





Name	: Mrs. MADHURI	Collected On	: 14/12/2024 11:29 am
Lab ID.	[:] 216798	Received On	: 14/12/2024 11:39 am
Age/Sex	: 30Years / Female	Reported On	: 14/12/2024 7:30 pm
Ref By	: JINKUSHAL CARDIAC CARE & SUPER SPECIALITY HOS	Report Status	: FINAL

*LIPID PROFILE					
TEST NAME	RESULTS	UNIT	REFERENCE RANGE		
TOTAL CHOLESTEROL	209.0	mg/dL	Desirable blood cholesterol: -		
(CHOLESTEROL			<200 mg/dl.		
OXIDASE,ESTERASE,PEROXIDA			Borderline high blood cholesterol:		
SE)			- 200 - 239 mg/dl.		
			High blood cholesterol: -		
			>239 mg/dl.		
S.HDL CHOLESTEROL (DIRECT	41.6	mg/dL	Major risk factor for heart :<30		
MEASURE - PEG)			mg/dl.		
			Negative risk factor for heart		
			disease :>=80 mg/dl.		
S. TRIGLYCERIDE (ENZYMATIC,	147.8	mg/dL	Desirable level : <161 mg/dl.		
END POINT)			High :>= 161 - 199 mg/dl.		
			Borderline High :200 - 499 mg/dl.		
			Very high :>499mg/dl.		
VLDL CHOLESTEROL	30	mg/dL	UPTO 40		
(CALCULATED VALUE)					
S.LDL CHOLESTEROL	138	mg/dL	Optimal:<100 mg/dl.		
(CALCULATED VALUE)		-	Near Optimal: 100 - 129 mg/dl.		
			Borderline High: 130 - 159 mg/dl.		
			High : 160 - 189mg/dl.		
			Very high :>= 190 mg/dl .		
LDL CHOL/HDL RATIO	3.32		UPTO 3.5		
(CALCULATED VALUE)					
CHOL/HDL CHOL RATIO	5.02		<5.0		
(CALCULATED VALUE)					
Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).					

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT ------

Checked By SHAISTA Q Som...

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) Consultant Histocytopathologist Regd.No.: 3401/09/2007

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COMPLETE BLOOD COUNT				
TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
HEMOGLOBIN	12.8	gm/dl	12.0 - 15.0	
HEMATOCRIT (PCV)	38.4	%	36 - 46	
RBC COUNT	4.42	x10^6/uL	4.5 - 5.5	
MCV	87	fl	80 - 96	
МСН	29.0	pg	27 - 33	
МСНС	33	g/dl	33 - 36	
RDW-CV	13.2	%	11.5 - 14.5	
TOTAL LEUCOCYTE COUNT	7400	/cumm	4000 - 11000	
DIFFERENTIAL COUNT				
NEUTROPHILS	63	%	40 - 80	
LYMPHOCYTES	29	%	20 - 40	
EOSINOPHILS	02	%	0 - 6	
MONOCYTES	06	%	2 - 10	
BASOPHILS	00	%	0 - 1	
PLATELET COUNT	298000	/ cumm	150 to 410	
MPV	11.4	fl	6.5 - 11.5	
PDW	15.9	%	9.0 - 17.0	
РСТ	0.340	%	0.200 - 0.500	
RBC MORPHOLOGY	Normocytic Normo	ochromic		
WBC MORPHOLOGY	Normal			
PLATELETS ON SMEAR	Adequate			

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT ------

Checked By SHAISTA Q



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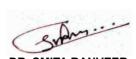


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URINE ROUTINE EXAMINATION				
EST NAME	RESULTS	UNIT	REFERENCE RANGE	
JRINE ROUTINE EXAMINATION				
PHYSICAL EXAMINATION				
VOLUME	20ml			
COLOUR	Pale Yellow		Pale Yellow	
APPEARANCE	Slightly hazy		Clear	
CHEMICAL EXAMINATION				
REACTION	Acidic		Acidic	
(methyl red and Bromothymol blue	e indicator)			
SP. GRAVITY	1.015		1.005 - 1.022	
(Bromothymol blue indicator)				
PROTEIN	Absent		Absent	
(Protein error of PH indicator)				
BLOOD	Absent		Absent	
(Peroxidase Method)				
SUGAR	Absent		Absent	
(GOD/POD)				
KETONES	Absent		Absent	
(Acetoacetic acid)				
BILE SALT & PIGMENT	Absent		Absent	
(Diazonium Salt)				
JROBILINOGEN	Normal		Normal	
(Red azodye)				
EUKOCYTES	Absent		Absent	
(pyrrole amino acid ester diazoniur	n salt)			
NITRITE	Absent		Negative	
(Diazonium compound With tetrahy	drobenzo quinolin 3-ph	enol)		
MICROSCOPIC EXAMINATION				
RED BLOOD CELLS	Absent	/ HPF	Absent	
PUS CELLS	2-3	/ HPF	0 - 5	
EPITHELIAL	6-8	/ HPF	0 - 5	
CASTS	Absent			
CRYSTALS	Absent			

