



Patient Name : Lajumiben Narendrabhai Parmar

Sample No. : 20250312652



Patient ID : 20250308657

Visit No. : OPD20250329158

Age / Sex : 38y/Female

Call. Date : 10/03/2025 08:30

Consultant : DR KANCHI DESAI

S. Coll. Date : 10/03/2025 08:57

Ward : -


Report Date : 10/03/2025 15:26

CBC, ESR

Investigation	Result	Normal Value
Hemoglobin :	13.4 gm/dl	12.5 to 16.0 gm/dl
P.C.V. :	41.4 %	37.0 to 47.0 %
M.C.V. :	88.8 fL	78 to 100 fL
M.C.H. :	28.8 pg	27 to 31 pg
M.C.H.C. :	32.4 g/dl	32 to 36 g/dl
RDW :	14.4 % [H]	11.5 to 14.0 %
RBC Count :	4.66 X 10 ⁶ / cumm	4.2 to 5.4 X 10 ⁶ / cumm
Polymorphs :	67 %	38 to 70 %
Lymphocytes :	29 %	15 to 48 %
Eosinophils :	2 %	0 to 6 %
Monocytes :	2 % [L]	3 to 11 %
Total :	100	< 100 > 100
WBC Count :	12000 /cmm	4000 to 10000 /cmm
Platelets Count :	308000 /cmm	1,50,000 to 4,50,000 /cmm
ESR - After One Hour :	28 mm/hr [H]	1 to 20 mm/hr

Dr.Mehul Desai
M.B.D.C.P
Reg.No.G-9521



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Age / Sex : 38y/Female	Call. Date : 10/03/2025 08:30
Consultant : DR KANCHI DESAI	S. Coll. Date : 10/03/2025 08:58
Ward : -	Report Date : 10/03/2025 15:13

Blood Group

Investigation	Result	Normal Value
BLOOD GROUP :		
ABO	O	
Rh	Positive	



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FBS & PPBS

Investigation	Result	Normal Value
Blood Sugar (FBS) :	96 mg/dl	74 - 100 mg/dl
Urine Sugar (FUS) :	Nil	
Blood Sugar (PP2BS) :	119 mg/dl	70 to 120 mg/dl
Urine Sugar (PP2US) :	Nil	

RENAL FUNCTION TEST

Investigation	Result	Normal Value
Creatinine :	0.6 mg/dl	0.6 - 1.4 mg/dl
Urea :	10 mg/ dl	13 - 45 mg/dl
Uric Acid :	4 mg/dl	3.5 - 7.2 mg/dl
Calcium :	8.8 mg/dl	8.5 - 10.5

HBA1C

Investigation	Result	Normal Value
Glycosylated Hb :	5 %	Near Normal Glycemia : 6 to 7 Excellent Control : 7 to 8 Good Control : 8 to 9 Fair Control : 9 to 10 Poor Control : > 10
Average Plasma Glucose of Last 3 Months :	96.8	

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LFT (Liver Function Test)

Investigation	Result	Normal Value
Total Bilirubin :	0.4 mg/dl	0.2 to 1.0 mg/dl
Direct Bilirubin :	0.1 mg/dl	0.0 to 0.2 mg/dl
Indirect Bilirubin :	0.3 mg/dl	0.0 to 0.8 mg/dl
AST (SGOT) :	10 U/L	5 to 34 U/L
ALT (SGPT) :	11 U/L	0 to 55 U/L
Total Protein (TP) :	7 g/dL	6.4 to 8.3, g/dl
Albumin (ALB) :	4.3 g/dl	3.5 to 5.2 g/dl
Globulin :	2.7 g/dl	2.3 to 3.5 g/dl
A/G Ratio :	1.59	
Alkaline Phosphatase (ALP) :	213 U/L [H]	40 to 150 U/L
GAMMAGT :	16 U/L	12 - 43 U/L

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Lipid Profile

Investigation	Result	Normal Value
Sample :	Fasting	
Sample Type :	Normal	
Cholesterol (Chol) :	160 mg/dl	Low risk : < 200 Moderate risk : 200 - 239 High risk : > or = 240
Triglyceride :	269 mg/dl [H]	Normal : < 200.0 High : 200 - 499 Very High : > or = 500
HDL Cholesterol :	39 mg/dl [L]	Low risk : >or = 60 mg/dL High risk : Up to 35 mg/dL
LDL :	67.2 mg/dl [L]	131.0 to 159.0(N) < 130.0(L) > 159.0(H)
VLDL :	53.8 mg/dl [H]	Up to 0 to 34 mg/dl
LDL/HDL Ratio :	1.72	Low risk : 0.5 to 3.0 Moderate risk : 3.0 to 6.0 Elevted level high > 6.0
Total Chol / HDL Ratio :	4.1	Low Risk : 3.3 to 4.4 Average Risk : 4.4 to 7.1 Moderate Risk : 7.1 to 11.0 High Risk : > 11.0
Total Lipids :	768 mg/dl [H]	400 to 700 mg/dl

Note :- Lipemic samples give high triglyceride value and falsely low LDL value.

