

**TEST REPORT**

Reg. No : 2503100155 UHID : UHID30049 Reg. Date : 11-Mar-2025
Name : DHARMABIR KUMAR Collected On : 11-Mar-2025 08:54
Age/Sex : 36 Years / Male Report Date : 11-Mar-2025
Ref. By : MEDIWHEEL

Parameter	Result	Unit	Reference Interval
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COMPLETE BLOOD COUNT (CBC)

Hemoglobin (SLS method)	13.1	g/dL	13.0 - 17.0
Hematocrit (Electrical Impedance)	40.0	%	40 - 54
RBC Count (Electrical Impedance)	4.60	million/cmm	4.5 - 5.5
WBC Count (Flowcytometry)	5720	/cmm	4000 - 10000
Platelet Count (Electrical Impedance)	112000	/cmm	150000 - 410000
MCV (Calculated)	87.0	fL	83 - 101
MCH (Calculated)	28.4	Pg	27 - 32
MCHC (Calculated)	32.6	%	31.5 - 34.5
RDW (Calculated)	12.6	%	11.5 - 14.5

DIFFERENTIAL WBC COUNT

Neutrophils (%)	59	%	38 - 70
Lymphocytes (%)	34	%	20 - 45
Monocytes (%)	04	%	2 - 8
Eosinophils (%)	03	%	1 - 4
Basophils (%)	00	%	0 - 1
Neutrophils (Absolute)	3375	/cmm	1800 - 7700
Lymphocytes (Absolute)	1945	/cmm	1000 - 3900
Monocytes (Absolute)	229	/cmm	200 - 800
Eosinophils (Absolute)	172	/cmm	20 - 500
Basophils (Absolute)	0	/cmm	0 - 100
Neutrophil-Lymphocyte Ratio(NLR)	1.68	/cmm	0.7 - 4.0

PERIPHERAL SMEAR EXAMINATION


RBC Morphology RBCs are Normochromic Normocytic.
WBC Morphology Total WBC and differential count is within normal.
Platelets **Platelets are mildly reduced**
Parasites Malarial parasite is not detected.

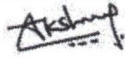
ERYTHROCYTE SEDIMENTATION RATE

ESR (After 1 hour) 12 mm/hr 0 - 14

----- End Of Report -----

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Approved by:  Dr. Yesha H. Shah
(MD.Pathology)

 Mr. Akshay Parmar
M.Sc(Biochemistry)

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FBS

Fasting Blood Sugar (FBS) 101.9 mg/dL 70 - 110

Glucose Oxidase-Peroxidase

Criteria for the diagnosis of diabetes 1. HbA1c \geq 6.5 *

Or

2. Fasting plasma glucose $>$ 126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.

Or

3. Two hour plasma glucose \geq 200mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucose dissolved in water.

Or


4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose \geq 200 mg/dL.

*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing.

American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34:S11.

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HEMOGLOBIN A1 C ESTIMATION

Specimen: Blood EDTA

Hb A1C <i>HPLC, NGSP Certified</i>	6.7	%	>8 : Action Suggested , 7-8 : Good Control , <7 : Goal , 6-7 : Near Normal Glycemia, <6 : Non-diabetic Level
Mean Blood Glucose <i>Calculated</i>	145.59	mg/dL	

Criteria for the diagnosis of diabetes:

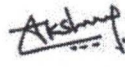
1. HbA1c ≥ 6.5 *Or
 2. Fasting plasma glucose >126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.Or
 3. Two hour plasma glucose ≥ 200 mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucosedissolved in water.Or
 4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥ 200 mg/dL.
- *In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34:S11.

Importance of HbA1C (Glycated Hb.) in Diabetes Mellitus:

- HbA1C, also known as glycated heamoglobin, is the most important test for the assessment of long term blood glucose control(also called glycemc control).
- HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of longterm glycemc control than blood glucose determination.
- HbA1c is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy (Eye-complications), nephropathy (kidney-complications) and neuropathy (nerve complications), are potentially serious and can lead to blindness, kidney failure, etc.- Glyemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD) is considered most important. (Ref. National Glycohaemoglobin Standardization Program - NGSP).