Checked By

Rajashri_Dumbre



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Ref By	: JINKUSHAL CARDIAC CARE & SUPER SPECIALITY HO	Report Status	: FINAL
Consulting			

URINE ROUTINE EXAMINATION				
TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
BACTERIA	Present(+)		Absent	
YEAST CELLS	Absent		Absent	
ANY OTHER FINDINGS	Absent		Absent	
REMARK Result relates to sample tested. Kindly correlate with clinical findings.				
Result relates to sample tested, Kindly correlate with clinical findings.				

----- END OF REPORT ------

Checked By Rajashri_Dumbre

Sudmin

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Consulting Dr. : DR. MAYUR JAIN

			IMMUNO A	SSAY		
TEST NAME		RESULTS		UNIT	REFERENCE RANGE	
TFT (THYROID	FUNCTION TES	<u>6T)</u>				
SPECIMEN		Serum				
Т3		173.0		ng/dl	84.63 - 201.8	
T4		12.5		µg/dl	5.13 - 14.06	
TSH		1.26		µIU/ml	0.270 - 4.20	
DONE ON FULLY	AUTOMATED AN	ALYSER MAGLUM	I SNIBE X3	F - 7		
T3 (Triiodo Thyr		T4 (Thyroxir				
AGE	RANGE		RANGES			
1-30 days	100-740	1-14 Days	11.8-22.6			
1-11 months	105-245	1-2 weeks	9.9-16.6			
1-5 years	105-269	1-4 months	7.2-14.4			
6-10 years	94-241	4-12months	7.8-16.5			
11-15 years	82-213	1-5 years	7.3-15.0			
15-20 years	80-210	5-10 years	6.4-13.3			
		11-15 years	5.6-11.7			
TSH(Thyroid stir	-	ie)				
	RANGES					
0-14 Days	1.0-39					
2 weeks -5 mon						
6 months-20 yea	ars 0.7-6.4					
Pregnancy	0125					
1st Trimester 2nd Trimester	0.1-2.5 0.20-3.0					
3rd Trimester	0.20-3.0					

INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By SHAISTA Q

Sydam ...

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HAEMATOLOGY				
TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
BLOOD GROUP				
SPECIMEN	WHOLE BLOOD E	DTA & SERUM		
* ABO GROUP	'B'			
RH FACTOR	POSITIVE			
Method: Slide Agglutination	and Tube Method (Forward gro	uping & Reverse gro	puping)	
Result relates to sample tested, Kindly correlate with clinical findings.				
	END	OF REPORT		

Checked By SHAISTA Q

Sydam

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*RENAL FUNCTION TEST							
TEST NAME	RESULTS	UNIT	REFERENCE RANGE				
BLOOD UREA	25.8	mg/dL	13 - 40				
(Urease UV GLDH Kinetic)							
BLOOD UREA NITROGEN	12.06	mg/dL	5 - 20				
(Calculated)							
S. CREATININE	1.03	mg/dL	0.6 - 1.4				
(Enzymatic)							
S. URIC ACID	4.5	mg/dL	2.6 - 6.0				
(Uricase)							
S. SODIUM	139.6	mEq/L	137 - 145				
(ISE Direct Method)							
S. POTASSIUM	3.85	mEq/L	3.5 - 5.1				
(ISE Direct Method)							
S. CHLORIDE	106.1	mEq/L	98 - 110				
(ISE Direct Method)							
S. PHOSPHORUS	3.79	mg/dL	2.5 - 4.5				
(Ammonium Molybdate)							
S. CALCIUM	9.8	mg/dL	8.6 - 10.2				
(Arsenazo III)							
PROTEIN	6.70	g/dl	6.4 - 8.3				
(Biuret)							
S. ALBUMIN	3.87	g/dl	3.2 - 4.6				
(BGC)							
S.GLOBULIN	2.83	g/dl	1.9 - 3.5				
(Calculated)							
A/G RATIO	1.37		0 - 2				
calculated							
BIOCHEMISTRY TEST DONE ON F	ULLY AUTOMATED (EM 2	00) ANALYZER.					

