

Fitness Certificate

Date of Issue : 12.10.2019

I, Dr. SHRIDHAR DESHMUKH do hereby certify that

[Redacted]

Born on -05/09/1989

Blood Group :

underwent an **Pre Emp Medical check up Medical Examination** on 12.10.2019

and is Fit without restriction .

Company – YASH TECH.

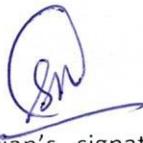
Position –

Employee / Gin No -

Remarks :

Medical Centre : **RUBY HALL CLINIC HINJAWADI**

Dr. Shridhar Deshmukh
MD (General Medicine)
Reg No. 2013/05/1235
.Ruby Hall Clinic
Hinjawadi, Pune - 411057



Physician's signature

Medical Council Registration Number

This certificate of fitness, is valid for a period of three months from date of medical examination



Rajeev Gandhi Infotech Park, MIDC, Phase No. 1, Plot No P-33, Hinjawadi, Pune - 411057.

• Ph: 020 66999999 • Email : hinjawadi@rubyhall.com • 24 hrs Helpline - 7757005773 • Website : www.rubyhall.com, www.hinjawadi.rubyhall.com



DR. SHRIDHAR DESHMUKH

Degree : M.B.B.S., M.D (Med)

Ext :

Website :

Date/Time : 13/10/2019, 12:37:30 pm

Full Address : Hinjawadi Rajiv Gandhi Infotech Park,,

Hinjawadi, Pune-411057

Contacts : [9823644255], frontofficerhch@gmail.com

Timing :

Prescription Number : 1

Patient's MRN : H00000063691

Patient's Phone Number : 8983090023

Patient's Address : B-704 MALPANI GREENS, KASPATE
VASTI WAKAD,

Sex : Male Age : 30 Years Weight : 102 kgs

CONSULTATION DETAILS

Patient has visited for

No

Family H/O HTN

H/O raised BP

General Examination

BMI : 33.69 kg/m² | Weight : 102 kgs | Height : 174 cm | RR : 18 BPM | BP (Sys/Dia) : 146/ 104 mmHg | Pulse : 84 bpm | Temp : 98 F

Investigation Review Notes

Triglycerides Raised

Diagnosis

HEALTH CHECK UP

PATIENT INSTRUCTIONS

Recommendation

BP Charting for 5 days

Low salt diet

F/U SOS



Dr. Shridhar Deshmukh

M.B.B.S., M.D (Med)

2013/05/1265

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DEPARTMENT OF BIOCHEMISTRY

Patient Name :		Age /Gender :30 Y(s)/Male
Bill No/ UHID No	:OH016515 / H00000063691	Report Date :12-Oct-2019 10:31 am
Received Date	:12-Oct-2019 09:32 am	Specimen :SERUM
Lab No/Result No	:191000733 / RES159054	
Referred By	:Dr. HOSPITAL CASE	

Investigation	Result	Reference Range	Method
GLUCOSE (FASTING)	: 114.0	Prediabetic : 100 - 125 mg/dL Diabetic : >= 126 mg/dL Normal : < 100.0 mg/dL	GOD-POD

REFERENCE : ADA 2015 GUIDELINES

GLUCOSE (POST PRANDIAL)	: 124.0	Normal : < 140 mg/dl	GOD-POD
		Prediabetic : 140 - 199 mg/dl	
		Diabetic : >= 200 mg/dl	

ADA 2015 guidelines

CREATININE	: 0.8	0.6 - 1.3 mg/dL	Enzymatic
URIC ACID	: 7.5	3.5-7.2 mg/dL	Uricase
ALANINE TRANSAMINASE.	: 20	< 50 U/L	KINETIC
ASPARTATE TRANSAMINASE	: 30.0	10.0 - 40.0 U/L	Kinetic
GAMMA-GT (GGT)	: 23.0	7.0 - 50.0 U/L	Kinetic

