

Dr. Nishant Singh

MBBS, M.D. (MEDICINE), DIP.DIABETES (MUMBAI)
CONSULTANT PHYSICIAN & DIABETES EXPERT
JAYPEE HOSPITAL NOIDA
REG.NO.DMC-32821
email - mail2nidaan@gmail.com
WHATSAPP NUMBERS - 9911608980/8448212596

SUNDAY ONLY PREMIUM OPD NIDAAN CLINIC
BY PRIOR APPOINTMENTS ONLY
11:00 AM TO 1:00 PM

EX. TEACHING FACULTY, MEDICINE
Maulana Azad Medical College and LNJP Hospital, Delhi
EX. TEACHING FACULTY, MEDICINE
University College of Medical Science and GTB Hospital, Delhi
FORMERLY AT - YATHARTH HOSPITALS AND FORTIS
HOSPITAL NOIDA

TRAINING AND DIPLOMA
Diploma in Diabetes Management, Nanavati Hospital, Mumbai
Certificate in Diabetes Nutrition and Lifestyle Approach, ADA
Certificate Program in Diabetes Management by BMJ, UK

MEMBERSHIP & AWARDS
International Diabetes Federation (IDF)
American Society of Hypertension
Association Of Physicians Of India
Research Society for the Study of Diabetes in India

• NIDAAN CLINIC
LD-17, AMRAPALI ZODIAC, SECTOR 120, NOIDA
MONDAY TO SATURDAY
Timing : 9:30AM TO 10:30AM & 5:30 PM TO 9:20PM

• JAYPEE HOSPITAL
MONDAY TO SATURDAY
Timing : 11:00AM TO 3:00PM

Name: Kusum Verma
Age/Sex: 47y / F
Office ID: NS8307

Date: 01-11-2021 02:04 pm
Mobile: 8448212596

Vitals: Pulse: 86 /min, SPO2: 99 %, Temperature: 96.9 °F, Weight: 69 kg, BP: 128/88 mmHg

Investigation results:

HbA1c Test: 01-11-2021: HbA1c: 8.4 %

CBC - Complete Blood Count: 01-11-2021: Hemoglobin: 9.8 g/dl

Diagnosis: Vertigo, benign positional, Vascular Headache, Migrainous vertigo, Iron deficiency anemia syndrome, DM - Diabetes mellitus, Fatty Liver, low vitamins b12/vit d

	दवाएँ	मात्रा	आवृत्ति	अवधि	कुल
1	Tablet Vertin (8 mg) BETHAHISTINE(8 MG)	1 tablet नाश्ते के बाद, दोपहर के खाने के बाद, रात के खाने के बाद <u>Then</u> 1 tablet नाश्ते के बाद, रात के खाने के बाद <u>Then</u> 1 tablet नाश्ते के बाद	1 - 1 - 1 1 - 0 - 1 1 - 0 - 0	3 दिन 3 दिन 3 दिन	18 tablets
2	Tablet Valera M (5/1000 mg) EVOGLIPTIN 5 MG+METFORMIN 1000 MG	1 tablet नाश्ते के बाद	1 - 0 - 0	10 दिन	10 tablets
3	Tablet Semi-Amaryl (0.5 mg) GLIMEPIRIDE(0.5 MG)	1 tablet नाश्ते से पहले, if fastin around 100 stop it	1 - 0 - 0	10 दिन	10 tablets
4	Tablet Seder OM ELEMENTAL IRON(30 MG) + FOLIC ACID(300 MCG) + VITAMIN B12(0.75 MCG) + VITAMIN C(50 MG)	1 tablet नाश्ते के बाद, iron tablets	1 - 0 - 0	10 दिन	10 tablets
5	Tablet GB 29 Total METHYLCOBALAMIN(1500 MCG) + NORTRIPTYLINE(10 MG) + PREGABALIN(75 MG)	1/2 tablet रात के खाने के बाद	0 - 0 - 1/2	10 दिन	5 tablets
6	Capsule Uprise D3 (60 K) Vit D3(60000 IU)	1 units खाने के बाद	सप्ताह में एक बार	1 महीना	4 capsules
7	Tablet Spinfree CINNARIZINE(20 MG) + DIMENHYDRINATE(40 MG)	1 tablet नाश्ते के बाद, रात के खाने के बाद, if chakkar	1 - 0 - 1	जरूरत पड़ने पर	

