



20254166 / KUNAL DAS / 33 Yrs / M / 0 Cms / 0 Kg Date: 08-Mar-2025 Technician : ROHINI KUMARI Examined By:

Stage	Time	Duration	Speed(mph)	Elevation	METs	Rate	% THR	BP	RPP	PVC	Comments
Standing	00:05	0:05	00.0	00.0	01.0	114	61 %	130/90	148	00	
Warm Up	00:19	0:14	00.0	00.0	01.0	110	59 %	130/90	143	00	
ExStart	00:35	0:16	01.0	00.0	01.0	122	65 %	130/90	158	00	
BRUCE Stage 1	03:35	3:00	01.7	10.0	04.7	142	76 %	130/90	184	00	
BRUCE Stage 2	06:35	3:00	02.5	12.0	07.1	157	84 %	140/90	219	00	
PeakEx	06:44	0:09	03.4	14.0	07.3	160	86 %	140/90	224	00	
Recovery	07:44	1:00	01.1	00.0	01.1	142	76 %	150/90	213	00	
Recovery	08:44	2:00	00.0	00.0	01.0	127	68 %	150/90	190	00	
Recovery	09:44	3:00	00.0	00.0	01.0	120	64 %	150/90	180	00	
Recovery	10:44	4:00	00.0	00.0	01.0	116	62 %	140/90	162	00	
Recovery	11:44	5:00	00.0	00.0	01.0	121	65 %	140/90	169	00	
Recovery	12:42	5:57	00.0	00.0	01.0	118	63 %	130/90	153	00	

REPORT

Sample Name: Stress Test Graded Exercise Treadmill
Description: To rule out to CAD.

INDICATIONS: To rule out to CAD.

PROCEDURE DONE: Graded exercise treadmill stress test.

STRESS ECG RESULTS: The patient was stressed by continuous graded treadmill testing for Exercise Time 06:10 Mins. of the standard Bruce protocol. The initial HR was recorded as 114 bpm, and the maximum predicted Target Heart Rate 187.

The Test was completed because of **TARGET HEART RATE ACHIEVED**.

CONCLUSIONS:

1. Stress test is **NEGATIVE** for ischemia.
2. Good functional capacity.
3. Blood pressure response to exercise is normal.



