



Name : Mr. AHUJA CHARAN
Lab ID. : 224072
Age/Sex : 37Years / Male
Ref By : COMPANY PACKAGE-JINKUSHAL
Consulting Dr. : DR. MAYUR JAIN

Collected On : 19/2/2025 7:53 pm
Received On : 19/2/2025 8:03 pm
Reported On : 19/2/2025 9:22 pm
Report Status : FINAL

***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	293.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	44.2	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease: >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	291.5	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	58	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	191	mg/dL	Optimal: <100 mg/dl. 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 (CALCULATED VALUE)	4.32		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	6.63		<5.0

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

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	13.4	gm/dl	13 - 18
HEMATOCRIT (PCV)	40.2	%	42 - 52
RBC COUNT	4.87	x10 ⁶ /uL	4.70 - 6.50
MCV	83	fl	80 - 96
MCH	27.5	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	13.5	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	6410	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	46	%	40 - 80
LYMPHOCYTES	45	%	20 - 40
EOSINOPHILS	03	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	273000	/cumm	150 to 410
MPV	11.1	fl	6.5 - 11.5
PDW	16.2	%	9.0 - 17.0
PCT	0.300	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Lymphocytosis		
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.

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GROUP			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'O'		
RH FACTOR	POSITIVE		

Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)

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***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	20.2	mg/dL	19 - 45
BLOOD UREA NITROGEN (Calculated)	9.44	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.73	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	9.1	mg/dL	3.5 - 7.2
S. SODIUM (ISE Direct Method)	142.2	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.39	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	100.0	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.87	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.3	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.34	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.46	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.88	g/dl	1.9 - 3.5
A/G RATIO calculated	1.55		0 - 2

BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200) ANALYZER.

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

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

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LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.43	mg/dL	0.1 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.17	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.26	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	28.2	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	63.7	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	75.0	U/L	53 - 128
S. PROTIEN (Method-Biuret)	7.34	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.46	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.88	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.55		0 - 2

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

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	83.3	mg/dL	70 - 110
URINE GLUCOSE FASTING	Absent		
URINE KETONE FASTING	Absent		
BLOOD GLUCOSE PP	82.6	mg/dL	70 - 140
URINE GLUCOSE PP	Absent		
URINE KETONE PP	Absent		

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms + Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED HAEMOGLOBIN)	6.1	%	Hb A1c
			> 8 Action suggested
			< 7 Goal
			< 6 Non - diabetic level

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
AVERAGE BLOOD GLUCOSE (A. B. G.)	128.4	mg/dL	NON - DIABETIC : <=5.6 PRE - DIABETIC : 5.7 - 6.4 DIABETIC : >6.5

METHOD Particle Enhanced Immunturbidimetry
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.

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

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

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Consultant Histocytopathologist
Regd.No.: 3401/09/2007



2D ECHOCARDIOGRAPHY & COLOR DOPPLER REPORT

NAME	MR CHARAN AHUJA
DATE	19/02/2025
REF BY	HEALTH CHECK UP
DONE BY	DR MAYUR JAIN (9867280303/ 9222888070)

2D

- All cardiac chambers are normal in size.
- No concentric left ventricular hypertrophy.
- No regional wall motion abnormality.
- Normal LV systolic function. LVEF is approximately 65% visually.
- Normal RV systolic function.
- All valves are normal in structure.
- IAS and IVS are intact.
- Aortic arch normal.
- No e/o clot/ vegetation/ effusion.

M-MODE

LVIDd	55	mm	Ao	33	mm
LVIDs	36	mm	LA	42	mm
EDV	184	ml			
ESV	64	ml			
EF	65	%			
IVS(d)	9.6	mm			
PW(d)	10.6	mm			

COLOR DOPPLER

- No stenotic or regurgitant lesion at any valve
- No significant gradient across aortic valve.
- Grade I LV diastolic dysfunction.
- No significant pulmonary hypertension.

IMPRESSION

- Grade I LV diastolic dysfunction.
- Good LV systolic function.

Many thanks for reference



Dr, Mayur N Jain
MD DM cardiology- gold medalist
FACC, FSCAI, ICOB- USA; AFESC - UK
Consultant interventional cardiologist