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LIVER FUNCTION TEST			
SGPT <i>Optimized UV-IFCC</i>	33.4	U/L	1 - 45
SGOT <i>Optimized UV-IFCC</i>	24.5	U/L	1 - 35
Total Bilirubin <i>DCA method</i>	0.71	mg/dL	0 - 2.0
Direct Bilirubin <i>DCA method</i>	0.40	mg/dL	0.0 - 0.4
INDIRECT BILIRUBIN <i>Calculated</i>	0.31	mg/dL	0.0 - 1.6
Alkaline Phosphatase <i>PNP-AMP Buffer, Multiple-point rate</i>	54	U/L	53 - 128
Total Protein	6.62	g/dL	6.4 - 8.2
Albumin <i>By Bromocresol Green</i>	3.87	g/dL	3.5 - 5.2
Globulin <i>Calculated</i>	2.75	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	1.41		0.8 - 2.0

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RENAL FUNCTION TEST			
Creatinine <i>Enzymatic ,IDMS Traceable</i>	0.80	mg/dL	0.7 - 1.3
Urea <i>Urease-GLDH, enzymatic UV</i>	24.3	mg/dL	19.0 - 45.0
BUN <i>Calculated</i>	11.36	mg/dL	7 - 18
Uric Acid <i>Enzymatic using TBHBA</i>	4.2	mg/dL	3.5 - 7.2
Sodium <i>Direct ISE</i>	138.3	mmol/L	137 - 145
Potassium <i>Direct ISE</i>	4.51	mmol/L	3.6 - 5.1
Chloride <i>Direct ISE</i>	95.3	mmol/L	94 - 110
Ionized Calcium <i>Direct ISE</i>	4.87	mg/dL	4.4 - 5.4

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LIPID PROFILE

Cholesterol <i>CHOD-PAP method</i>	214	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride <i>Enzymatic with GPO method</i>	760.9	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL <i>Calculated</i>	152.18	mg/dL	15 - 35
LDL CHOLESTEROL	21.72	mg/dL	Optimal : < 100.0 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190.0
HDL Cholesterol <i>Magnetic Cholesterol Oxidase</i>	40.1	mg/dL	Low : < 40 High : > 60
Cholesterol /HDL Ratio <i>Calculated</i>	5.34		0 - 5.0
LDL / HDL RATIO <i>Calculated</i>	0.54		0 - 3.5
Total Lipids <i>Calculated</i>	1909.80		400 - 1000

- Pre-analytical requirements for given tests are -Fasting status anywhere between 10-12 hours before collection. Avoid alcohol beverages before lipid panel - minimum 24 hrs.
- Lipid profile results can be erroneous if pre-analytical requirements are not met properly.
- Any medical decision based on test results is to be taken with 2 or more consecutive results suggesting pattern.
- Please note that any lipid lowering drug may interfere in results estimation.
- Sudden commencement or sudden withdrawal of Lipid lowering drug will interfere with test result.

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THYROID FUNCTION TEST

T3 (Triiodothyronine) <i>CMIA</i>	0.84	ng/mL	0.6 - 1.81
T4 (Thyroxine) <i>CMIA</i>	5.52	µg/dL	4.5 - 12.5
TSH <i>ELFA-Enzyme Linked Fluorescent Assay</i>	3.763	µIU/ml	0.35 - 4.94

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4. Quantification of TSH is significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

TSH levels During Pregnancy :

First Trimester : 0.1 to 2.5 µIU/mL

Second Trimester : 0.2 to 3.0 µIU/mL


Third trimester : 0.3 to 3.0 µIU/mL

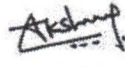
Reference : Carl A. Burtis, Edward R. Ashwood, David E. Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Edition.

Philadelphia: WB Saunders, 2012:2170

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BLOOD GROUP & RH

SPECIMEN: EDTA AND SERUM; METHOD: HAEMAGGLUTINATION

ABO	'B'
Rh (D)	Negative

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PHYSICAL EXAMINATION

Height	173.00	cm	
Weight	78.50	kg	
Blood Pressure	124/80	mmHg	
Pulse Rate	74	/min	

