

### Fitness Certificate

Date of Issue : 21.10.2019

I, Dr. SUDHA DESAI do hereby certify that

[Redacted]  
Born on - 28/12/1994

Blood Group :

underwent an **Pre Emp Medical check up Medical Examination** on 19.10.2019

and is Fit without restriction .

Company – YASH TECH.

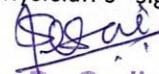
Position –

Employee / Gin No -

Remarks :

Medical Centre : RUBY HALL CLINIC HINJAWADI

Physician's signature



Dr. Sudha Desai  
Medical Council Registration Number  
DNB (Gen. Medicine), iDCCM

Consultant & Intensivist - ICU Incharge

Ruby Hall Clinic  
Hinjawadi, Pune - 411057

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



## DR. SUDHA DESAI

Degree : DNB Gen Medicine, IDCCM

Ext :

Website :

Date/Time : 21/10/2019, 12:16:19 pm

Prescription Number : 1

Full Address : Hinjewadi Rajiv Gandhi Infotech Park,,

Hinjewadi, Pune-411057

Contacts : [9870149717], frontofficerhch@gmail.com

Timing :

Patient's Address : WAGHOLI, PUNE,

Patient's Phone Number : 9422787097

Sex : Male Age : 24 Years Weight : 83.6 kgs

### CONSULTATION DETAILS

#### Patient has visited for

Health check

#### General Examination

O<sub>2</sub> : 98 % | BMI : 26.99 kg/m<sup>2</sup> | Weight : 83.6 kgs | Height : 176 cm | RR : 18 BPM | BP (Sys/Dia) : 116/ 86 mmHg | Pulse : 90 bpm | Temp : 98 F

#### Systemic Examination

Chest : clear, AEBE, CVS:S 1,S2 heard.

#### Investigation Review Notes

Dyslipidemia, rest is normal.

#### Diagnosis

health checkup

### Rx

Medication Name	Dosage	Duration
TAB ATORVA 10 MG	(1) -- every night	o o l . 3 months
TAB MATILDA FORTE	(1) -- every morning	t o o . 1 month

#### Treatment Plan/Notes

Diet n exercise , weight reduction.

### PATIENT INSTRUCTIONS

#### Recommendation

F/U IN MED OPD.



Dr. Sudha Desai

DNB Gen Medicine, IDCCM

06031466

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



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### DEPARTMENT OF BIOCHEMISTRY

<b>Patient Name</b> :		<b>Age /Gender</b> :24 Y(s)/Male
<b>Bill No/ UHID No</b> :	OH016739 / H00000064283	<b>Report Date</b> :19-Oct-2019 10:30 am
<b>Received Date</b> :	19-Oct-2019 09:34 am	<b>Specimen</b> :SERUM
<b>Lab No/Result No</b> :	191001427 / RES161059	
<b>Referred By</b> :	Dr. HOSPITAL CASE	

<b>Investigation</b>	<b>Result</b>	<b>Reference Range</b>	<b>Method</b>
GLUCOSE (FASTING)	: 94.0	Prediabetic : 100 - 125 mg/dL Diabetic : >= 126 mg/dL Normal : < 100.0 mg/dL	GOD-POD

REFERENCE : ADA 2015 GUIDELINES

GLUCOSE (POST PRANDIAL)	:	108.0	Normal : < 140 mg/dl Prediabetic : 140 - 199 mg/dl Diabetic : >= 200 mg/dl	GOD-POD
ADA 2015 guidelines				

CREATININE	:	0.6	0.6 - 1.3 mg/dL	Enzymatic
URIC ACID	:	5.0	3.5-7.2 mg/dL	Uricase
ALANINE TRANSAMINASE.	:	65	< 50 U/L	KINETIC
ASPARTATE TRANSAMINASE	:	41.0	10.0 - 40.0 U/L	Kinetic

**Notes :** KINDLY CORRELATE CLINICALLY

GAMMA-GT (GGT)	:	24.0	7.0 - 50.0 U/L	Kinetic
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#### LIPID PROFILE