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT ------

Checked By SHAISTA Q



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LIVER FUNCTION TEST							
TEST NAME	RESULTS	UNIT	REFERENCE RANGE				
TOTAL BILLIRUBIN	0.60	mg/dL	0.2 - 1.2				
(Method-Diazo)							
DIRECT BILLIRUBIN	0.28	mg/dL	0.0 - 0.4				
(Method-Diazo)							
INDIRECT BILLIRUBIN	0.32	mg/dL	0 - 0.8				
Calculated							
SGOT(AST)	19.8	U/L	0 - 37				
(UV without PSP)							
SGPT(ALT)	23.0	U/L	UP to 40				
UV Kinetic Without PLP (P-L-P)							
ALKALINE PHOSPHATASE	42.0	U/L	42 - 98				
(Method-ALP-AMP)							
S. PROTIEN	6.7	g/dl	6.4 - 8.3				
(Method-Biuret)							
S. ALBUMIN	3.87	g/dl	3.5 - 5.2				
(Method-BCG)							
S. GLOBULIN	2.83	g/dl	1.90 - 3.50				
Calculated							
A/G RATIO	1.37		0 - 2				
Calculated							

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT ------

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Consulting Dr. : DR. MAYUR JAIN

HAEMATOLOGY						
TEST NAME	RESULTS	UNIT	REFERENCE RANGE			
ESR						
ESR	40	mm/1hr.	0 - 20			

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT ------

Checked By SHAISTA Q

Superior

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) Consultant Histocytopathologist Regd.No.: 3401/09/2007

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Consulting Dr. : DR. MAYUR JAIN