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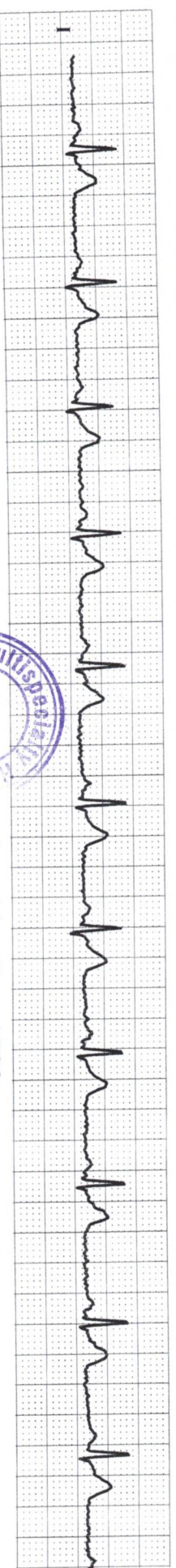
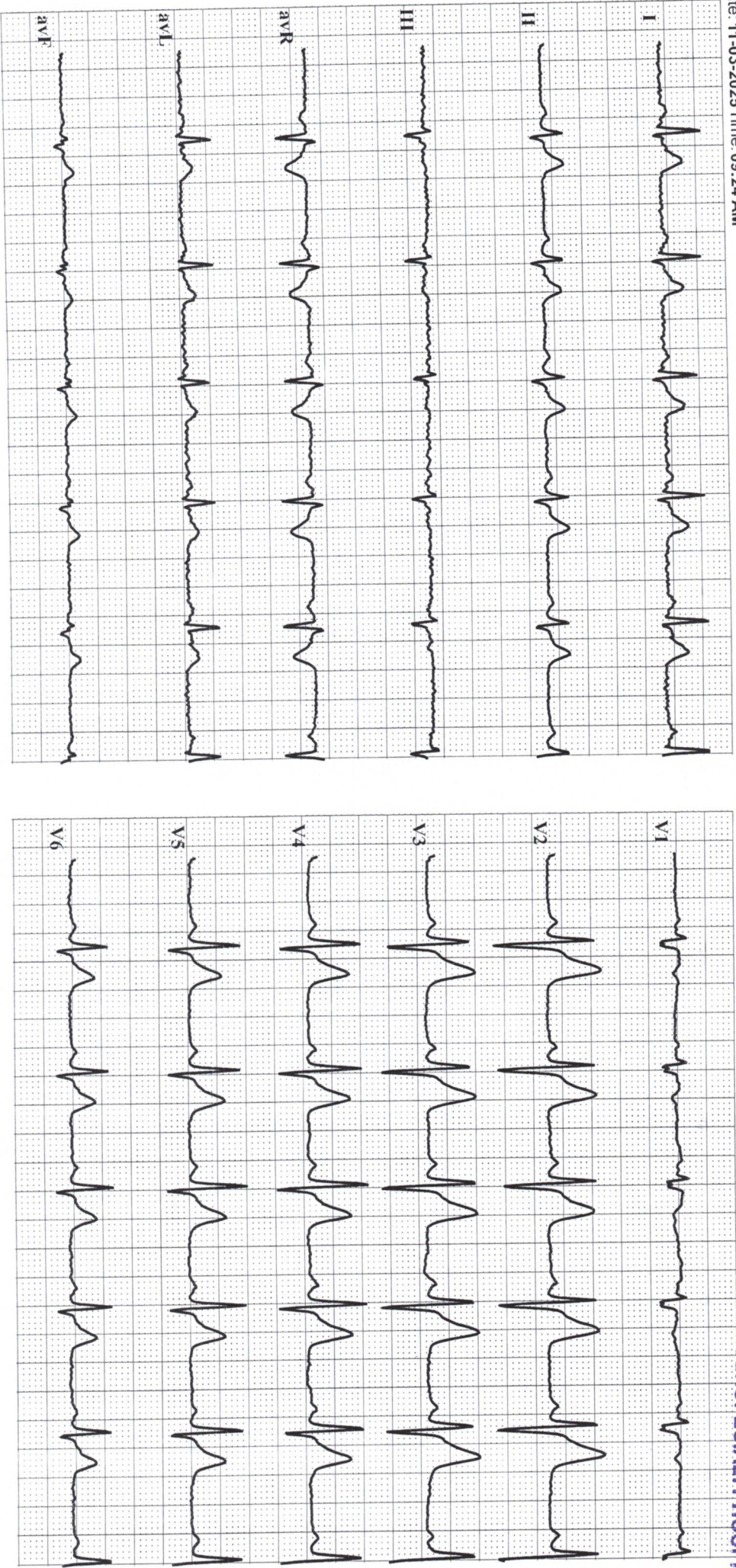
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438
36 Yrs/ M
Date: 11-03-2025 Time: 09:24 AM