8	Tablet Prusent (2 mg) <i>PRUCALOPRIDE(2 MG)</i>	1 tablet	0 - 0 - 1	जरूरत पड़ने पर	
		रात के खाने के बाद, for constipation / bloating abdominal fullness/ gas stuck feeling			
9	Tablet Naxdom (500 & 10) <i>DOMPERIDONE(10 MG) + NAPROXEN(500 MG)</i>	1 tablet	1 - 1 - 1	जरूरत पड़ने पर	
		नाश्ते के बाद, दोपहर के खाने के बाद, रात के खाने के बाद, if headache take when needed			

Note to Pharmacist: Kindly substitute brands as needed

Advised Investigations: neuropathy testing, eye retinal exam

Instructions:

- every 7 day once do reading fasting sugars , after 2hrs of breakfast sugars,after 2 hrs of lunch and 2hrs after dinner also not this in a - log diary make a diabetes trend diabetes
- bayer Contour or johnson and johnson accucheck insta one touch series are good reliable glucometers
- Target before meals sugars < 120 and After meals Sugar <160
- Avoid sweets and sugar products like fruit juice, ice cream, biscuits, chocolate, etc
- avoid paratha/desi ghee on roti and tadkaa of oil, avoid buffalo milk also prefer cow milk/toned milk/ non veg items with gravy/ mutton etc.
- Regular exercise daily

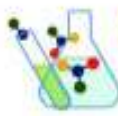
Follow up:



Dr. Nishant Singh
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REG NO -DMC32821
अपना दवा का पर्चा ऑनलाइन प्राप्त करें docon.co.in पर



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Government Registered Lab

Date	29/10/2021	Srl No.	1091	LAB ID:	2110291091
Name	Mrs. KUSUM	Age	47 Yrs.	Sex	F
Ref. By	Dr. MANOJ AGARWAL			Patient Id:	

Test Name	Value	Unit	Normal Value
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HAEMATOLOGY

COMPLETE BLOOD COUNT (CBC)

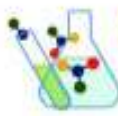
HAEMOGLOBIN (Hb)	9.8	gm/dl	11.5 - 16.5
TOTAL LEUCOCYTE COUNT (TLC)	8,300	/cumm	4000 - 11000

DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHIL	58	%	40 - 75
LYMPHOCYTE	35	%	20 - 45
EOSINOPHIL	02	%	01 - 06
MONOCYTE	05	%	02 - 10
BASOPHIL	00	%	0 - 0
R B C COUNT	4.2	Millions/cmm	3.8 - 4.8
P.C.V / HAEMATOCRIT	32.1	%	35 - 45
M C V	74.8	fl.	80 - 100
M C H	22.8	Picogram	27.0 - 31.0
M C H C	30.5	gm/dl	33 - 37
PLATELET COUNT	2.16	Lakh/cmm	1.50 - 4.50
ESR (WESTEGREN' s METHOD)	34	mm/1st hr.	0 - 20

**** End Of Report ****

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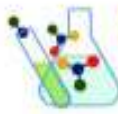
Test Name	Value	Unit	Normal Value
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BIOCHEMISTRY

BLOOD SUGAR RANDOM 217.3 mg/dl 70 - 140

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Test Name	Value	Unit	Normal Value
<u>KIDNEY FUNCTION TEST (RFT)</u>			
BLOOD UREA	13.4	mg /dl	10.0 - 45.0
SERUM CREATININE	0.72	mg%	0.5 - 1.4
SERUM URIC ACID	3.5	mg%	2.4 - 6.2
SODIUM	133.0	mmol/L	135.0 - 148.0
POTASSIUM	4.3	mmol/L	3.5 - 5.5
CALCIUM	9.2	mg/dl	8.0 - 10.2
CHLORIDE	102.0	mmol/L	94.0 - 110.0