LIPID PROFILE

CHOLESTEROL	: 159.0	130.0 - 220.0 mg/dL	Enzymatic
TRIGLYCERIDES	: 250.0	35.0 - 180.0 mg/dL	Enzymatic
HDL CHOLESTEROL	: 36.0	35 - 65 mg/dL	Enzymatic
LDL CHOLESTEROL	: 73.0	10.0 - 130.0 mg/dL	Calculated
VLDL CHOLESTEROL	: 50.0	5.0 - 36.0 mg/dL	Calculated
CHOL/HDL RATIO	: 4.4	2.0 - 6.2	Calculated

ATP III NCEP GUIDELINES FOR INTERPRETATION OF LIPID PROFILE

PARAMETER	DESIRABLE	BORDERLINE	REQUIRES TREATMENT
Total Cholesterol	Below 200	200 - 240	Above 240
HDL Cholesterol	Above 60	40 - 59	Below 40
LDL Cholesterol\Tab	Below 130	130-160	Above 160



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DEPARTMENT OF BIOCHEMISTRY

Patient Name : [REDACTED]
Bill No/ UHID No : OH016515 / H00000063691
Received Date : 12-Oct-2019 09:32 am
Lab No/Result No : 191000733 / RES159054
Referred By : Dr. HOSPITAL CASE

Age /Gender : 30 Y(s)/Male
Report Date : 12-Oct-2019 10:31 am
Specimen :

Investigation	Result	Reference Range	Method
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Note: This test is performed on automated BIO CHEMISTRY analyzer - Vitros250

*** End Of Report ***

Verified By

ANAND



NOTE:

- * Clinically correlate, Kindly discuss if necessary.
- * This report relates only to the item received.

Dr. NILADRI HALDAR, MD PATHOLOGY

Sr.Registrar

Rajeev Gandhi Infotech Park, MIDC, Phase No. 1, Plot No P-33, Hinjawadi, Pune - 411057.

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DEPARTMENT OF CLINICAL PATHOLOGY

Patient Name	[REDACTED]	Age /Gender	: 30 Y(s)/Male
Bill No/ UHID No	: OH016515 / H00000063691	Report Date	: 12-Oct-2019 5:04 pm
Received Date	: 12-Oct-2019 01:36 pm	Specimen	: STOOL
Lab No/Result No	: 191000839 / RES159419		
Referred By	: Dr. HOSPITAL CASE		

Investigation Result

STOOL ROUTINE

MACROSCOPIC TEST

COLOUR.	:	BROWN
CONSISTENCY	:	SEMI SOLID
MUCUS	:	ABSENT
BLOOD	:	ABSENT

MICROSCOPIC TEST

PUS CELLS	:	1 - 2/HPF
RED BLOOD CELLS	:	ABSENT
MACROPHAGES	:	ABSENT
TROPHOZOITES	:	ABSENT
YEAST CELLS	:	ABSENT
CYSTS	:	ABSENT
OVA	:	ABSENT
FAT GLOBULES	:	ABSENT
STARCH GLOBULES	:	ABSENT
OIL GLOBULES	:	ABSENT
MUSCLE FIBRES	:	ABSENT
STARCH	:	ABSENT
OTHERS.	:	ABSENT
STOOL FOR OCCULT BLOOD	:	ABSENT

URINE ROUTINE

PHYSICAL EXAMINATION

COLOUR	:	Pale Yellow
APPEARANCE	:	Clear

CHEMICAL TEST

pH	:	5.5	5.0-7.0
SPECIFIC GRAVITY	:	1.020	1.015-1.030
ALBUMIN	:	Absent	Absent
SUGAR	:	Absent	Absent
KETONE BODIES	:	Absent	Absent
BILE PIGMENTS	:	Absent	Absent
UROBILINOGEN	:	Normal	Normal
NITRITES	:	Absent	Absent
LEUCOCYTES ESTERASE	:	Absent	Absent