BIOCHEMISTRY						
TEST NAME	RESULTS	UNIT	REFERENCE RANGE			
GLYCOCELATED HEMOGLOBIN (H	BA1C)					
HBA1C (GLYCOSALATED	5.4	%	Hb A1c			
HAEMOGLOBIN)			> 8 Action suggested			
			< 7 Goal			
			< 6 Non - diabetic level			
AVERAGE BLOOD GLUCOSE (A. B.	108.0	mg/dL	65.1 - 136.3			

```
G.)
METHOD
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Particle Enhanced Immunoturbidimetry

HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.

BLOOD GLUCOSE FASTING & PP

BLOOD GLUCOSE FASTING	109.4	mg/dL	70 - 110
BLOOD GLUCOSE PP	70.0	mg/dL	70 - 140
Method (GOD-POD). DONE ON FULLY A	UTOMATED ANALYSER (EM2	00).	

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting speciman. Last dinner should consist of bland diet.

2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

Sumi

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	BIOCHEMISTRY							
TEST NAME	RESULTS	UNIT	REFERENCE RANGE					
INTERPRETATION - Normal glucose tolerance : 7 - Impaired Fasting glucose (IF - Diabetes mellitus : >=126 m	G) : 110-125 mg/dl							
POSTPRANDIAL/POST GLUCOS - Normal glucose tolerance : 7 - Impaired glucose tolerance : - Diabetes mellitus : >=200 m	0-139 mg/dl 140-199 mg/dl							
CRITERIA FOR DIAGNOSIS OF - Fasting plasma glucose >=1. - Classical symptoms +Randor - Plasma glucose >=200 mg/c - Glycosylated haemoglobin >	26 mg/dl m plasma glucose >=200 mg Il (2 hrs after 75 grams of glu							
***Any positive criteria should GAMMA GT	l be tested on subsequent da 18.6	y with same or othe U/L	er criteria. 5 - 55					

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By SHAISTA Q

Sugar