**** End Of Report ****

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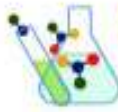
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Ref. By	Dr. MANOJ AGARWAL			Patient Id:	

Test Name	Value	Unit	Normal Value
<u>LIVER FUNCTION TEST (LFT)</u>			
BILIRUBIN TOTAL	0.40	mg/dl	0 - 1.20
CONJUGATED (D. Bilirubin)	0.10	mg/dl	0.00 - 0.30
UNCONJUGATED (I.D. Bilirubin)	0.30	mg/dl	0.00 - 0.80
SGOT	42.5	IU/L	0 - 35
SGPT	44.4	IU/L	0.0 - 40.0
ALKALINE PHOSPHATASE IFCC Method	200.9	U/L	80 - 306
TOTAL PROTEIN	6.8	gm/dl	6.3 - 8.0
ALBUMIN	4.1	gm/dl	3.5 - 5.5
GLOBULIN	2.7	gm/dl	2.3 - 3.5
GAMMA GT	22.0	IU/L	6.0 - 42.0

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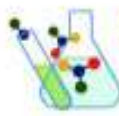
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IMMUNOLOGY

TSH	2.94	uIU/ml
Chemiluminescence		
<u>ADULTS</u>	0.35 - 5.50	uIU/ml

COMMENT:

THE LEVELS OF THYROID HORMONE (T3 & T4) ARE LOW IN CASE OF PRIMARY, SECONDARY AND TERTIARY HYPOTHYROIDISM AND SOMETIMES IN NONTHYROIDAL ILLNESS ALSO.

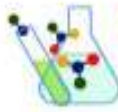
INCREASED LEVELS ARE FOUND IN GRAVE'S DISEASE, HYPERTHYROIDISM AND THYROID HORMONE RESISTANCE. LEVELS ARE ALSO RAISED IN T3 THYROTOXICOSIS.

T3

TSH LEVELS ARE RAISED IN PRIMARY HYPOTHYROIDISM AND ARE LOW IN HYPERTHYROIDISM AND SECONDARY HYPOTHYROIDISM.

In Pregnancy:

LEVEL	TOTAL T3	TOTAL T4	TSH
Ist Trimester	0.81-0.90	6.6-12.4	0.1-2.5
IInd Trimester	1.0-2.60	6.6-15.5	0.2-3.0
IIIrd Trimester	1.0-2.6	6.6-15.5	0.3-3.0



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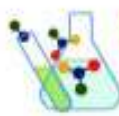
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Test Name	Value	Unit	Normal Value		

**** End Of Report ****

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Name	Mrs. KUSUM	Age	47 Yrs.	Sex	F
Ref. By	Dr. MANOJ AGARWAL			Patient Id:	

Test Name	Value	Unit	Normal Value
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SEROLOGY

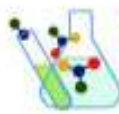
VITAMIN D 25 HYDROXY ELISA	18.0	ng/mL	30.00 - 100.00
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SUMMARY:-This test is done to determine if you have too much or too little vitamin D in your blood. **Lower-than-normal levels** can be due to a vitamin D deficiency, which can result from: Lack of exposure to sunlight Lack of enough vitamin D in the diet Liver and kidney diseases Poor food absorption Use of certain medicines, including phenytoin, phenobarbital, and rifampin.

Vitamin D	ng/ml
Deficient	<10.00
Insufficient	10 - 30
Sufficient	30 - 100
Toxic	> 100

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Test Name	Value	Unit	Normal Value
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HAEMATOLOGY

SERUM VITAMIN B12	204.5	pg/ml	187.0 - 883.0
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SUMMARY:-Low Values are a sign of a vitamin B12 deficiency. People with this deficiency are likely to have or develop symptoms.