Patient: [REDACTED]
 kunal
 MA: Kunal Das
 Age: ... 33y M / F
 ... cm / ... kg

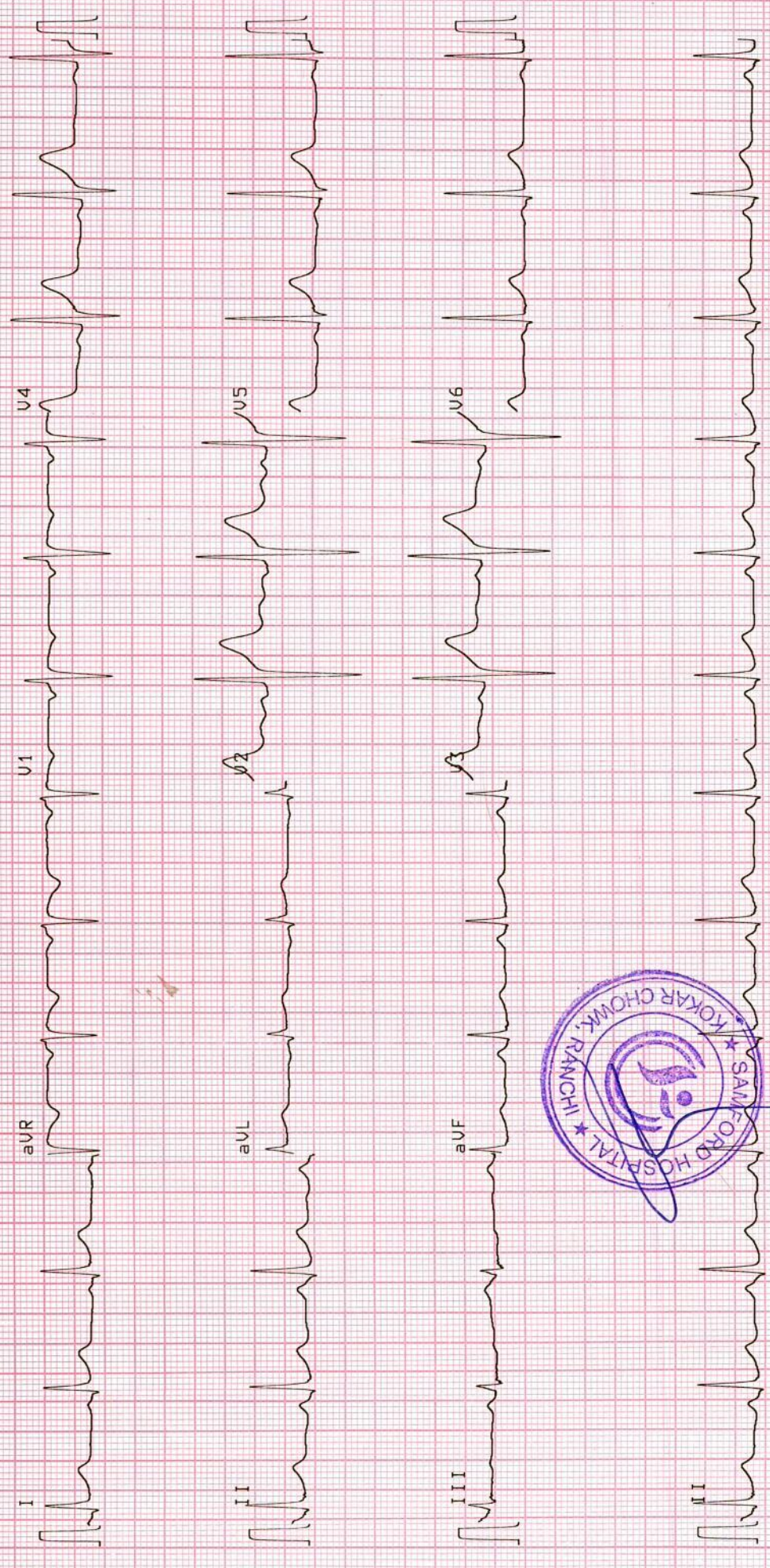
SINUS RHYTHM
 LEFT ATRIAL ABNORMALITY

UNCONFIRMED REPORT

HR 75/min
 Axis: P 64°
 QRS 42°
 T 26°
 Intervals:
 RR 804 ms
 P 110 ms
 PR 146 ms
 QRS 94 ms
 QT 370 ms
 QTc 416 ms
 P (II) 0.15 mV
 S (V1) -1.15 mV
 R (V5) 1.67 mV
 Sokol. 3.31 mV

10 mm/mV

10 mm/mV



Patient Name	KUNAL DAS	Requested By	DR. HEALTH CHECKUP
MRN	20254166	Procedure Date	08.03.2025
Age/Sex	33 Y/ MALE	Reporting Date	08.03.2025

USG WHOLE ABDOMEN

Liver: The liver is normal in size ~ **14.5cm** and outline. **It shows a increased echopattern.** The intra and extra hepatic biliary passage are not dilated. The portal vein is normal in calibre at the porta hepatis(11mm).

Gall bladder: The gall bladder is well distended shows normal wall thickness with no evidence of calculi.

CBD: The CBD is of normal caliber(4.1mm).

Pancreas: The pancreas is normal in size and echogenicity with distinct outline. No obvious focal lesion is seen.

Spleen: **The spleen is mild enlarged in size ~ 12.3cm.**

Kidneys: Both kidneys were normal in position and measured as follows:

Right kidney measures 9.7 x 4.6cm.

Left kidney measures 10.6 x 5.2cm.

The renal cortical thickness and corticomedullary differentiation were adequate on both sides. No evidence of renal calculus or hydronephrosis seen on either side.

Urinary bladder: The urinary bladder is normal in size. Its wall shows a smooth outline. There is no evidence of any intraluminal or perivesical abnormality.

Prostate: The prostate is normal in size measures (vol - 8gms) and showed a normal parenchymal echotexture.

No evidence of ascites or lymphadenopathy seen.

No pleural effusion seen.

IMPRESSION:

- **Grade I fatty liver.**
- **Mild splenomegaly.**

(Please correlate clinically).



DR. JITENDRA KUMAR, (DMRD)
Sr. Consultant Radiologist.

Note: - We regret typographical errors if any. Please contact us for correction.

This report is not valid for medico-legal purpose

Typed By: AY.

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Patient Name	KUNAL DAS	Requested By	DR. HEALTH CHECKUP
MRN	20254166	Procedure Date	08.03.2025
Age/Sex	33 Y/ MALE	Reporting Date	08.03.2025

X-RAY CHEST PA VIEW

Result:

Both lung fields are clear.

Both hila are normal.

Both CP angles are normal.

Cardiac contour and size are within normal limits.

