

Dr. Vimmi Goel
Head - Non Invasive Cardiology
Incharge - Preventive Health Care
MBBS, MD (Internal Medicine)
Reg. No: MMC- 2014/01/0113

Preventive Health Check up
KIMS Kingsway Hospitals
Nagpur
Phone No.: 7499913052



Name: Mr. yadnik sedmake Date: 22/10/24

Age: 42y Sex: M Weight: 70.8 kg Height: 159.4 inc BMI: 27.9

BP: 147/98 mmHg Pulse: 95/m bpm RBS: _____ mg/dl
SpO2: 100%

Name: Mr. Yadnik Sedmake Date: 20/11/24

Age: 42 yrs Sex: M / F Weight: _____ kg Height: _____ inc BMI: _____

BP: _____ mmHg Pulse: _____ bpm RBS: _____ mg/dl

Allergy: _____

Routine Dental Checkup

PMH - NRH

PDH - H/O prosthesis $\bar{=}$ $\frac{1}{5}$

O/E

- Caries $\bar{=}$ $\frac{1}{4}$

- Calculus +

- Pericoronal flap $\bar{=}$ $\frac{1}{8}$

Actu - RCF & Capping $\bar{=}$ $\frac{1}{4}$

Oral Prophylaxis.

SOS extraction $\bar{=}$ $\frac{1}{8}$

Dr. Sidnyasa

DEPARTMENT OF OPHTHALMOLOGY
OUT PATIENT ASSESSMENT RECORD

YADNIK SEDMAKE 42Y(S) 11M(S) 7D(S)/M UMR2324008618 7350789611	CONSULT DATE : 20-11-2024 CONSULT ID : OPC2425092316 CONSULT TYPE : WALK IN VISIT TYPE : NORMAL TRANSACTION TYPE : CORPORATE	DR. ASHISH PRAKASHCHANDRA KAMBLE MBBS,MS, FVRS,FICO CONSULTANT DEPT OPHTHALMOLOGY
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VITALS

Temp : -- °F **Pulse :** -- /min **BP (mmHg) :** -- /-- **spO2 :** -- %RA **Pain Score :** -- /10 **Height :** -- cms

Weight : -- kgs **BMI :** --

CHIEF COMPLAINTS

ROUTINE EY CHECK UP

MEDICATION PRESCRIBED

#	Medicine	Route	Dose	Frequency	When	Duration
1	I SOFT EYE DROP	Topical	1-1-1-1	Every Day	NA	2 months
Instructions : BOTH EYES						
Composition : SODIUM HYALURONATE 0.1% W/V						

NOTES

GLASS PRESCRIPTION :-
DISTANCE VISION

EYE	SPH	CYL	AXIS	VISION
RIGHT EYE	00	00	00	6/6
LEFT EYE	00	00	00	6/6

NEAR ADDITION

RIGHT EYE	+1.25D	N6
LEFT EYE	+1.25D	N6

Ashish Kamble

Dr. Ashish Prakashchandra Kamble
MBBS,MS, FVRS,FICO
Consultant

Printed On : 20-11-2024 14:18:00

REMARK- PROGRESSIVE WITH BLUE CUT GLASSES



MC-6773

**KIMS-KINGSWAY
HOSPITALS****KIMS-KINGSWAY
HOSPITALS****CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY**

Patient Name : Mr. YADNIK SEDMAKE	Age / Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:33 am	Report Date : 20-Nov-24 11:57 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	14.7	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		46.8	40.0 - 50.0 %	Calculated
RBC Count		5.72	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		82	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		25.7	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		31.4	31.5 - 35.0 g/l	Calculated
RDW		19.9	11.5 - 14.0 %	Calculated
Platelet count		198	150 - 450 10 ³ /cumm	Impedance
WBC Count		5400	4000 - 11000 cells/cumm	Impedance

DIFFERENTIAL COUNT

Neutrophils	55.1	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes	29.4	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils	10.4	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes	5.1	2 - 10 %	Flow Cytometry/Light microscopy
Basophils	0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count	2975.4	2000 - 7000 /cumm	Calculated
Absolute Lymphocyte Count	1587.6	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count	561.6	20 - 500 /cumm	Calculated
Absolute Monocyte Count	275.4	200 - 1000 /cumm	Calculated
Absolute Basophil Count	0	0 - 100 /cumm	Calculated



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CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. YADNIK SEDMAKE	Age /Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:33 am	Report Date : 20-Nov-24 11:57 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
PERIPHERAL SMEAR				
Microcytosis		Microcytosis +(Few)		
Hypochromasia		Hypochromia +(Few)		
Anisocytosis		Anisocytosis +(Few)		
WBC		As above		
Platelets		Adequate		Light microscopy
ESR		02	0 - 15 mm/hr	Automated Westergren's Method

*** End Of Report ***

This is an Amended and Revised Report of BIL2425065499 on 11/20/2024 10:23:28AM

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 9670

Test results related only to the item tested.

