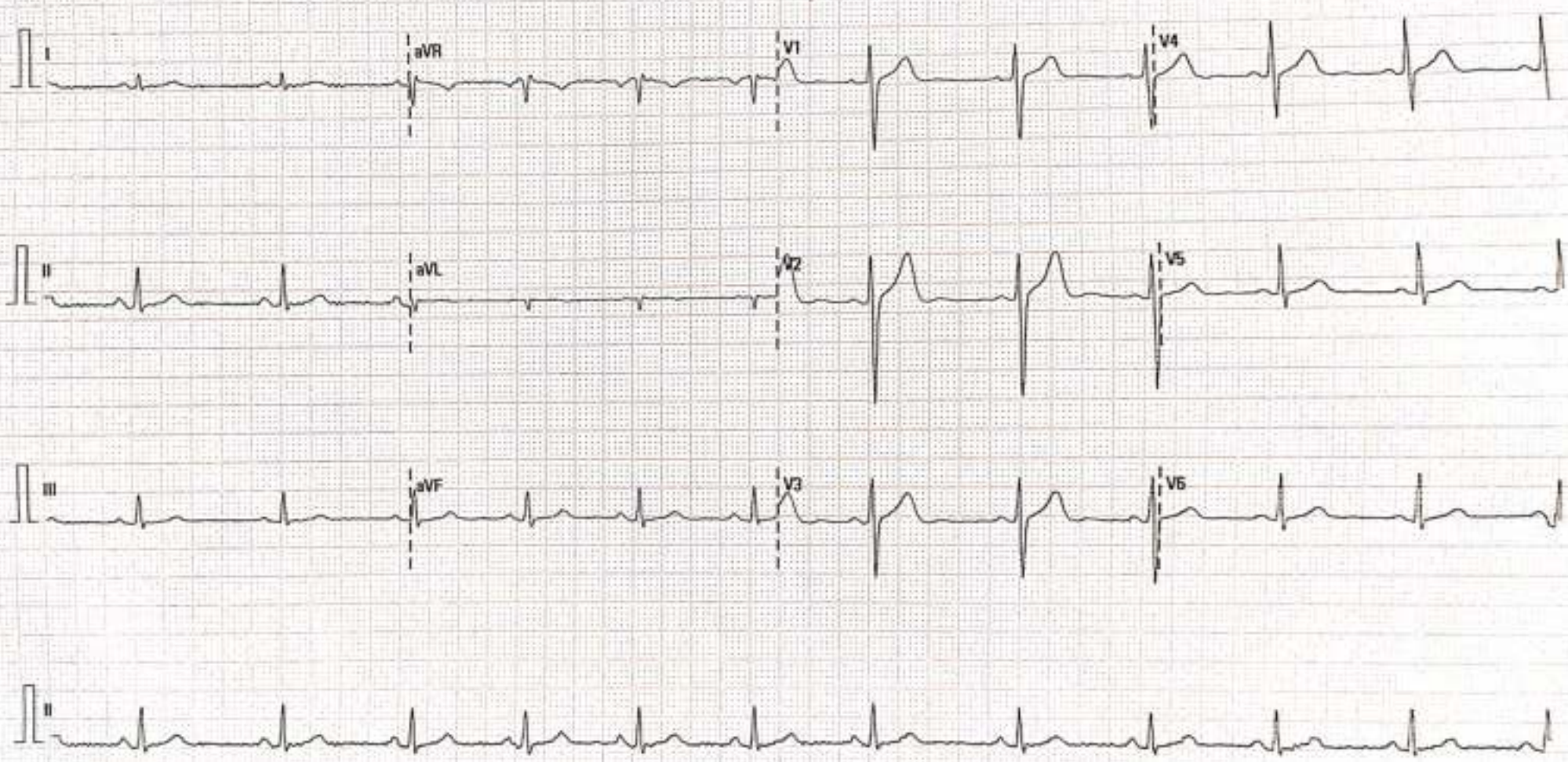
ID: ch-2024-0053592
Name: pratik d, shah
Age: 31 Years
Gender: Male

10-02-2024 10:42:33 AM

Vent. Rate	71 bpm
PR Interval	134 ms
QRS Duration	76 ms
QT/QTc Interval	366/385 ms
P/QRS/T Axes	61/67/61 deg
QTc:Hodges	

Sinus arrhythmia

Unconfirmed Diagnosis



25 mm/s | 10 mm/mV | 50 Hz~ | BDR 20 Hz | CHARUSAT HOSPITAL | 02.03.00/V28.4.1 | SNJFN-52001657

DENTAL REGISTRATION FORM

Date & Time : 20 - 2 - 2024

Registration No. : CH - 7024 - 0053592

Name : Patil. Dineshchandra. Shah Contact No. : _____

Age : 37 Emergency Contact No. : _____

Sex : M Address : _____

OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine checkup.

Family History :

- ☐ Diabetes
- ☐ Hypertension
- ☐ IHD
- ☐ Others (Specify) :

- ☐ Hypertension
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Bleeding Disorder

Habits : ☐ Tobacco ☐ 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 ઈંજેકશનની 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 આધૂરી છોડીશ કે અનિયમિત રહીશ તો તેની નિષ્ફળતા માટે ડૉક્ટર કે ચારૂસેટ 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 : _____

Treatment Plan : _____

Date : 10/2/24

Time : _____

Name of Doctor Dr. Markwadi

Signature : _____

CHRF/DENTAL/5016

CHARUSAT HOSPITAL
Care with compassion

OPHTHALMIC REGISTRATION FORM

Reg. No. : CH-2024-005354

Date : 20-2-2024

Patient's Name : Parmar. Dineshchandra. Shah Age : 37

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 /

Routine 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 / - / RE / LE / BE

Family History : Glaucoma / RP / DM / NAD.

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

NAD.

EYE DETAILS :

	RE	LE
V/A with PH	6/6	6/6
IOP	12 mmHg	12 mmHg
OWN GLASS :	-	-
AR :	-0.25 x 23°	-0.25/-0.25 x 136°

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
	SPH.	CYL.	AXIS	SPH.	CYL.	AXIS
Dis	plano		6/6	plano		6/6
Nr. Add.	+		N6			N6
Comp						

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

Remark :

Signature :

CHRS/OPTH/5089