MICROSCOPIC TEST

PUS CELLS.	:	1-2	0-5 /hpF
RED BLOOD CELLS.	:	Absent	0 - 2 /hpF
EPITHELIAL CELLS.	:	1-2	0 - 5 /hpF
BACTERIA	:	Absent	Absent
CAST	:	Absent	Absent
YEAST CELLS	:	Absent	Absent
CRYSTALS	:	Absent	Absent
OTHERS	:	Absent	Absent



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DEPARTMENT OF CLINICAL PATHOLOGY

Patient Name [REDACTED]
Bill No/ UHID No : OH016515 / H00000063691
Received Date : 12-Oct-2019 09:32 am
Lab No/Result No : 191000733 / RES159244
Referred By : Dr. HOSPITAL CASE

Age /Gender : 30 Y(s)/Male
Report Date : 12-Oct-2019 1:42 pm
Specimen :
Sec/Cup/Rep : No. 0357

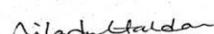
Investigation	Result	Reference Range
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Note: This test is performed on automated CLINICAL PATHOLOGY analyzer - URI PLUS200

*** End Of Report ***

Verified By

SGD1



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DEPARTMENT OF HAEMATOLOGY

Patient Name	[REDACTED]	Age /Gender : 30 Y(s)/Male
Bill No/ UHID No	: OH016515 / H00000063691	Report Date : 12-Oct-2019 9:59 am
Received Date	: 12-Oct-2019 09:32 am	Specimen : EDTA WHOLE BLOOD
Lab No/Result No	: 191000733 / RES159033	
Referred By	: Dr. HOSPITAL CASE	

Investigation	Result	Reference Range	Method
HAEMOGRAM REPORT			
W.B.C.COUNT	: 12600	4000 - 11000 /ul	Coulter Principle
Differential Count			
NEUTROPHILS	: 67.3	40 - 75 %	Derived from WBC Histogram
LYMPHOCYTES	: 21.9	20 - 40 %	
MONOCYTES	: 7.3	2-10 %	
EOSINOPHILS	: 3.4	1.0 - 6.0 %	
BASOPHILS	: 0.1	0.0 - 1.0 %	
ABSOLUTE NEUTROPHIL COUNT	: 8.48	2 - 7 $\times 10^3$ cells/ul	
ABSOLUTE LYMPHOCYTE COUNT	: 2.76	1 - 3 $\times 10^3$ cells/ul	
ABSOLUTE MONOCYTE COUNT	: 0.92	0.2-1.0 $\times 10^3$ cells/ul	
ABSOLUTE EOSINOPHIL COUNT	: 0.43	0.02-0.5 $\times 10^3$ cells/ul	
ABSOLUTE BASOPHIL COUNT	: 0.01	0.02-0.1 $\times 10^3$ cells/ul	
R.B.C COUNT	: 4.88	4.5 - 6.5 million/ul	Coulter Principle
HAEMOGLOBIN	: 14.8	13 - 17 g/dl	Cyanmethhaemoglobin, Photometry
HAEMATOCRIT	: 42.6	40-50 %	Calculated Parameter
MCV	: 87	83-99 fL	Coulter Principle
MCH	: 30.3	27 - 32 pg	Calculated parameter
MCHC	: 34.7	31.5 - 34.5 g/dL	Calculated Parameter
RDW	: 12.8	11.6-14.0 %	Calculated from RBC Histogram
PLATELET COUNT	: 451	150 - 450 $\times 10^3$ /ul	Coulter principle
MPV	: 6.8	7.8-11 fL	Coulter Principle
WBC MORPHOLOGY	: Neutrophilic Leukocytosis.		
ESR at 1 Hour	: 13	0 - 15 mm/hr	Modified Westergren Method

INTERPRETATION :

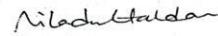
ESR is a screening test to detect presence of systemic disease; however a normal result does not rule out a systemic disease.