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	A A A A A A A A A A A A A A A A A A A	avL	avr		*		ID Name Gender : Age Dept Bed No. :
					ł		20241214091255 MRS MADHURI BAN F 30 Years
							HR : 65 bpm PR : 134 ms QRS : 96 ms QT/QTC : 426/435 ms P/QRS/T : 47/76/30 ° P/QRS/T : 0.698/0.372 mv RV5-5V1 : 1.070 mv
					ł	}	° ° 72 mv
- {	7.6		7	Ev	and a second		≪Interpret.tions >> Sinus rhythia Normal ECC
	<pre>}</pre>	Ì				And and a second	
	ł	ł	ł	}	<pre>}</pre>		Confirm and sign :
	}	ł	ł	}	$\frac{1}{2}$		
	1					}.	



NAME : MRS. MADHURI	AGE : 32YRS/FEMALE
	DATE: 14.12.2024

FULL ABDOMEN USG

LIVER: Normal in size (13.9 cm) and shows bright echotexture. No focal lesion is seen. Hepatic vasculature appears normal. No e/o IHBR dilatation seen.

PORTAL VEIN / SPLENIC VEIN / CBD: are normal in caliber.

GALL BLADDER: Is well distended. No calculi/wall thickening / sludge.

SPLEEN: Is normal in size, shape, position and shows normal homogeneous echotexture. No focal lesion seen.

PANCREAS: visualized head is normal in size and shows normal homogeneous echotexture. Rest is obscured by bowel gas.

KIDNEYS: Right kidney: 8.5 x 3.5 cmLeft kidney: 9.4 x 4.2 cm.Both kidneys are normal in size, shape, position, and echotexture. Both kidneys show
normal cortico-medullary differentiation. No calculi/ HN/HU seen.

URINARY BLADDER: Is well distended and appears normal. No SOL /wall thickening.

UTERUS: Is normal in size 6.2 x 3.1 x 3.8 cm anteverted and shows normal echotexture. No focal lesion seen. Central Endometrial eco-complex measures 6.2 mm. Cervix appears normal.

OVARIES: Both ovaries appear normal. Bilateral adnexa are clear.