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Dr. Suwarna Kawade, MBBS,MD (Pathology)

CONSULTANT

Page 2 of 2

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CIN: U74999MH2018PTC303510



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KIMS-KINGSWAY
HOSPITALS

CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. YADNIK SEDMAKE	Age / Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:32 am	Report Date : 20-Nov-24 11:45 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	97	< 100 mg/dl	GOD/POD,Colorimetric
GLYCOSYLATED HAEMOGLOBIN (HBA1C)				
HbA1c		5.3	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100511

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Dr. Suwarna Kawade, MBBS,MD (Pathology)
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KIMS-KINGSWAY
HOSPITALS

KIMS-KINGSWAY
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CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. YADNIK SEDMAKE	Age / Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 12:44 pm	Report Date : 20-Nov-24 02:51 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Post Prandial Plasma Glucose	Plasma	101	< 140 mg/dl	GOD/POD, Colorimetric

Interpretation:

Clinical Decision Value as per ADA Guidelines 2021

Diabetes Mellites If,

Fasting \geq 126 mg/dl

Random/2Hrs. OGTT \geq 200 mg/dl

Impaired Fasting = 100-125 mg/dl

Impaired Glucose Tolerance = 140-199 mg/dl

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100131

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Dr. GAURI HARDAS, MBBS,MD

CONSULTANT PATHOLOGIST

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**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mr. YADNIK SEDMAKE	Age /Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:33 am	Report Date : 20-Nov-24 11:45 am

LIPID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	175	< 200 mg/dl Enzymatic(CHE/CHO/PO D)
Triglycerides		103	< 150 mg/dl
HDL Cholesterol Direct		35	> 40 mg/dl
LDL Cholesterol Direct		131.36	< 100 mg/dl
VLDL Cholesterol		21	< 30 mg/dl
Tot Chol/HDL Ratio		5	3 - 5

<u>Intiate therapeutic</u>	<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	>130, optional at 100-129
Multiple major risk factors conferring 10 yrs CHD risk>20%		<100
Two or more additional major risk factors,10 yrs CHD risk <20%	>130	10 yrs risk 10-20 % >130
No additional major risk or one additional major risk factor	>160	10 yrs risk <10% >160
		<160

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100026

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MC-6773



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CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. YADNIK SEDMAKE	Age /Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:33 am	Report Date : 20-Nov-24 11:45 am

LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.81	0.2 - 1.3 mg/dl	
Direct Bilirubin		0.21	0.1 - 0.3 mg/dl	
Indirect Bilirubin		0.60	0.1 - 1.1 mg/dl	
Alkaline Phosphatase		79	38 - 126 U/L	
SGPT/ALT		33	10 - 40 U/L	
SGOT/AST		32	15 - 40 U/L	
Serum Total Protein		8.21	6.3 - 8.2 gm/dl	
Albumin Serum		4.68	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.53	2.0 - 4.0 gm/dl	
A/G Ratio		1.3		

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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Dr. Suwarna Kawade, MBBS,MD (Pathology)

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HOSPITALS**

**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mr. YADNIK SEDMAKE	Age / Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:33 am	Report Date : 20-Nov-24 11:45 am

RFT	Parameter	Specimen	Result Values	Biological Reference	Method
	Blood Urea	Serum	16	19.0 - 43.0 mg/dl	Direct ion selective electrode
	Creatinine		0.9	0.66 - 1.25 mg/dl	
	GFR		109.4	>90 mL/min/1.73m square.	
	Sodium		139	136 - 145 mmol/L	
	Potassium		4.82	3.5 - 5.1 mmol/L	
*** End Of Report ***					

Suggested Clinical Correlation * If necessary, Please discuss

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Dr. Suwarna Kawade, MBBS,MD (Pathology)

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**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mr. YADNIK SEDMAKE
Age / Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:33 am
Report Date : 20-Nov-24 12:25 pm

THYROID PROFILE

Parameter
 T3
 Free T4
 TSH


<u>Specimen</u>	<u>Results</u>
Serum	1.41
	1.27
	3.81

Biological Reference
 0.55 - 1.70 ng/ml
 0.80 - 1.70 ng/dl
 0.50 - 4.80 uIU/ml

Method
 Enhanced
 chemiluminescence

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss
 Verified By : : 11100026
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Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST

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 CIN: U74999MH2018PTC303510

N.B.: Hence


**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY**

Patient Name : Mr. YADNIK SEDMAKE
Bill No/ UMR No : BIL2425065499/UMR2324008618
Received Dt : 20-Nov-24 10:48 am