DHARMABIR KUMAR
Kg / Ht cms Ref. No.:
Gain: 10 mm/mV
BP:--/-- mmHg
Sweep: 25 mm/S
Filter: 0.1 - 35 Hz
Notch: On
Hr: 71
P Int: 74
PR Int: 124
QRS Int.: 136
QT Int.: 340
QTc Int.: 370
P Axis: 24
QRS Axis: 23
T Axis: 26

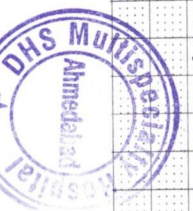
Ref: 30352
Tech: (General Medicine)
DHS MULTISPECIALITY HOSPITAL



Comments: Sinus Rhythm

Right bundle branch block
Non-specific ST-T abnormality (elevation)

Impression: Normal ECG



PATIENT NAME**MR. DHARMABIR KUMAR****AGE / SEX****36YRS/MALE****REF. DOCTOR****DR. DHS DOCTOR TEAM****DATE****11/03/2025****2D ECHO CARDIOGRAPHY REPORT****Observation:**

1. Normal size LV size with normal LV systolic function. LVEF: 65%.
2. No RWMA.
3. Normal LV compliance.
4. Normal sized LA, RA and RV. Normal RV function.
5. All valves are normal in structure.
6. IAS and IVS are intact.
7. No PAH.
8. No clot/ vegetation / pericardial effusion.
9. Doppler: Trivial MR, Trivial TR, No AR, No PR.
10. IVC is normal in size and well collapse on inspiration.

Conclusion:

Normal LV systolic function.
No RWMA.
No PAH.

**Measurements :**

LVIDD	45.0 mm	AO	29.0mm
LVIDS	35.0 mm	LA	35.0mm
LVEF	65%		
IVSD/LVPWD	09.0mm/09.0mm		

DOPPLER STUDY:

Valves	velocity	Max gradient	Mean gradient	Area	Regurgitation
Aortic	1.5	4.2			No AR
Mitral	E:0.3 A: 0.0				Trivial MR
Pulmonary	0.2	2.3			No PR
Tricuspid	0.4	1.2			Trivial TR

Dr. ARCHIT PARIKH
DR. ARCHIT PARIKH
G - 30352
M. D.(General Medicine)
DHS MULTISPECIALTY HOSPITAL

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DHS Properties and Hospitals LLP. | CIN : AAA-7816

DHARMABIR KUMAR
36 Y/M
HEALTH CHECK UP
11/03/2025

U.S.G. OF ABDOMEN AND PELVIS

Liver: appears normal in size and shows normal echotexture. No focal lesion is seen. No dilated IHBR is seen. Portal vein and CBD appear normal in course and caliber.

Gall bladder: is moderately distended & appears normal. No calculus, sludge or mass is seen. Gall bladder wall thickness appears normal.

Pancreas: appears normal in size & echopattern. No focal lesion is seen.

Spleen: appears normal in size and shows normal echotexture. No focal lesion is seen.

Both Kidneys appear normal in size, position and echopattern. C-M differentiation is well preserved on either side. No calculus or hydronephrosis on either side. Cortical thickness appears normal on both sides. No focal lesion is seen on either side.

Urinary bladder is moderately distended & appears normal. No calculus, internal echoes or mass is seen. Urinary bladder wall thickness appears normal.

Prostate appears normal in size and echopattern.

Para-aortic region appears normal. No abdominal lymphadenopathy is seen. Bowel loops appear normal in caliber & show normal peristalsis. No abnormal dilatation of bowel loops or wall thickening is seen. No fluid collection or lump formation is seen in RIF. No ascites is seen.

IMPRESSION:

No significant abnormality seen

Clinical correlation suggested. Thanks for reference.



DR. BHADRESH CHUDASAMA
MD RADIOLOGY

Patient Name	DHARMABIR KUMAR	Patient ID	UHID30049
Age/Gender	36 Years / M	Study Date	11-Mar-2025
Referred By		Reported Date	11-Mar-2025

X – RAY CHEST PA VIEW:

Both lung fields under vision appear normal.
Cardiac size appears normal.
Both costophrenic angles are clear.
Hilar regions are normal.
Both domes appear normal in position.
Bony thorax under vision appears normal.



Dr.Sunny Shivilani
MD Radiology REG G-33548

Date Reported: 11-Mar-2025

This Report is done and digitally signed via Tele Radiology Done at Radiscan Diagnostic Ahmedabad. For any clinical discrepancy, please discuss with the Radiologist. This report is not valid for any medico-legal purposes