PERITONEAL CAVITY: No ascites or enlarged lymph nodes. Bowel gas ++

OPINION:

• GRADE I FATTY LIVER.

DROB

DR. DEVENDRA PATIL (M.D.Radiology) CONSULTANT RADIOLOGIST

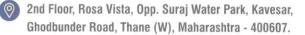
Please co-relate the findings with clinical examination, history & blood investigations.



022 - 46015511/22, 9222888070, 9082386200

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www.jinkushalcardiaccare.com

JINKUSHAL

JINKUSHAL CARDIAC CARE HOSPITAL THANE(W)

Name: MAL	HURI BAN			Date: 14-12-2024	Time: 12:11
Age: 30 Clinical History: Medications:	Gender: F	Height: 165 cms	Weight: 96 Kg	ID: MADHUR	IBAN
Test Details	:				
Protocol: Bruce		Predicted Max HR:	190	Target HR: 161 (85%	of Pr. MHR)
Exercise Time:	0:06:45	Achieved Max HR:			· · · · · · · · · · · · · · · · · · ·
Max BP:	130/80	Max BP x HR:	21840	Max Mets: 7.6	
Test Termination	Criteria:				

Protocol Details:

NT.

Stage Name	Stage Time	METS	Speed kmph	Grade %	Heart Rate	BP mmHg	RPP	Max ST Level	Max ST Slope mV/s
Standing	00:17	1	0	0	77	100/60	7700	-0.6 II	2.9 V2
HyperVentilation	00:21	1	0	0	81	100/60	8100	-0.6 II	3.3 V2
PreTest	00:30	1	1.6	0	88	110/60	9680	-1.4 V3	2.3 V2
Stage: 1	03:00	4.7	2.7	10	129	110/60	14190	-0.7 III	2.6 V2
Stage: 2	03:00	7	4	12	154	120/70	18480	-1.6 II	2.6 V2
Peak Exercise	00:45	7.6	5.5	14	168	130/80	21840	-1.1 V6	2.6 V2
Recovery1	01:00	1	0	0	146	130/80	18980	0.4 II	0.3 II
Recovery2	00:46	1	0	0	106	130/80	13780	-0.5 III	2.8 V2

Interpretation

GOOD EFFORT TOLERANCE NO ARRYTHMIA NO ANGINA OR DYSPNOEA NO SIGNIFICANT ST-T CHANGES AT PEAK EXERCISE / RECOVERY

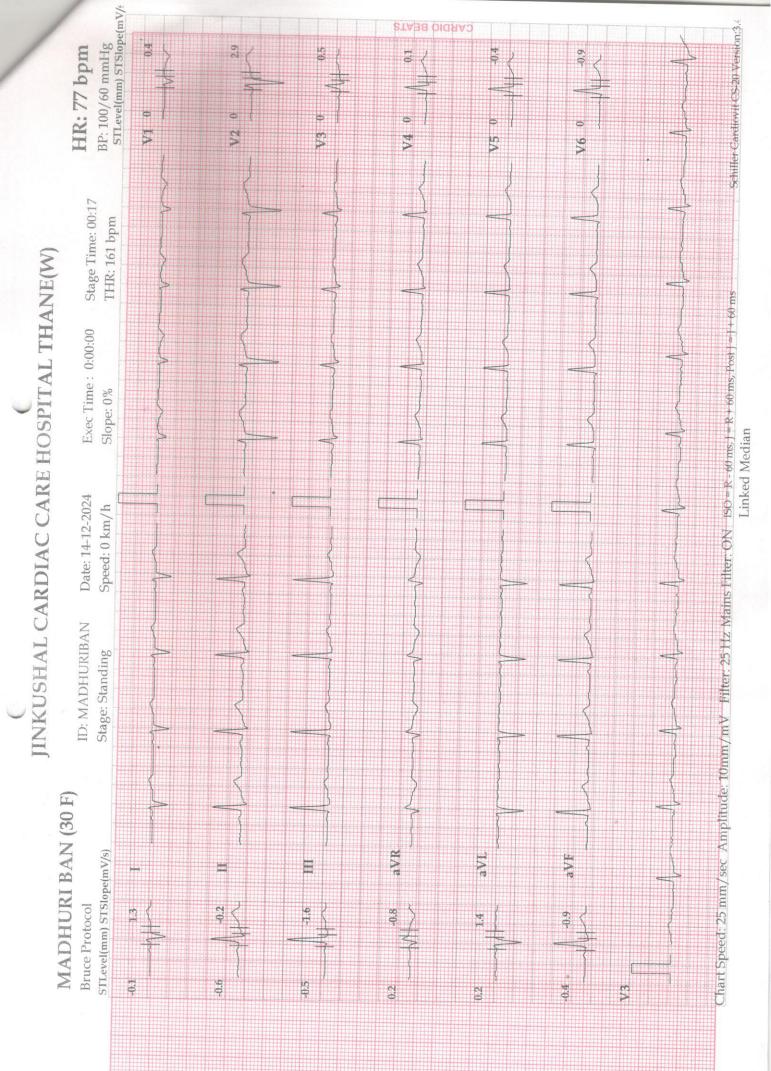