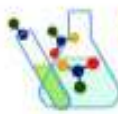
Causes of vitamin B12 deficiency include:Not enough vitamin B12 in diet (rare except with a strict vegetarian diet), Diseases that cause malabsorption (for example, celiac disease and Crohn's disease), Lack of intrinsic factor, Above normal heat production (for example, with hyperthyroidism), Pregnancy. **Increased vitamin B12 levels are uncommon.** Usually excess vitamin B12 is removed in the urine. **Conditions that can increase B12 levels include:** Liver disease (such as cirrhosis or hepatitis), Myeloproliferative disorders (for example, polycythemia vera and chronic myelocytic leukemia).

**** End Of Report ****

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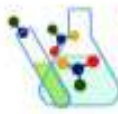
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Name	Mrs. KUSUM	Age	47 Yrs.	Sex	F
Ref. By	Dr. MANOJ AGARWAL			Patient Id:	

Test Name	Value	Unit	Normal Value
IRON STUDIES			
SERUM IRON	41.0	ug/dl	37.00 - 150.00
TOTAL IRON BINDING CAPACITY	377.0	ug/dl	250.0 - 450.0
Transferrin Saturation	10.0	%	16.0 - 50.0
Unsaturated Iron Binding Capacity	340.0	ug/dL	110-370
SERUM FERRITIN	23.0	ng/ml	22.00-322.00

The ferritin test is used to assess a person's iron stores in the body. The test is often ordered along with an iron level and total iron-binding capacity (TIBC, calculated based on blood level of transferrin) to detect a low iron level (iron deficiency) or too much iron in the body (iron overload) as well as to assess the severity of these conditions.

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Ref. By	Dr. MANOJ AGARWAL			Patient Id:	

Test Name	Value	Unit	Normal Value
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URINE EXAMINATION TEST

URINE EXAMINATION

PHYSICAL EXAMINATION

QUANTITY	30	ml.	
COLOUR	PALE YELLOW		PALE YELLOW
TRANSPARENCY	CLEAR		CLEAR
SPECIFIC GRAVITY	1.025		1.000-1.030
PH	5.0		5.0-6.5

CHEMICAL EXAMINATION

ALBUMIN	NIL		NIL
REDUCING SUGAR	NIL		NIL
NITRATE	NEGATIVE		NEGATIVE
KETONES BODIES	NIL	mg/dl	NIL
BILIRUBIN	NEGATIVE		NEGATIVE

MICROSCOPIC EXAMINATION

PUS CELLS	3-4	/HPF	2-4
RBC'S	NIL	/HPF	NIL
CASTS	NIL		NIL
CRYSTALS	NIL		
EPITHELIAL CELLS	1-2	/HPF	2-4
BACTERIA	NIL		NIL
OTHERS	NIL		NIL

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ALFA IMAGING ULTRASOUND AND X-RAY CLINIC

Name:	Mrs. Kusum Soni	Age/Sex:	47 Y/F
Ref. by:	Dr. Manoj Uday Nagar	Date:	01.11.2021
Investigation:	USG WHOLE ABDOMEN		

Liver is mildly enlarged in size (measuring approx. 15.8 cm) and shows diffusely increased parenchymal echogenicity. No focal SOL noted. Vascular channels are clear. No evidence of I.H.B.R. dilatation seen.
PV is normal.

Gall Bladder is not seen (post operative status).

CBD caliber 6.8 mm, no calculus seen in CBD.

Spleen is normal in size (measuring approx. 11.1 cm), shape and echotexture. No focal SOL noted.

Pancreas is normal in size, shape & echotexture. No focal SOL noted.

Both Kidneys are normal in size, shape, position, outline & echogenicity. CMD is well preserved. No evidence of calculus/mass lesion or hydronephrosis seen.

Right kidney: 10.1 x 4.4 cm

Left kidney: 11.0 x 4.8 cm

Urinary Bladder is well distended with normal wall thickness. Lumen is clear. No calculi / mass lesion noted. No diverticulum noted.