CHOLESTEROL	:	150.0	130.0 - 220.0 mg/dL	Enzymatic
TRIGLYCERIDES	:	344.0 ↑ .	35.0 - 180.0 mg/dL	Enzymatic
HDL CHOLESTEROL	:	30.0	35 - 65 mg/dL	Enzymatic
LDL CHOLESTEROL	:	52.0	10.0 - 130.0 mg/dL	Calculated
VLDL CHOLESTEROL	:	69.0	5.0 - 36.0 mg/dL	Calculated
CHOL/HDL RATIO	:	5.1	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 : OH016739 / H00000064283  
Received Date : 19-Oct-2019 09:34 am  
Lab No/Result No : 191001427 / RES161059  
Referred By : Dr. HOSPITAL CASE

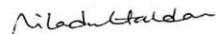
Age /Gender : 24 Y(s)/Male  
Report Date : 19-Oct-2019 10:30 am  
Specimen :

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

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

**Verified By**

ASM



**NOTE:**

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

**Dr. NILADRI HALDAR, MD PATHOLOGY**

**Sr.Registrar**

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### **DEPARTMENT OF CLINICAL PATHOLOGY**

<b>Patient Name</b>	: [REDACTED]	<b>Age / Gender</b>	: 24 Y(s)/Male
<b>Bill No/ UHID No</b>	: OH016/39 / H00000064283	<b>Report Date</b>	: 19-Oct-2019 1:35 pm
<b>Received Date</b>	: 19-Oct-2019 09:34 am	<b>Specimen</b>	: URINE
<b>Lab No/Result No</b>	: 191001427 / RES161195	<b>Sec/Cup/Rep</b>	: No. 0272
<b>Referred By</b>	: Dr. HOSPITAL CASE		

<b>Investigation</b>	<b>Result</b>	<b>Reference Range</b>
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#### **URINE ROUTINE**

#### **PHYSICAL EXAMINATION**

COLOUR	: Pale Yellow
APPEARANCE	: Clear

#### **CHEMICAL TEST**

pH	: 5.0	5.0-7.0
SPECIFIC GRAVITY	: 1.030	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

**Note: This test is performed on automated CLINICAL PATHOLOGY analyzer - URI PLUS200**

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

#### **Verified By**

SAINATH



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**Sr.Registrar**



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### DEPARTMENT OF HAEMATOLOGY

<b>Patient Name</b>	[REDACTED]	<b>Age / Gender</b>	: 24 Y(s)/Male
<b>Bill No/ UHID No</b>	: OH016739 / H00000064285	<b>Report Date</b>	: 19-Oct-2019 9:57 am
<b>Received Date</b>	: 19-Oct-2019 09:34 am	<b>Specimen</b>	: EDTA WHOLE BLOOD
<b>Lab No/Result No</b>	: 191001427 / RES161035		
<b>Referred By</b>	: Dr. HOSPITAL CASE		

<b>Investigation</b>	<b>Result</b>	<b>Reference Range</b>	<b>Method</b>
<b>HAEMOGRAM REPORT</b>			
<b>W.B.C.COUNT</b>	: 5300	4000 - 11000 /ul	Coulter Principle
<b>Differential Count</b>			Derived from WBC Histogram
NEUTROPHILS	: 56.7	40 - 75 %	
LYMPHOCYTES	: 32.3	20 - 40 %	
MONOCYTES	: 8.8	2-10 %	
EOSINOPHILS	: 2.1	1.0 - 6.0 %	
BASOPHILS	: 0.1	0.0 - 1.0 %	
ABSOLUTE NEUTROPHIL COUNT	: 3.02	2 - 7 $\times 10^3$ cells.ul	
ABSOLUTE LYMPHOCYTE COUNT	: 1.72	1 - 3 $\times 10^3$ cells.ul	
ABSOLUTE MONOCYTE COUNT	: 0.47	0.2-1.0 $\times 10^3$ cells.ul	
ABSOLUTE EOSINOPHIL COUNT	: 0.11	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	: 5.05	4.5 - 6.5 million.ul	Coulter Principle
<b>HAEMOGLOBIN</b>	: 17.1	13 - 17 g/dl	Cynmethhaemoglobin, Photometry Calculated Parameter
HAEMATOCRIT	: 47.9	40-50 %	Coulter Principle
MCV	: 95	83-99 fL	Calculated parameter
MCH	: 33.9	27 - 32 pg	Calculated Parameter
MCHC	: 35.7	31.5 - 34.5 g/dL	Calculated from RBC Histogram
RDW	: 12.1	11.6-14.0 %	Coulter principle
<b>PLATELET COUNT</b>	: 301	150 - 450 $\times 10^3$ /ul	Coulter Principle
MPV	: 7.6	7.8-11 fl	Modified Westergren Method
ESR at 1 Hour	: 09	0 - 15 mm/hr	