The bony rib cage is normal.

Soft tissues are normal.

IMPRESSION: NORMAL STUDY.

We regret typographical errors if any. Please contact us for correction.

(Please correlate clinically).



DR. ANUJ, MD
Consultant Radiologist.

Department of Pathology

Patient Name : Mr. Kunal Das
UHID : 20254166
Age/Sex : 33 yr 2 mo 7 D /M
Referred By : Dr. Self .
Status : Final

Investigation No : 20250310883
Requested Date : 08/03/2025 08:26am
Collection Date : 08/03/2025 08:49am
Reported Date : 08/03/2025 11:04am



Haematology

Complete Blood Count(CBC)(1394)

(Hematology analyzer and microscopy)

<u>Test</u>	<u>Result</u>	<u>Unit</u>	<u>Bio. Ref. Interval</u>
RBC Count	5.16	million/cumm	4.5-5.5
Hb Haemoglobin (1389)	14.9	gm/dl	12.0-17.0
HCT	44.7	%	40-50
MCV	86.6	Fl	80-100
MCH	28.9	Pg	27-32
MCHC	33.2	g/dl	32-36
Platelet Count (1395)	1.64	lac/cumm	1.50-4.50
RDW	14.0	%	11-14
TLC (Total Leucocyte Count)(1390)	6300	/cumm	4000 - 11000
DLC (Differential Leucocyte Count)(1391)			
Neutrophils	53	%	45-75
Lymphocytes	38	%	20-45
Eosinophils	07	%	1-6
Monocytes	02	%	2-10
Basophils	00	%	0-1
ESR(ERYTHROCYTE SEDIMENTATION RATE)(1392) (Westergren)	10	mm at 1st hr	0-10

Result Entered By

Mr. Sanjeev Prasad

Ms. Madhu Kumari

Dr. Anubhuti Choudhary
(Consultant Pathologist)

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DEPARTMENT OF PATHOLOGY

Patient Name : Mr. Kunal Das
UHID : 20254166
Age/Sex : 33 yr 2 mo 7 D /M
Referred By : Dr. Self .
Status : Final

Investigation No : 20250310874
Requested Date : 08/03/2025 08:26am
Collection Date : 08/03/2025 08:48am
Reported Date : 08/03/2025



Blood Grouping and RH Typing(1418)

TEST NAME	RESULT
ABO	'O'
RH	Positive

--- End Of Report ---

Result Entered By
Mr. Sanjeev Prasad

Suddeep
Mr. Suddeep Oraon

Anubhuti
Dr. Anubhuti Choudhary
(Consultant Pathologist)

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DEPARTMENT OF PATHOLOGY

Patient Name : Mr. Kunal Das
UHID : 20254166
Age/Sex : 33 yr 2 mo 7 D /M
Referred By : Dr. Self .
Status : Final

Investigation No : 20250310880
Requested Date : 08/03/2025 08:26AM
Collection Date : 08/03/2025 08:49AM
Reported Date : 08/03/2025



HbA1C(Glycosylated Haemoglobin)(1510)(HPLC)

Test Name	Result	Unit	Reference Range
HbA1c	4.7		4.5-6.5
Mean Plasma Glucose* Calculated	88.1	mg/dL	

Mean Plasma Glucose is based on estimated Average Glucose (eAG) value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

Reference Range (HBA1c)

- Good control
- Fair control
- Poor control

- : 4.5 - 6.4 %
- : 6.5 - 7.4 %
- : Above - 7.5 %

Note: Anaemia can lead to erroneous increase or decrease in HbA1C reading to misinterpretation of the disease condition, hence it might not be a reliable indicator to assist the glycaemic index.
Advice: Fructosamine test.

Interval

- 1.59
- 120
0 - 5.50

--- End Of Report ---

Entered By
Sh Ghosh

Ms. Madhu Kumari

Dr. Anubhuti Choudhary
(Consultant Pathologist)

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is related to the item tested.
Professional opinion and cannot be used for medicolegal purpose.
result should be interpreted with clinico radiological correlation.
Unexpected/abnormal result contact the laboratory.