Pre void urine volume is 195 cc.

Post void residual urine volume is nil.

Uterus is bulky (measuring approx. 10.1 x 6.2 x 4.8 cm). ET measures approx. 6.1 mm. Reveals two to three round to oval hypoechoic solid lesions (size 30 x 25 x 19 mm, 19 x 11 mm in posterior myometrium ; 22 x 16 mm in anterior myometrium) ---no fibroids. Two large nabothian cysts noted in uterine cervix ---? Changes of chronic cervicitis.

Both Ovaries are normal in size, shape and echotexture.

No free fluid seen in the peritoneal cavity.

Bowel loops are grossly normal.

No significant retroperitoneal lymphadenopathy noted.

IMPRESSION:

- Mild hepatomegaly with grade II-III fatty liver.
- Bulky uterus with multiple mural fibroids.
- Two large nabothian cysts in uterine cervix ---? Changes of chronic cervicitis.

Please correlate clinically.

Monica Sethi
Dr. MONICA SETHI, DMRD (RADIO-DIAGNOSIS)
CONSULTANT RADIOLOGIST

For appointment: 9811642881, 01204371296

Timing: Morning 9:00am to 2:00pm, Evening 5:30 pm to 7:30 pm

Address: Shop No. 14, Lower Ground floor, Mahagoni Mart, Sector-78, Noida

Email: alfaimaging@gmail.com

SONOLOGY CLOSED



Date :- 03-03-2021 Ref.No :- B Id :- 203 Collected :- InLab

Patient's Name :- Smt. KUSUM . Age :- 48/Y Sex :- F

Referred By Dr. :- Dr. .

Investigation Reqd :- CBC,B.S.R.,S.URIA,S.CREATININE,Urine R/M.,

Test Name	Result(s)	Ref.Value(s)
Complete Blood Count (CBC)		
CBC		
Platelete Count	2.96 Lac/mm	1.5-4.5
Total Leukocyte Count	9.5 /cumm	4.0-11.0
Haemoglobin	11.1 grm %	11-16
RBC Count	4.05 mill/mm	4.50-5.50
Packed Cell Volume	34.0 %	36 -45
MCV	84.0 fl.	80 - 96
MCH	27.4 pg	28-33
MCHC	32.6 g/dl	32-36

Leukocyte Count Differential :

Neutrophils	71 %	40-70
Lymphocytes	25 %	20-40
Eosinophils	04 %	1-6
Monocytes	00 %	0-2
Basophils	00 %	0.0-1.0

Bio-Chemical Report

Random Blood Sugar	142.00 mg/dl	70-160
S.Urea	21.34 md/dl	15-45
S.Creatinine	0.83 mg/dl	0.7-1.2

**** End of Report ****

Pathologist/Lab-Tech

Rajesh



Star Pathology & Digital X-Ray

Star Life Line- Health Checkup

Date :- 03-03-2021 Ref.No. :- B Id :- 203 Collected :- InLab
Patient's Name :- **Smt. KUSUM** . Age :- 48/Y Sex :- F
Referred By Dr. :- Dr. .
Investigation Reqd :- CBC, B.S.R., S.UREA, S.CREATININE, Urine R/M.

Test Name	Result(s)	Ref.Value(s)
Urine Examination Report		
PHYSICAL		
Amount	10	ml(Approx.)
Colour	Straw	
Appearance	Clear	
Reaction (PH)	8.0	
Sp.Gravity	1.020	
CHEMICAL		
Protein	Nil	
Glucose	Nil	
Blood	Nil	
Ketone	Nil	
Bile Salts	Nil	
Bile Pigment	Nil	
Chyle	Nil	
MICROSCOPIC		
Pus Cells	Occ	/hpf
Epith Cells	Nil	/hpf
RBCs.	Nil	/hpf
Casts	Nil	/hpf
Crystals	Nil	/hpf
Bacteria	Nil	/hpf
Mucos Thread	Nil	/hpf
Others	NAD	/hpf

**** End of Report ****

Pathologist/Lab-Te

Rajesh Kumar DMLT

Not For Medico Legal Purpose

Timing : 8.00 A.M. To 6.00 P.M.