IMPRESSION : TMT IS NEGATIVE FOR INDUCIBLE ISCHEMIA @ 7.6 METS

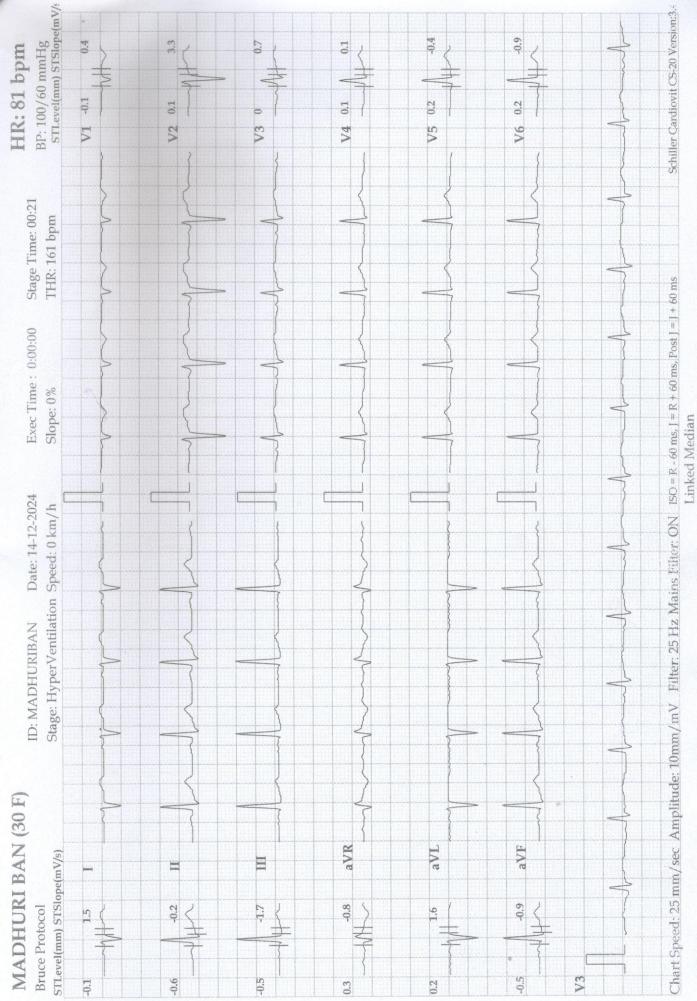
* Doctor: DR MAYUR JAIN

(Summary Report edited by User) Cardiovit CS-20 Version:3.4

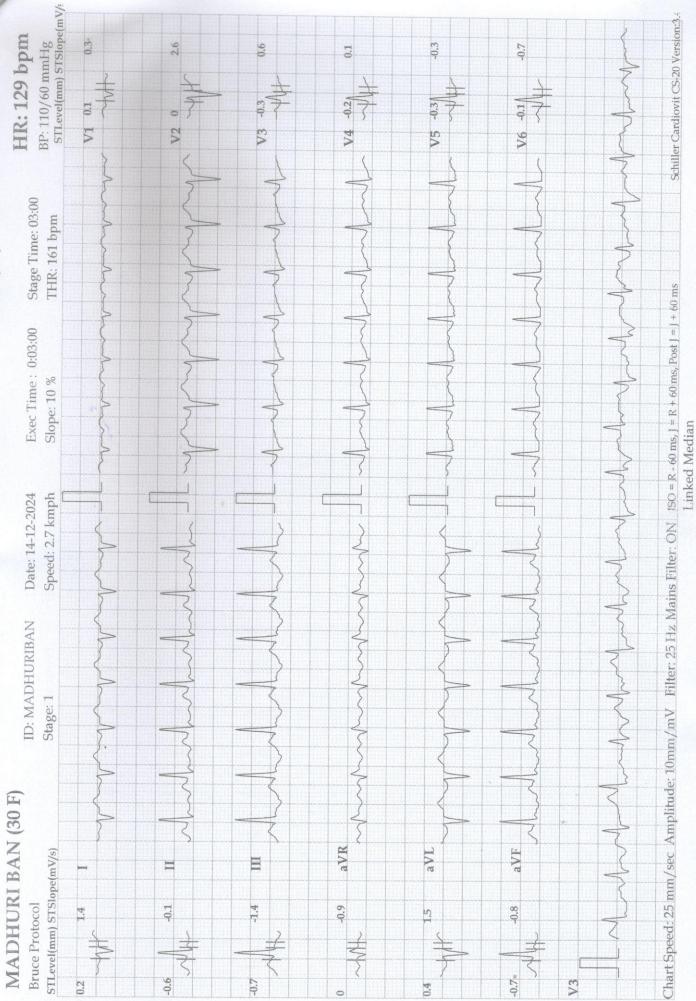
Ref. Doctor: SELF

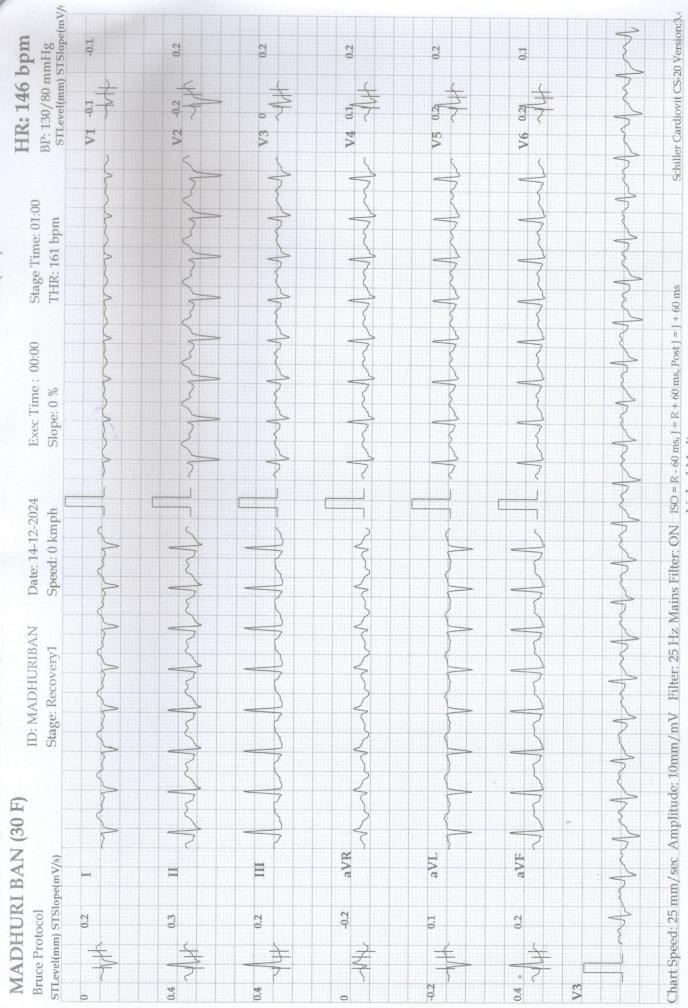




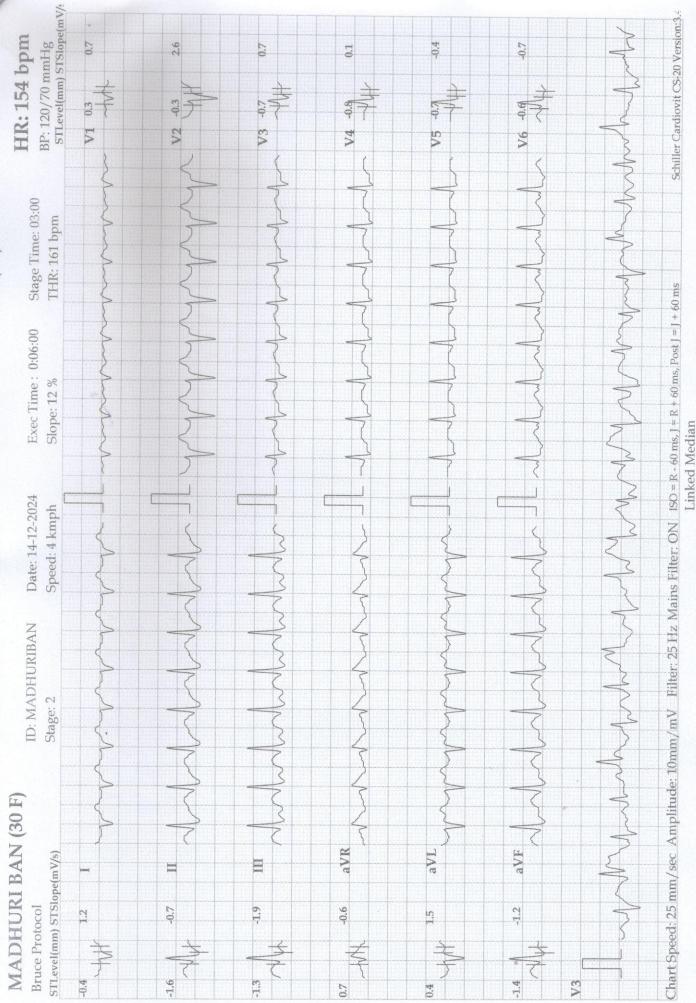


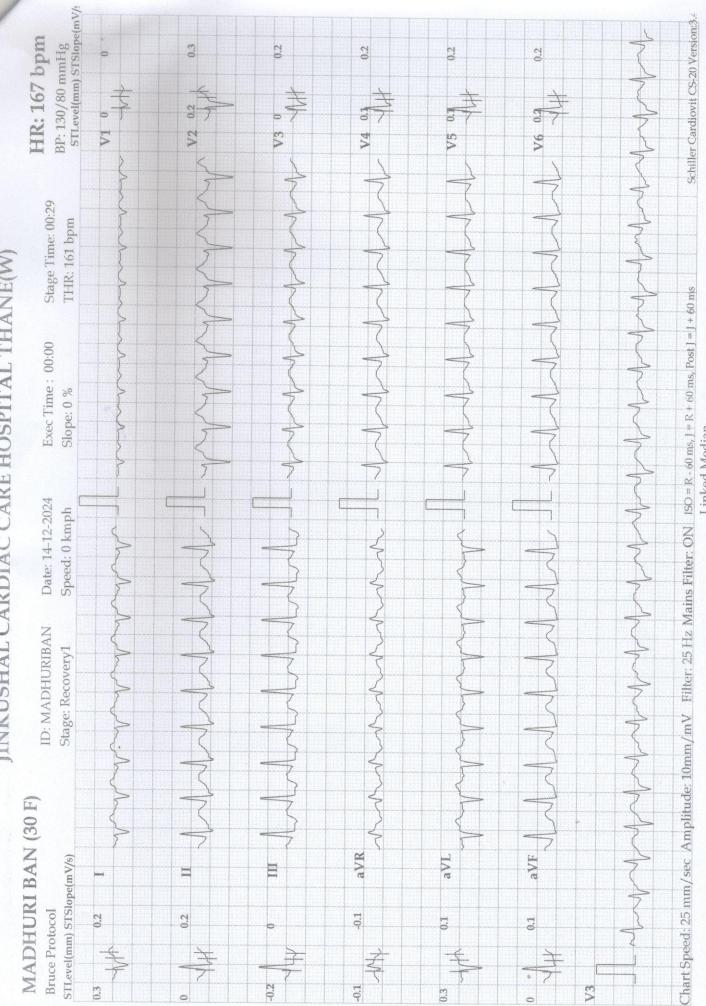




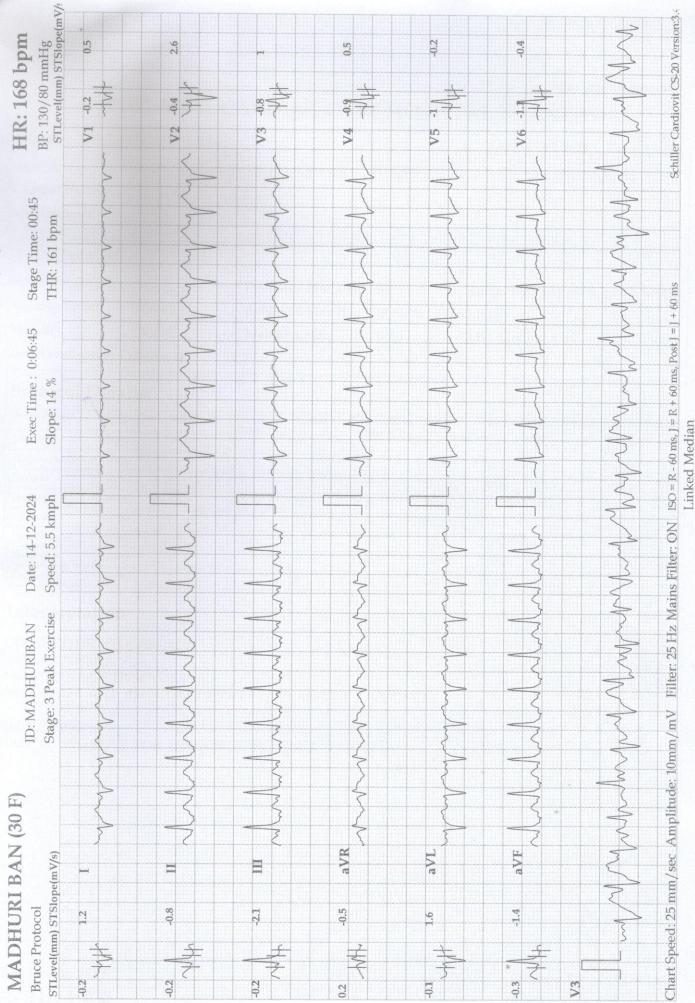


Linked Median





Linked Median



SEFRA DIGITAL X-RAY

JINKUSHAL HOSPITAL, Rosa Vista, Opp. Suraj Water Park, Waghbill, G.B. Road, Thane (W) Mob.: 7678031047 / 9833520607 | Time : 9 am. to 9 pm. | SUNDAY ON CALL)

PORTABLE X-RAY AVAILABLE

PATIENT NAME : MRS. MADHURI BAN

AGE / SEX 31 YRS / F

REF BY DR: JINKUSHAL HOSPITAL

DATE: 14/12/2024	
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X-ray Chest PA

Bilateral lung fields appear clear. No obvious pleural/parenchymal lesion noted.

Bilateral hila are normal.

Both costo-phrenic and cardio-phrenic angles appear clear.

Cardiac silhouette is within normal limits.

Both domes of diaphragm appear normal.

Bony thoracic cage & soft tissues appear normal.

Impression: No significant abnormality detected.

Suggest Clinical correlation and further evaluation.

Thanks for referral

Platy

Dr. Devendra Patil MD Radiology

Disclaimer: report is done by teleradiology after the images acquired by PACS (picture archiving and communication system) and this report is not meant for medicolegal purpose Investigations have their limitations. Solitary pathological/Radiological and other investigations never confirm the final diagnosis. They only help in diagnosing the disease in correlation to clinical symptoms and other related tests. Please interpret accordingly. Patient's identification in online reporting is not established, so in no way patient identification is possible for medico-legal cases.