**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 \*\*\*

**Verified By**

SGD1



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**Dr. NILADRI HALDAR, MD PATHOLOGY**

**Sr.Registrar**

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### **DEPARTMENT OF SEROLOGY**

<b>Patient Name</b> :		<b>Age /Gender</b> :24 Y(s)/Male
<b>Bill No/ UHID No</b> :	OH016739 / H00000064283	<b>Report Date</b> :19-Oct-2019 1:47 pm
<b>Received Date</b> :	19-Oct-2019 09:34 am	<b>Specimen</b> :
<b>Lab No/Result No</b> :	191001427 / RES161217	
<b>Referred By</b> :	Dr. HOSPITAL CASE	

<b><u>Investigation</u></b>	<b><u>Result</u></b>	<b><u>Method</u></b>
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#### **DRUG OF ABUSE - (PANEL OF 6)**

URINE CREATININE.	:	172.0	Normal human urine : >20 mg/dL ?Diluted urine sample : 6-20 mg/dL ?Substituted urine sample : < 6 mg/dL	
AMPHETAMINE	:	NEGATIVE	NEGATIVE	Greater than 1000 ng/mL
BARBITURATE	:	NEGATIVE	NEGATIVE	Greater than 200 ng/mL
BENZODIAZEPINE	:	NEGATIVE	NEGATIVE	Greater than 300 ng/mL
COCAINE	:	NEGATIVE	NEGATIVE	Greater than 300 ng/mL
MORPHINE/OPIATES	:	NEGATIVE	NEGATIVE	Greater than 300 ng/mL
PHENCYCLIDINE PHOSPHATE (PCP)	:	NEGATIVE	NEGATIVE	Greater than 25 ng/mL

Method

Urine Drugs : Rapid Immunochromatography

Specificity

Presence of interfering substances may lead to decreased specificity.

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

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**Verified By**

SGD1



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**Dr. NILADRI HALDAR, MD PATHOLOGY**

**Sr.Registrar**

Name: [REDACTED]  
Age : 024 Years  
Gender: M  
PID: H00000064283  
OPD :

Exam Date: 19-Oct-2019  
Accession: 41345103923  
Exam: CHEST X RAY  
Physician: HOSPITAL CASE^^^^

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 VISHAL BAHIR**  
**ASSOCIATE CONSULTANT**  
**MD RADIODIAGNOSIS**

Date: 19-Oct-2019 11:21:05





## OUT-PATIENT RECORD

Patient Name	[REDACTED]	Age/Sex	: 24 Years / Male
Hospital No.	: HU00000064283	Date/Time	: 19/10/2019, 11:23:32 am
Consultant Name	: Dr. Sapna Kotwaliwale	Episode No	: PAN191014229

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HISTORY, EXAMINATION, INVESTIGATIONS, TREATMENT AND PROGRESS

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### CONSULTATION DETAILS

#### General Examination

#### Physical Examination

EYE :

Vision - 6/5 with glass ( Both eyes )

Intraocular pressure - Normal ( Both eyes )

Cornea - clear, bright, smooth surface ( Both eyes )

Anterior chamber - Normal ( Both eyes )

FUNDUS :

Disc - Normal ( Both eyes )

N5

Colour Vision- normal

#### Diagnosis

Preventive Health Check

### PATIENT INSTRUCTIONS

#### Recommendation

To Avoid Computer Vision Syndrome- Take a break from working on the screen every 30 mins for 5 mins  
Remember to blink your eyes as often as you can Keep your screen brightness to the lowest setting possible

A handwritten signature in black ink, appearing to read "Sapna Kotwaliwale".