धर में सम्मिल लाने की सुविधा उपलब्ध है। Mob.: 9695572575

गैस्ट्रो लीवर हॉस्पिटल

छात्रसंघ बीरागा से 50 कदम पूर्व, पिडलेगंज, गोरखपुर
 Mob: 0551-2200120, E-mail: gihgkp@gmail.com



Dr. Anuj Sarkari
डॉ० अंजुज सरकारी
 M.Ch. (गैस्ट्रो) गणेश गंगी पी.जी.आई. लखनऊ
 M.S. (सर्जरी)
 पेट रोग विशेषज्ञ एवं गैस्ट्रोसर्जन
 लीवर, पित्त तन्त्र एवम् पेल्विक्याटिक सर्जन
 ज्वर केंसर रोग विशेषज्ञ
 लैप्रोस्कोपिक एवम् एण्डोस्कोपिक सर्जन

mis-kusum
 Age 47 years / F
 पानी की सफाई

पूर्व आचार्य -
 बी वैकटेश्वर इन्स्टीट्यूट ऑफ
 मेडिकल साइंसेज तिरुपति (ए.पी.)
 विरोध फेलोशिप -
 इन्स्टीट्यूट ऑफ लैप्रोस्कोपिक सर्जरी, ए
 एण्डोस्कोपिक सर्जरी एच ERCP (DMED) दिल्ली (I.A

28/9/21 PR 103
 BP - 125/71
 wt - 69 kg.

थोड़ा थोड़ा कई बार खाये
 खाने के तुरन्त बाद न लेटे

NO J | A | B | Add
 St - L.S.C.S / Gr.B. Stone
 Abt site - wt
 Fever - cough
 Sleep @ urine

- 1 ROBERT 16 1-17
- 2 MAZIN
- 3 ~~Aty...~~ 100
- 4 Heel pin 100
- 5 MGC 200 1-17 700
- 6 NGW 100.
- 7 Nachu 100 00 00

stool not clear L/H 2-3 time
 vertigo & weakness - 7 days
 sleep @

Limp 9/9/21

mis-kusum (N)

14

Jan 28/09/21

11/10/21 wt - 72 kg
 BP 119/88 P-98

- 127
- 128 Pantam 100. 100
- 129 Thymex 50 mg 100
- 130 ~~Aty...~~ 100

15

11/10/21

GASTRO LIVER HOSPITAL, GORAKHPUR.

Name Mrs - Kusam
 Address - Sant Kabinaya
 Referred by: self
 Age/Sex - 47 year / F
 Mobile 9838856321