ESR is also used to monitor course of disease or response to therapy if initially elevated.

*** End Of Report ***

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ANAND



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DEPARTMENT OF SEROLOGY

Patient Name [REDACTED]
Bill No/ UHID No : OHU16515 / H00000063691
Received Date : 12-Oct-2019 09:32 am
Lab No/Result No : 191000733 / RES159362
Referred By : Dr. HOSPITAL CASE

Age /Gender : 30 Y(s)/Male
Report Date : 12-Oct-2019 3:47 pm
Specimen :

<u>Investigation</u>	<u>Result</u>	<u>Method</u>
DRUG OF ABUSE - (PANEL OF 6)		
URINE CREATININE.	: 120	Normal human urine : >20 mg/dL ?Diluted urine sample : 6-20 mg/dL ?Substituted urine sample : < 6 mg/dL
AMPHETAMINE	: NEGATIVE	NEGATIVE
BARBITURATE	: NEGATIVE	NEGATIVE
BENZODIAZEPINE	: NEGATIVE	NEGATIVE
COCAINE	: NEGATIVE	NEGATIVE
MORPHINE/OPIATES	: NEGATIVE	NEGATIVE
PHENCYCLIDINE PHOSPHATE (PCP)	: NEGATIVE	NEGATIVE
Method		Greater than 1000 ng/mL
Urine Drugs : Rapid Immunochromatography		Greater than 200 ng/mL
Specificity		Greater than 300 ng/mL
Presence of interfering substances may lead to decreased specificity.		Greater than 300 ng/mL
		Greater than 25 ng/mL

*** End Of Report ***

*** End Of Report ***

Verified By

SGD1



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Dr. NILADRI HALDAR, MD PATHOLOGY

Sr.Registrar

Name:	[REDACTED]	Exam Date:	12-Oct-2019
Age :	66 years	Accession:	40830102413
Gender:	M	Exam:	CHEST X RAY
PID:	H00000063691	Physician:	HOSPITAL CASE^^^^
OPD :			

Health Check

Radiograph Chest PA View :

Both lung fields normal.

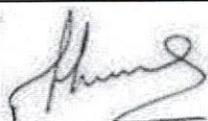
Both costo-phrenic angles are clear.

Cardiac silhouette and aortic knuckle are normal.

Both hilar shadows and the diaphragmatic contours are normal.

Thoracic soft tissues and the rib cage normal.

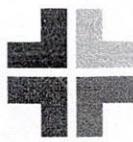
Impression : No significant abnormality noted.