Department of Pathology

Patient Name : Mr. Kunal Das
UHID : 20254166
Age/Sex : 33 yr 2 mo 7 D /M
Referred By : Dr. Self .
Status : Final

Investigation No : 20250310882
Requested Date : 08/03/2025 08:26AM
Collection Date : 08/03/2025 08:49AM
Reported Date : 08/03/2025 10:38AM



Biochemistry

<u>Test</u>	<u>Result</u>	<u>Unit</u>	<u>Bio. Ref. Interval</u>
Blood Sugar (Fasting)(1465)	105	mg/dl	70-110
Blood Sugar (post parandial)(1465)	115	mg/dL	70-140
Creatinine(1447) (Modified Jaffe Kinetic)	1.0	mg/dl	0.6-1.5
Uric Acid(1455)	7.4	mg/dl	3.6 - 7.2
Blood Urea Nitrogen (BUN) (1446)	11.2	mg/dl	5-25
BUN / Creatinine Ratio	11.2		4.0-21.5
<u>LFT (Liver Function Test)(1513)</u>			
<u>Test</u>	<u>Result</u>	<u>Unit</u>	<u>Bio. Ref. Interval</u>
Serum Bilirubin (Total) (1456)	0.5	mg/dL	0.1-1.2
Serum Bilirubin (Direct)	0.2	mg/dL	0.0-0.3
Serum Bilirubin (InDirect)	0.3	mg/dL	0.2-0.8
SGPT (1475)	73	U/L	0-45
SGOT (1476)	46	U/L	5-40
Alkaline Phosphatase (ALP) (1494)	99	U/L	41-137
Total Protein	7.4	g/dl	6.0 - 8.0
Albumin (1461)	4.4	g/dl	3.7-5.3
Globulin	3.0	g/dl	2.3-3.6
A/G Ratio	1.5		1.2-1.8
GGT	37	U/L	1-94

Result Entered By

Mr. Sanjeev Prasad

Mr. Sudeep Craon

Dr. Rajeev .
(M.D Pathologist)

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DEPARTMENT OF PATHOLOGY

Patient Name : Mr. Kunal Das
UHID : 20254166
Age/Sex : 33 yr 2 mo 7 D /M
Referred By : Dr. Self .
Status : Final

Investigation No : 20250310870
Requested Date : 08/03/2025 08:26am
Collection Date : 08/03/2025 08:49am
Reported Date : 08/03/2025



Urine Routine Examination(1383)(Strip / Microscopy)

TEST NAME	RESULT	UNIT	REFERENCE RANGE
VOLUME	20 ml		
COLOUR	Straw		
APPEARANCE	Clear		
SP GRAVITY	1.025		1.003 - 1.035
PH	6.0		4.7 - 7.5
PROTEIN	NOT DETECTED		NOT DETECTED
GLUCOSE	NOT DETECTED		NOT DETECTED
KETONE BODIES	NOT DETECTED		NOT DETECTED
BLOOD	NOT DETECTED		NOT DETECTED
BILIRUBIN	NOT DETECTED		NOT DETECTED
UROBILINOGEN	NOT DETECTED		NOT DETECTED
NITRITE	NOT DETECTED		NOT DETECTED
PUS CELLS	1 - 2	/HPF	0-5
EPITHELIAL CELLS	0 - 1	/HPF	0-5
RBC	NOT DETECTED	/HPF	NOT DETECTED
CAST	NOT DETECTED		NOT DETECTED
CRYSTAL	NOT DETECTED		NOT DETECTED
BACTERIA	NOT DETECTED		NOT DETECTED

--- End Of Report ---

Result Entered By
Mr. Sanjeev Prasad

Ms. Madhu Kumari

Dr. Anubhuti Choudhary
(Consultant Pathologist)

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Department of Pathology

Patient Name : Mr. Kunal Das
UHID : 20254166
Age/Sex : 33 yr 2 mo 7 D /M
Referred By : Dr. Self .
Status : Final

Investigation No : 20250310881
Requested Date : 08/03/2025 08:26AM
Collection Date : 08/03/2025 08:49AM
Reported Date : 08/03/2025 10:39AM



Biochemistry

Lipid Profile

(CHOD-POD)

Test	Result	Unit	Bio. Ref. Interval
Cholesterol(1463)	199	mg/dl	< 200
Triglycerides (1487)	220	mg/dl	< 150
HDL Cholesterol	45	mg/dl	40 - 60
LDL	110	mg/dl	60-130
VLDL Cholesterol	44	mg/dL	< 30
LDL /HDL Ratio	2.44		0.50-3.55

Immunology

THYROID PROFILE(1559)

(Chemiluminescence Assay(C.L.I.A))

Test	Result	Unit	Bio. Ref. Interval
T3	1.45	ng/mL	0.58 - 1.59
T4 (1561)	103.4	nmol/l	60 - 120
TSH (1562)	2.91	uIU/ml	0.50 - 5.50

Result Entered By

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