AL EXAMINATION REPORT
Madhuci Ban.
Male/ Female
UHID :
14 / 12/2024 Bill No. :
Married/ No. of Children / Unmarried/ Widow :
No any vero do.
TOICE fund Sx. Comples, 840 13C3 - Gyr. & loyr. ago report filled -201
Diet : Veg / Mixed : Addiction : Smoking / Tobacco Chewing / Alcohol / Any Other
HT / DM / IHD / Stroke / Any Other Mother = HT / DM / IHD / Stroke / Any Other Siblings = HT / DM / IHD / Stroke / Any Other
Drug Allergy ? No cry allegy.
For HT/DM/IHD/Hypothyroidism Any Other KIGO HTN Hypothyrochur : 6 years
G.E.: Mod. R.S.: - Uere C.V.S.: - 5, 50 C.N.S.: cusius

Height 165 cms	Weight 95-7 Kgs
BMI 35.76	
Pulse (per min.) 65 mm	Blood Pressure (mm of Hg) 110 70 mm of Hg
	Gynaecology
Examined by	Dr.
Complaint & Duration	
Other symptoms (Mict, bowels etc)	
Menstrual History	Menarche 15 yr Gycle Image: Loss Pain I.M.B. P.C.B.
	Pain I.M.B. P.C.B. L.M.P. 28 11 1021 Vaginal Discharge 20 1/24 discharge Cx. Smear Contraception 1/40 9 COD No DU B
Obstetric History	
Examination :	
Breast	
Abdomen	sytr.
P.S.	D pap smeet ter
P.V.	
Aynaecology Impression & Recommendation	
Recommendation	overweight. Peduce to weight.
hysician Impression	Adr. proper diet & excerising
	Hor propre diet 4 excerision Genecercy she is fit 4 she ten join the
Examined by :	 Overweight = To Reduce Weight Underweight = To Increase Weight
l6 Parwati	
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