BP mmHg PR SpO2 Wt Temp °F

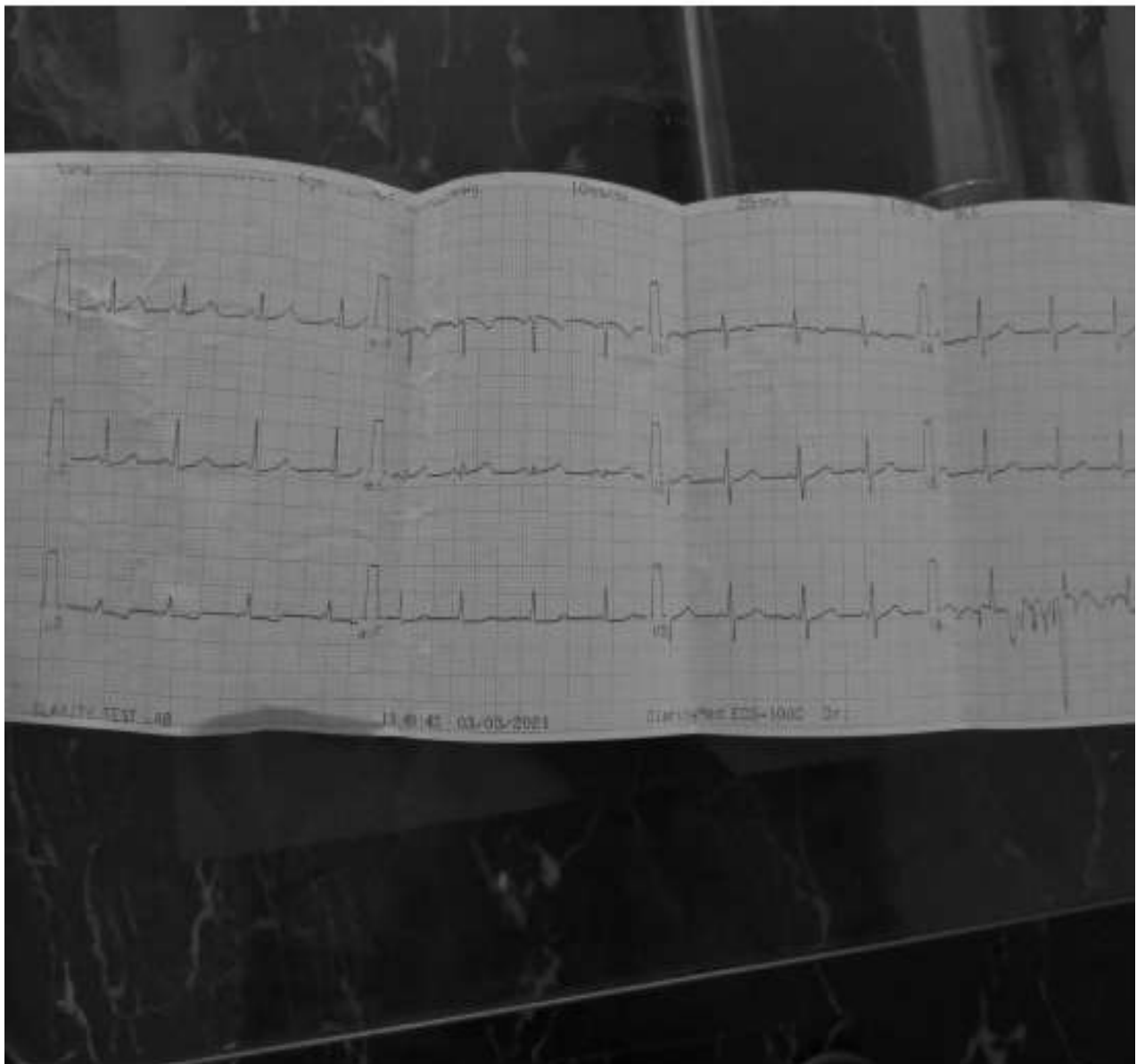
Chief Complaints -
 - vertigo & weakness
 sleep @
 stool not clear L/H. 2-3 time

DM HTN COPD CAD
 VHD CKD CLD Thyroid ↓ ↑
 Past H/O Jaundice Y/N H/O Drug Reaction Y/N
 H/O Blood Transfusion Y/N H/O ATT Y/N
 H/O Past Surgery L.S.C.S. 20 year GB. (22 year 1290)

Addiction- Alcohol Y/N Smoking Y/N Tobacco Y/N
 Appetite N ↑ ↓ Weight N ↑ ↓
 Fever Y/N Cough Y/N Sleep N ↓ ↑
 Stool: Frequency 2-3 time N/L/H Clear / Not Clear
 Urine: Frequency Urgency Slow Burning Y/N

HBsAg HCV HIV

Coh



Name Kiyasulm

Interpretation Report For ADULT

Age 48 Yrs, Ht. _____ cm, Wt. _____ kg

Sex M . BP _____ mmHg

Heart Rate 93 BPM

Sinus Rhythm
Short PR interval
Possibly normal ECG

	P	QRS	PQ	QT	QTc
QRS	73	80	110	360	445

REMARKS

	QT/QTc	QT/QR
QRS	81	56

Axis	P	QRS	T
	0°	59°	-19°

Unconfirmed Report
Dr: _____

PS: Not for medico-legal purposes.