**Dr. Sapna Kotwaliwale**

MBBS, DOMS

Consultant

Ophthalmology

88564

ID:

Name:

Sex: M

cm

kg

mmHg

years

**Name :-**

Ref.OH016739 - OPH00015821  
24.9.M-NH -

**Age / Sex :-**

**Date** 13/10/19

**HR Rate :-**

**Rhythm :-**

**Voltage :-**

**Axis :-**

**P Wave :-**

**PR Interval :-**

**QRS :-**

**ST :-**

**Others :-**

**Final Impression :-**

OSM

**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.

### AUDIOGRAM

Patient Name: [REDACTED]

Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Complaint: \_\_\_\_\_

Ref: OH016739 - OPH00015821  
24.9./M -NH -

Date: \_\_\_\_\_

Occupation: \_\_\_\_\_

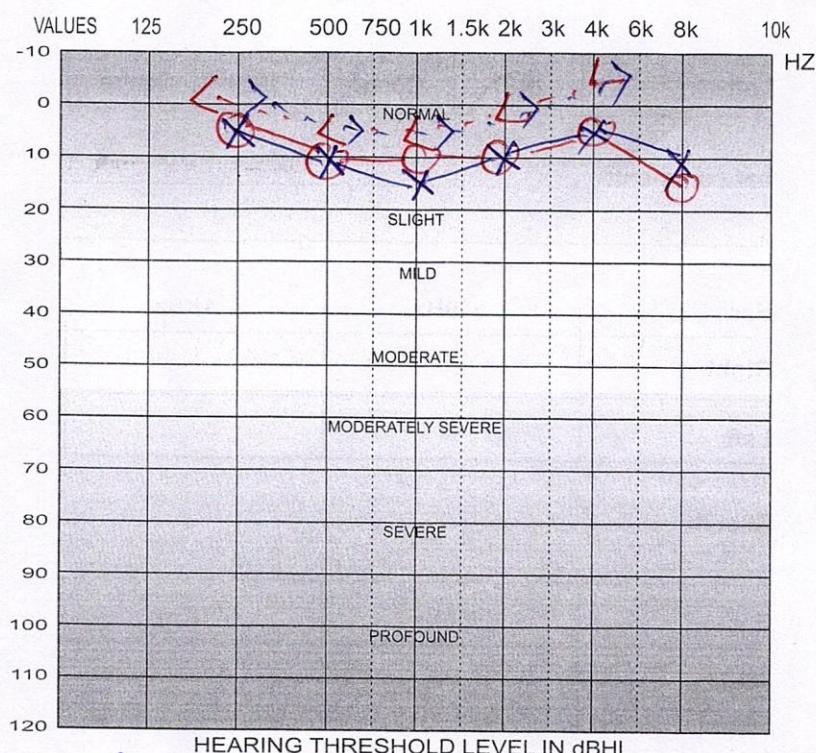
D.O.B.: \_\_\_\_\_

Registration No.: [REDACTED]

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	the the	
WEBER		X
BING		

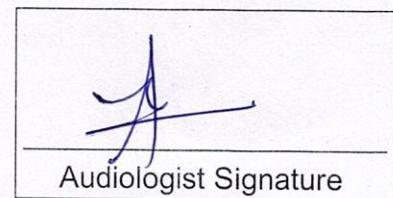


Diagnosis: Blk Normal hearing sensitivity.

Test Result:  Reliable  Fair  Poor

SRT: \_\_\_\_\_

SDS: \_\_\_\_\_



Audiologist Signature