DR NILOFER SHAH
MD RADIOLOGY, SR CONSULTANT RADIOLOGIST
REG NO 68923/1991

Date: 12-Oct-2019 11:07:11





Grant Medical Foundation
Ruby Hall Clinic
Hinjawadi

AUDIOGRAM

14/10/2019-ԱՎԱՐԱՐԱԿԱՆ

Patient Name: _____ Sex: _____ Age: _____

Complaint: _____ **Ref:** OH016515 - OPH00015598- _____ **Date:** _____

Ref: OH016515 - OPH00015598-
30.1./M -NH -

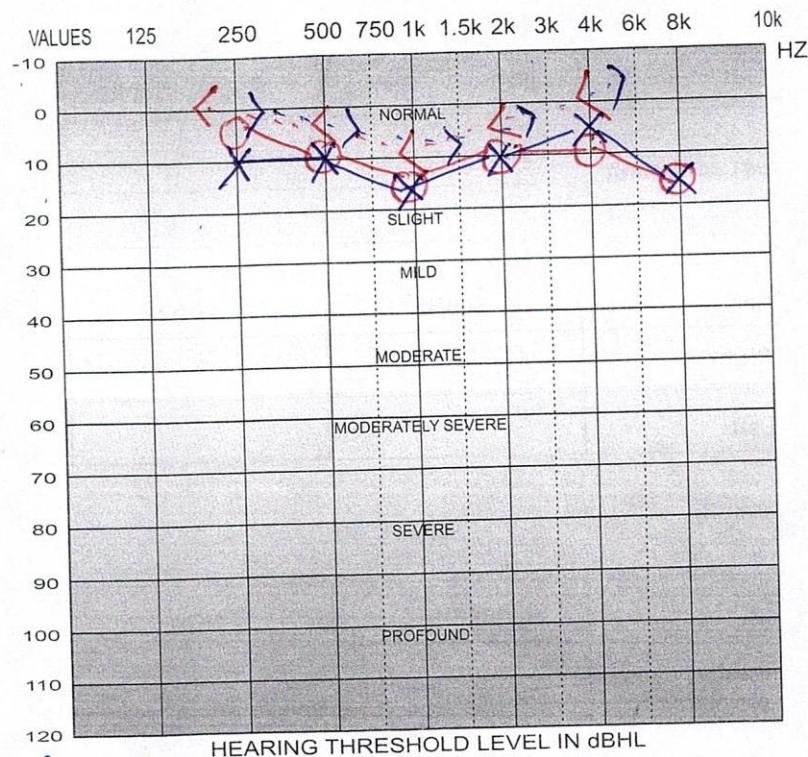
Date: _____

Occupation: _____ **D.O.B.:** _____

Registration No.: _____ Reference: _____

Test	Right Ear (Red)	Left Ear (Blue)
AIR	O-O	X-X
AIR OPP EAR MASKED	△-△	□-□
NO RESPONSE	○	X
BONE	<	>
BONE OPP EAR MASKED	[]

Test	Right Ear (Red)	Left Ear (Blue)
RINNE		
WEBER		
BING		



Dagnosis

BK Normal hearing Sensitivity

Test Result: Reliable Fair Poor

SRT:

SDS:



OUT-PATIENT RECORD

Patient Name	:	[REDACTED]	Age/Sex	:	30 Years / Male
Hospital No.	:	H00000063691	Date/Time	:	12/10/2019,09:56:55 am
Consultant Name	:	Dr. Naik Anmol	Episode No	:	PAN191013289

HISTORY, EXAMINATION, INVESTIGATIONS, TREATMENT AND PROGRESS

CONSULTATION DETAILS**Chief Complaint(s)**

no visual complaints

General Examination**Vitals**

RR : 19 BPM | BP (Sys/Dia) : 147/ 105 mmHg | Pulse : 84 bpm | Temp : 97.4 F

Physical Examination

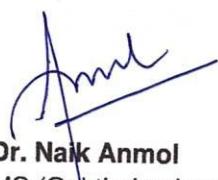
Both eyes BCVA: 6/6, N6; Both eyes colour vision normal;
Both eyes anterior segment and undilated fundus WNL;
Both eyes IOP within normal limits