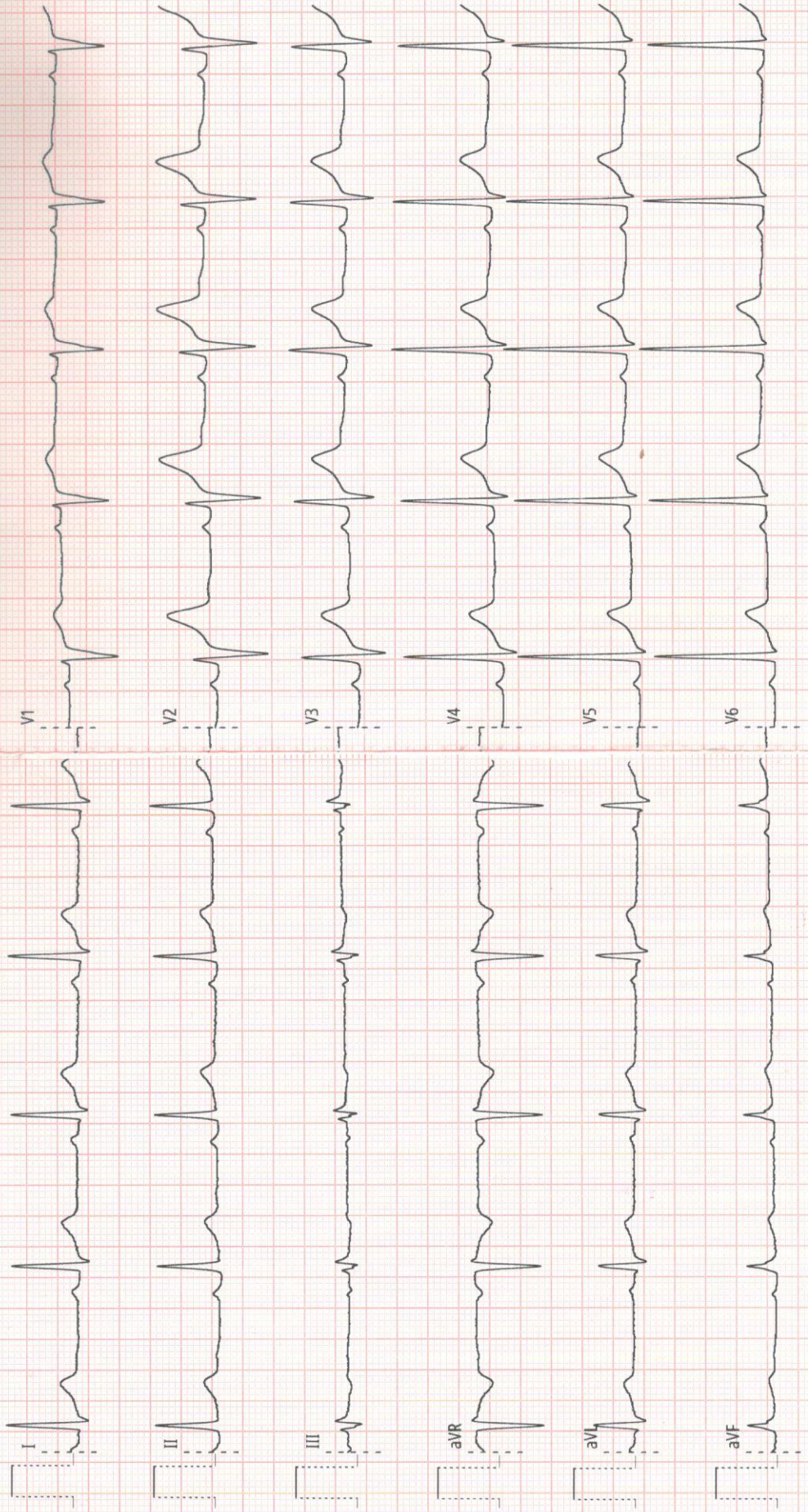
E:G report

Confirm and sign:

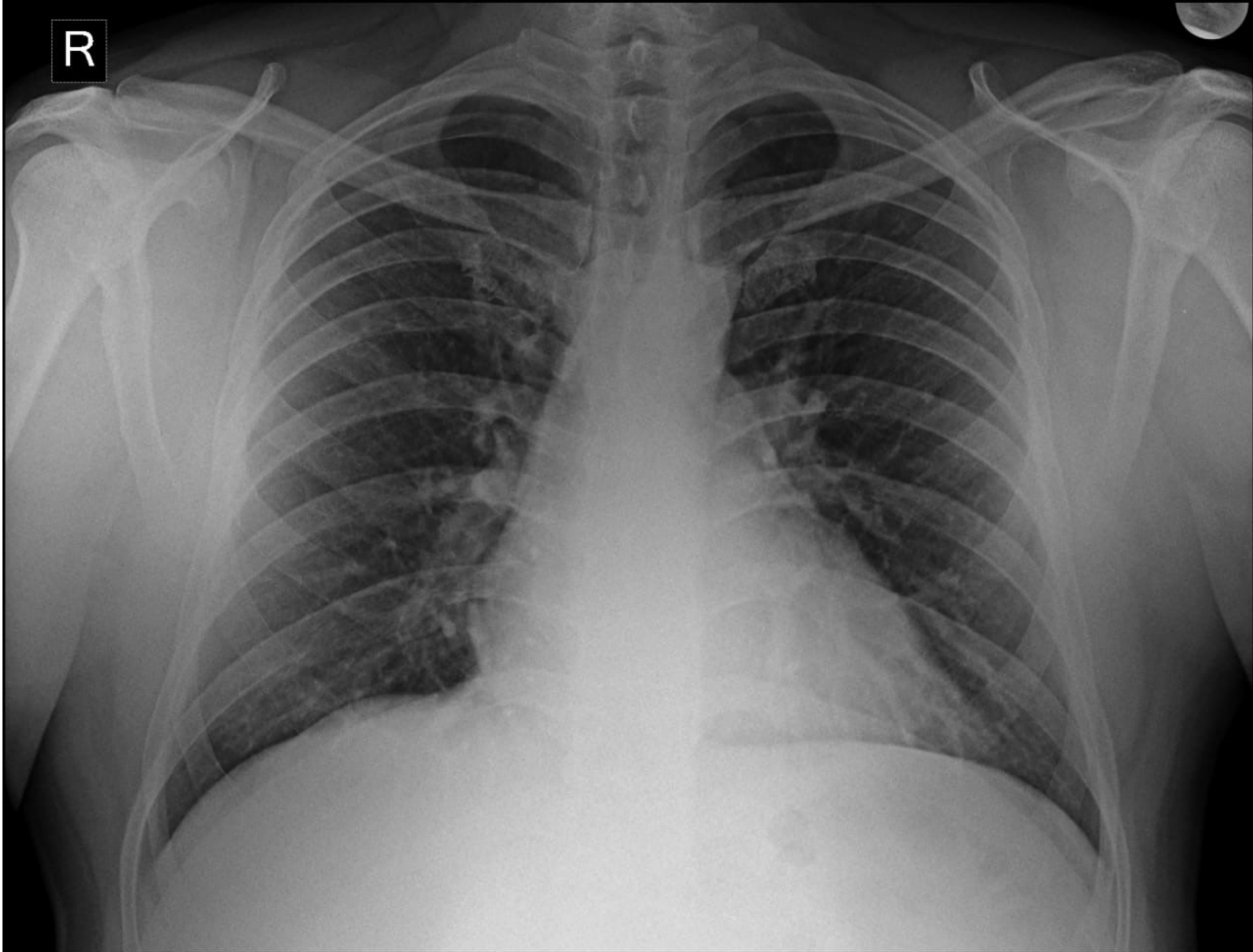
<< Interpretation >>

Sinus rhythm
Normal ECG

ID : 20250219100309
Name : avajia, charan
Gender : M
Age : 37 Years
Dept : company package
Bed No. :
HR : 60 bpm
PR : 172 ms
QRS : 106 ms
QT/QTc : 420/420 ms
P/QRS/T : 24/34/26 °
RV5/SV1 : 1.925/0.765 mv
RV5+SV1 : 2.690 mv



R



MR. CHARAN AHUJA. 37YRS. 19FEB25HP1 M CHEST,PA 19-Feb-25
SEFRA DIGITAL X-RAY. JINKUSHAL CARDIAC CARE HOSPITAL, THANE

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 : MR. CHARAN AHUJA	AGE / SEX 37 YRS / M
REF BY DR: JINKUSHAL HOSPITAL	DATE : 19 /02/2025

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

Dr. Patil

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.

NAME : MR. CHARAN AHUJA	AGE : 37YRS/MALE
REF BY: HEALTH CHECKUP	DATE : 26.02.2025

FULL ABDOMEN USG

LIVER: Enlarged in size 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: 10.7 x 5.1 cm Left kidney: 11.6 x 5.5 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.

PROSTATE: Is normal in size and echotexture. No focal lesion is seen. No e/o median lobe hypertrophy.

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

OPINION:

- HEPATOMEGALY WITH GRADE I FATTY LIVER.

Dr. Patil

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

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

Mr. Charan Ahuja

37/m

NO HTN / DM / IHD.

No chest pain / palpitation / DOE
No lower cough

O/E PR - 64/min
BP - 110/70 mmHg
SpO2 - 99% am

4/E Cx - S1S2 @
M - BSBE clear.
CND - common,
@ normal
among all children.
PIA soft - CRT, AS @

25/02/2025

WT - 93.5 kg

TC = 291.5

LDL = 191

LDL = 4.32

VLDL = 58

Hb = 13.4, TCC = 6410, PLT = 2
Creat = 0.73

ICV = 4.39, MAR = 142.2

Cap = 9.3, P10T = 7.34

PIB = 4.46

Shof = 63.7

FBS = 83.3, PP = 82.6

HbA1c = 6.1%

Adv

Cap - velozed morning 1st x 5 days
1/2 hrs before food

Plz E Dr. Mayur Jindal in app E after appointment.