Age /Gender : 42 Y(s)/Male
Referred By : Dr. Vimmi Goel MBBS,MD
Report Date : 20-Nov-24 11:53 am

URINE MICROSCOPY

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
<u>PHYSICAL EXAMINATION</u>				
Volume	Urine	40 ml		
Colour.		Pale yellow		
Appearance		Clear	Clear	
<u>CHEMICAL EXAMINATION</u>				
Specific gravity		1.010	1.005 - 1.025	ion concentration
Reaction (pH)		5.0	4.6 - 8.0	Indicators
Nitrate		Negative	Negative	
Urine Protein		Negative	Negative	protein error of pH indicator
Sugar		Negative	Negative	GOD/POD
Ketone Bodies		Negative	Negative	Legal's est Principle
Urobilinogen		Normal	Normal	Ehrlich's Reaction
Bilirubin		Negative	Negative	Diazonium
<u>MICROSCOPIC EXAMINATION</u>				
Pus Cells		0-1	0 - 4 /hpf	
R.B.C.		Absent	0 - 4 /hpf	
Epithelial Cells		0-1	0 - 4 /hpf	
Casts		Absent	Absent	
Crystals		Absent		

*** End Of Report ***

Suggested Clinical Correlation * If neccessary, Please discuss

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**Dr. Suwarna Kawade, MBBS,MD (Pathology)
CONSULTANT**



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY**



MC-6773

Patient Name : Mr. YADNIK SEDMAKE	Age / Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2425065499/UMR2324008618	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 20-Nov-24 10:33 am	Report Date : 20-Nov-24 12:31 pm

BLOOD GROUPING AND RH

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
BLOOD GROUP.	EDTA Whole Blood & Plasma/ Serum	" B "	Gel Card Method
Rh (D) Typing.		" Positive "(+Ve)	

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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Dr. Suwarna Kawade, MBBS,MD (Pathology)
CONSULTANT

N.E.
Hen

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	YADNIK SEDMAKE	STUDY DATE	20-11-2024 11:56:44
AGE/ SEX	42Y 11M8D / M	HOSPITAL NO.	UMR2324008618
ACCESSION NO.	BIL2425065499-9	MODALITY	DX
REPORTED ON	20-11-2024 13:54	REFERRED BY	Dr. Vimmi Goel

X-RAY CHEST PA VIEW

Both the lung fields are clear.

Heart and Aorta are normal.

Both hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

IMPRESSION -No pleuro-parenchymal abnormality seen.



DR NAVEEN PUGALIA
MBBS, MD [076125]
SENIOR CONSULTANT RADIOLOGIST.

PATIENT NAME:	YADNIK SEDMAKE	AGE /SEX:	42 YRS/MALE
UMR NO:	UMR2324008618	BILL NO:	BIL2425065499-11
REF BY	DR VIMMI GOEL	DATE:	20-NOV-2024

USG WHOLE ABDOMEN

LIVER is normal in size but shows increase in echotexture.
No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated.
PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No sludge or calculus seen.
Wall thickness is within normal limits.

Visualized head and body of PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in size shape and echotexture. No focal lesion seen.

Right kidney measures 10.8 x 5.3 cm. Left kidney measures 10.7 x 4.4 cm.
Both KIDNEYS are normal in shape, size and echotexture.
No evidence of calculus or hydronephrosis seen.
URETERS are not dilated.

URINARY BLADDER is partially distended. No calculus or mass lesion seen.

Prostate is normal in size, shape and echotexture. WT-20.7gms.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

- Grade II fatty infiltration.
- No other significant visceral abnormality seen.

Suggest clinical correlation.



DR NAVEEN PUGALIA
MBBS, MD [076125]
SENIOR CONSULTANT RADIOLOGIST

Kingway Hospitals
4 Kingsway, Mohan Nagar,
Near Kasturchand Park, Nagpur

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Mr. Yadnik , Sedmake
Patient ID: 0086180
Height:
Weight:
Study Date: 20.11.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

DOB: 14.12.1981
Age: 42yrs
Gender: Male
Race: Indian
Referring Physician: Mediwheel HCU
Attending Physician: Dr. Vimmi Goel
Technician: --

Medications:

--

Medical History:

NIL

Reason for Exercise Test:

Screening for CAD

Exercise Test Summary:

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:00	0.00	0.00	99	120/80	
		00:04	0.00	0.00	98		
EXERCISE	WARM-UP	00:05	0.00	0.00	99		
	STAGE 1	03:00	1.70	10.00	136		
	STAGE 2	03:00	2.50	12.00	148	140/80	
	STAGE 3	00:45	3.40	14.00	160		
RECOVERY		01:00	0.00	0.00	127	140/80	
		02:00	0.00	0.00	117	140/80	
		00:27	0.00	0.00			

The patient exercised according to the BRUCE for 6:44 min:s, achieving a work level of Max. METS: 9.20. The resting heart rate of 99 bpm rose to a maximal heart rate of 160 bpm. This value represents 89 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 140/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation:

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: appropriate.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: none.