Diagnosis

H52.1:Myopia

PATIENT INSTRUCTIONS**Recommendation**

continue same glasses; review after 1 year/ sos



Dr. Naik Anmol

MS (Ophthalmology), DNB, FMRF, FICO (U.K.) MRCSEd, MBBS
2011/05/1692

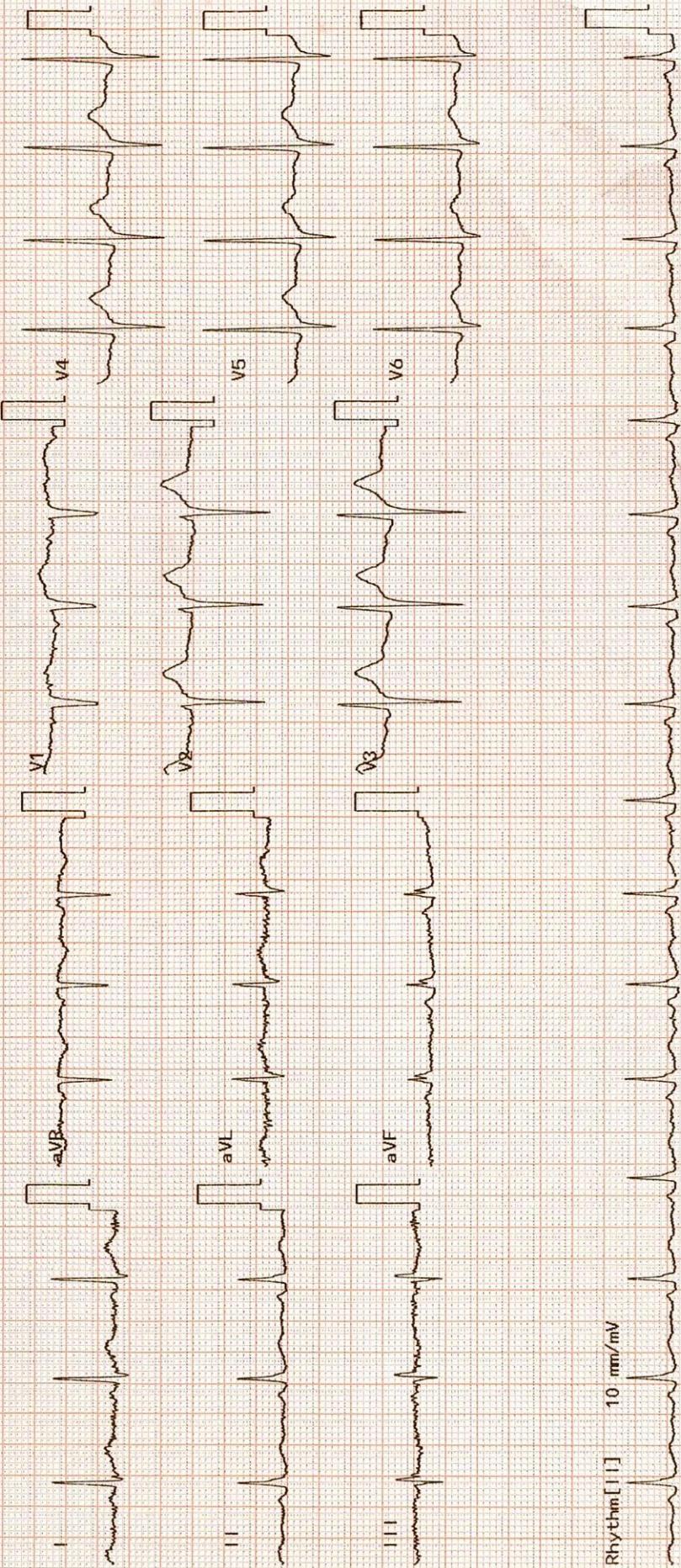
12-Oct-2019 AM10:43:02



Ref: OH016515 - OPH00015598-
30.1/M-NH -
2019-10-12

ID:	Name:	Birth date:	/	mmHg
Ex: M	kg			years
Indication:				
Symptoms:				
History:				
lent. rate	98	bpm		
R int	120	ms		
RS dur	88	ms		
IT/QTC(E) int	340/ 396	ms		
I/QRS/T axis	55/ 34/ 14	°		
IV5/SV1 amp	1.61 / 0.70	mV		
IV5+SV1 amp	2.32	mV		

10 mm/mV 25 mm/s Filter: H50 D 100 Hz 10 mm/mV 10 mm/mV



Rhythm[]] 10 mm/mV

2350K 03-05 04-05 Dept.: :

Exam: Ruby Hall Clinic Hinjewadi

NIHON KOHDEN



Name :-

HR Rate :-

Rhythm :-

Voltage :-

Axis :-

P Wave :-

PR Interval :-

CRS

5

Others :-

Final Impression :-

invincible MSSR.

Signature
Cardiologist / Physician

Note :- 1. This impression is based on ECG.

2. Clinical Co-relation is needed.

3. Please Take a Photocopy of this ECG.