Name	: MS. KUSUM	Age /sex	: 47 Year / Female
Lab No.	: 1021073790	Reg. Date/Time	: 25 Mar 2021 12:31
Ref By	: Dr. HARISH MAKKER	Print Date/Time	: 25 Mar 2021 17:29

MRI: CERVICAL SPINE

IMAGING SEQUENCES (NCMR)

AXIAL: T1 & T2 Wis. SAGITTAL: T1 & T2E T2 Wis. CORONAL: T2 Wis

Cervical spine is straightened with loss of usual spinal curvature. There is evidence of early degenerative changes affecting cervical spine. All the visualized intervertebral discs are partially dessicated. Vertebrae are also showing early degenerative changes in form of marginal osteophytosis at multiple levels.

Mild posterior disc bulge is observed at C5-6 level producing mild extradural compression over thecal sac without significantly compromising spinal canal and neural foramina.

Rest of the thecal sac with rest of the spinal cord is normal in signal intensity and configuration. Cord CSF interface is normally visualized. No intramedullary or intradural pathology is seen.

No evidence of any osseous or soft tissue anomaly at cranio-vertebral junction.

Pre and para-vertebral soft tissues are normal.

Screening of rest of the spine was done which reveals early degenerative changes with mild disc herniation at L5-S1 level.

IMPRESSION

- Early degenerative changes affecting cervical spine with disc bulge at C5-6 level.

Clinical correlation is necessary.

[Signature]

[DR. RAVENDRA SINGH, MD]

Member IOA
 Life Member IGOF
 Life Member AOPAS
 Life Member UPGA
 Life Member LOS
 Life Member Knee Associates
 Life Member Indian Spinal Society
 Life Member Indian Arthroscopy Society



Dr. Harish Makker

M.B.B.S., D.Ortho. (Gold Medalist)
 Ex. Resident Surgeon
 Hindu Rao Hospital, Delhi
 Reg. No. : 28833

Date: 6/2/21

Name: Karan Age: 47 Sex: M

Pro Sar knee MS

Handwritten notes and diagrams:
 No 'New Pain' under
 Vandy
 MDE Co M...
 Chart:
 26/2/21 - LS Co - MacFaire Bill
 to Decker clear & Co the
 2 Dist Desider
 1 Phytostyle → USG
 D...
 A diagram shows a person sitting on a chair with their right hand on their knee. A vertical line is drawn from the top of the page down to the knee, with a horizontal line crossing it. The area below the horizontal line is divided into three sections labeled 1, 2, and 3. Section 1 is the upper part of the knee, section 2 is the middle, and section 3 is the lower part. There are also some scribbles and other markings on the diagram.

282, Rajendra Nagar, Lucknow - 226004
 E-mail : drharishmakkar@gmail.com, Mob. : 8090921681, 9305424924

जिस जोड़ में चोट है उसके अलावा भी दुसरे जोड़ों की कसरत को समझ लें। अस्पताल / क्लीनिक का स्टाफ अपनी पूरी कोशिश करेंगे परन्तु जोड़ की कसरत के स्तर में थोड़ी कमी रह सकती है, जिसके विषय में आप डॉक्टर से समझ लें।

♦ प्लास्टर वाला हाथ/पैर ऊंचा उठाकर रखें। पैर/हाथ की उंगलियां बल्लाते रहें। ♦ नाखून नीला पड़ने पर अथवा तेज दर्द होने पर तुरन्त सम्पर्क करें।
 Morning : 9:00 A.M. - 1:00 P.M. N.B.: दूसरा मंगलवार सुबह 9 बजे से रविवार शाम बन्द
 Evening : 6:00 P.M. - 9:00 P.M.