Overall impression: Normal stress test.

Conclusions:

TMT is negative for inducible ischemia.


Dr. VIMMI GOEL
MBBS, MD
Sr. Consultant-Non Invasive Cardiology
Reg.No.: 2014/01/0113

42 Years

MR YADNIK SADMAKE
Male

20 Nov-24 11:11:44 AM

KIMS-KINGSWAY HOSPITALS

PBC DEPT.

Rate 90 Sinus rhythm.....normal P axis, V-rate 50-99

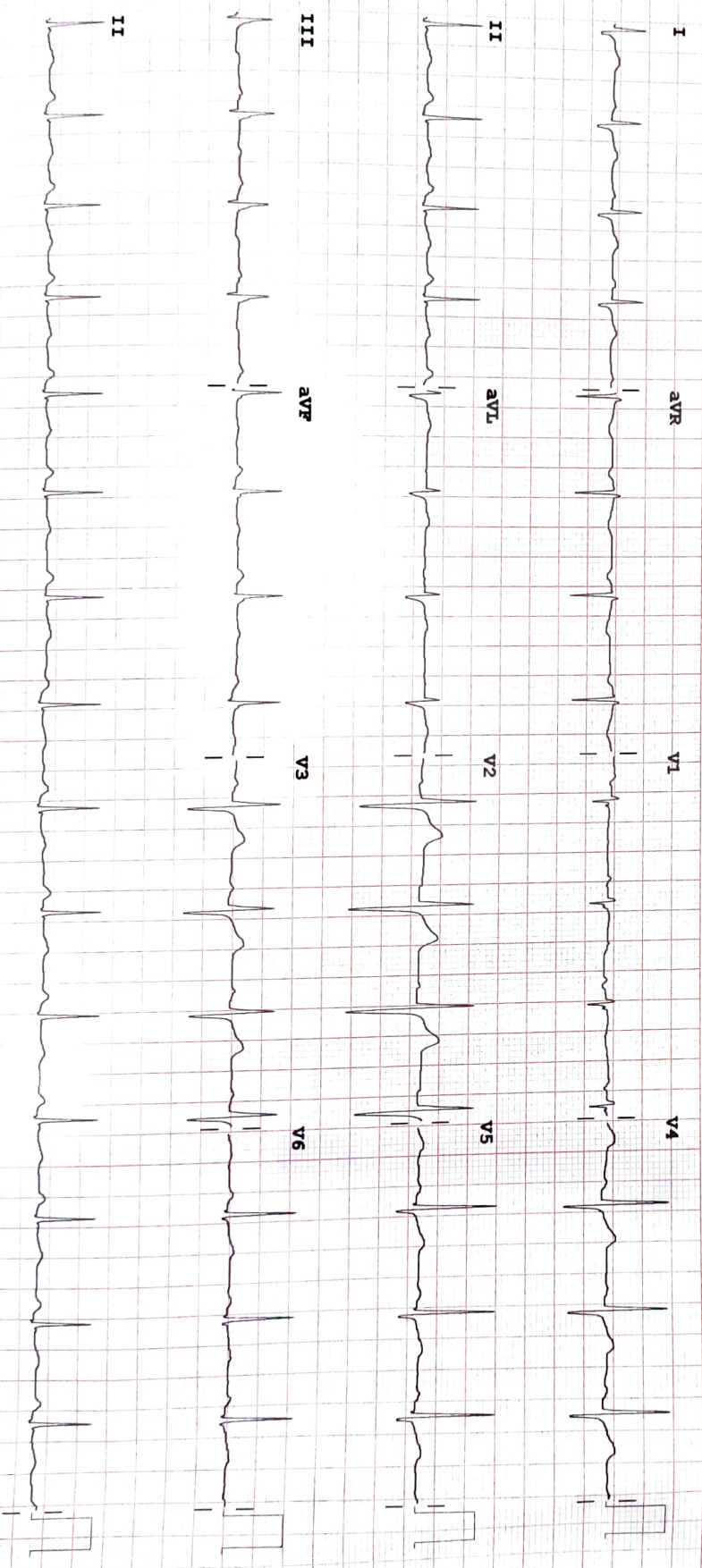
PR 155
QRSD 90
QT 339
QTc 415

--AXIS--
P 67
QRS 78
T 29

12 Lead: Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec

Limbo: 1 mm/mV

Chest: 10.0 mm/mV

F 50 ~ 0.50-150 Hz W

100B CU

p?

303

PHILIPS

RECOVER-MEDIA