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Urine R/M

Investigation	Result	Normal Value
Quantity - :	20 ml	
Colour - :	Pale Yellow	
Reaction (pH) :	6.0	4.6-8.0
Turbidity :	Clear	
Deposit :	Absent	Absent
Sp.Gravity :	1.005	1.005-1.010
Protein :	Absent	Absent
Glucose :	Absent	Absent
Bile Salts :	Absent	Absent
Bile pigments :	Absent	Absent
Ketones :	Absent	Absent
Urobilinogen :	Absent	
Blood :	Absent	Absent
Pus Cells :	Absent /hpf	0-5/hpf
Red Blood Cells :	Absent /hpf	Absent
Epithelial Cells :	0-1 /hpf	

Dr.Mehul Desai
M.B.D.C.P
Reg.No.G-9521



Unipath Specialty Laboratory (Baroda) LLP - Platinum Complex, Opp. HDFC Bank, Nr. Radha Krishna char rasta, Akota, Vadodara - 390020
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 Mobile: 7228800500 / 8155028222 | Email: info.baroda@unipathllp.in
 Home Visit / OPD Reception : 9998724579
 LLP Identification Number: AAN-8932



TEST REPORT

Reg. No. : 50301004508 Reg. Date : 10-Mar-2025 12:45 Collected On : 10-Mar-2025 12:45
 Name : Ms. LAJUMIBEN N PARMAR Approved On : 10-Mar-2025 13:53
 Age : 38 Years Gender : Female Ref. No. : Dispatch At :
 Ref. By : Tele No. :
 Location : SAVITA SUPERSPECIALTY HOSPITAL @ WAGHODIYA ROAD

Test Name	Results	Units	Bio. Ref. Interval
THYROID FUNCTION TEST			
T3 (triiodothyronine) <i>Method: CLIA</i>	1.27	ng/mL	0.6 - 1.81
T4 (Thyroxine) <i>Method: CLIA</i>	7.10	µg/dL	4.5 - 12.6
Thyroid Stimulating Hormone(TSH) <i>Method: CLIA</i>	2.850	µIU/mL	0.55 - 4.78
Sample Type: Serum			

Comments:
 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

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

This is an electronically authenticated report. "Please verify the authenticity of this report by scanning the QR code to ensure data integrity."

Test done from collected sample.

Printed On: 10-Mar-2025 13:55

Dr. Vishal Jhaveri
 M.B.B.S, D.C.P
 Reg. G-11011
 Page 1 of 1



PATIENT NAME: LAJUMIBEN PARMAR

AGE/SEX: 38 YRS/M

DATE: Monday, 10 March 2025

CHEST X-RAY (PA)

Both lung fields appear normal.

Both hila appear normal

Bilateral costo-phrenic angles appear grossly clear

Mediastinum and cardiac shadow appear normal

Bony thorax appears unremarkable

No evidence of free gas under domes of diaphragm

IMPRESSION:

- NO SIGNIFICANT ABNORMALITY NOTED IN LUNG FIELDS
- NORMAL CARDIAC SHADOW

DR SHARAD RUNGTA (MD & DNB)

CONSULTANT RADIOLOGIST

Not all pathologies can be detected on ultrasound in each scan. Further radiographic evaluation is suggested if required.



PATIENT NAME: LAJUMIBEN PARMAR

AGE/SEX: 38 YRS/F

DATE: Monday, 10 March 2025

ULTRASOUND OF ABDOMEN & PELVIS

LIVER appears normal in size and shows normal parenchymal echogenicity. No evidence of focal lesion. No evidence of dilated IHBR or portal vein. CBD appears normal.

GALL BLADDER is distended. No evidence of abnormal wall thickening or any significant calculus within.

PANCREAS appears normal. MPD is WNL.

SPLEEN appears normal in size and shows normal parenchymal echogenicity. No evidence of focal lesion.

BOTH KIDNEYS appear normal in size, shape and position.

Show normal cortical echogenicity. Corticomedullary differentiation is maintained.

No evidence of calculus or hydronephrosis on either side.

URINARY BLADDER is partially full. No evidence of abnormal wall thickening or any significant calculus within.

UTERUS appears normal in size and position. CET is 4.8 mm WNL. No evidence of focal lesion noted.

Bilateral ovaries appear normal in size. No evidence of focal or obvious mass lesion noted.


BOWEL LOOPS appear normal and show normal peristalsis.

No evidence of LYMPHADENOPATHY noted.

No evidence of ASCITES noted.

IMPRESSION:

- NO SIGNIFICANT ABNORMALITY AT PRESENT SCAN.


DR SHARAD RUNGTA (MD & DNB)
CONSULTANT RADIOLOGIST

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2D-ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT

NAME: LAJUMIBEN N PARMAR

AGE/SEX: 38 YRS/FEMALE

DATE: 10/03/2025

REF BY: DIRECT

OBSERVATION:

- NORMAL LV SIZE AND NORMAL LV SYSTOLIC FUNCTION. LVEF = 60% (VISUAL).
- NO RWMA AT REST.
- NO LV DIASTOLIC DYSFUNCTION.
- TRIVIAL MR. NO MS.
- NO AR. NO AS.
- TRIVIAL TR. NO PAH.
- NORMAL SIZED LA, RA & RV WITH NORMAL RV SYSTOLIC FUNCTION.
- NORMAL SIZED MPA, RPA & LPA.
- INTACT IAS & IVS.
- NO E/O INTRACARDIAC CLOT/VEGETATION/PE.
- NORMAL IVC.
- NORMAL PERICARDIUM.

LA: 35MM

AO: 23MM

IVS: 09/13MM

LVPW: 10/13MM

LVID: 41/26MM

CONCLUSION:

- NORMAL LV/RV SIZE AND SYSTOLIC FUNCTION.
- NO RWMA AT REST.
- LVEF = 60% (VISUAL).

DR.NIRAV BHALANI
[CARDIOLOGIST]

DR.ARVID SHARMA
[CARDIOLOGIST]

LAJUMIBEN, PARMAR
Female

38 Years

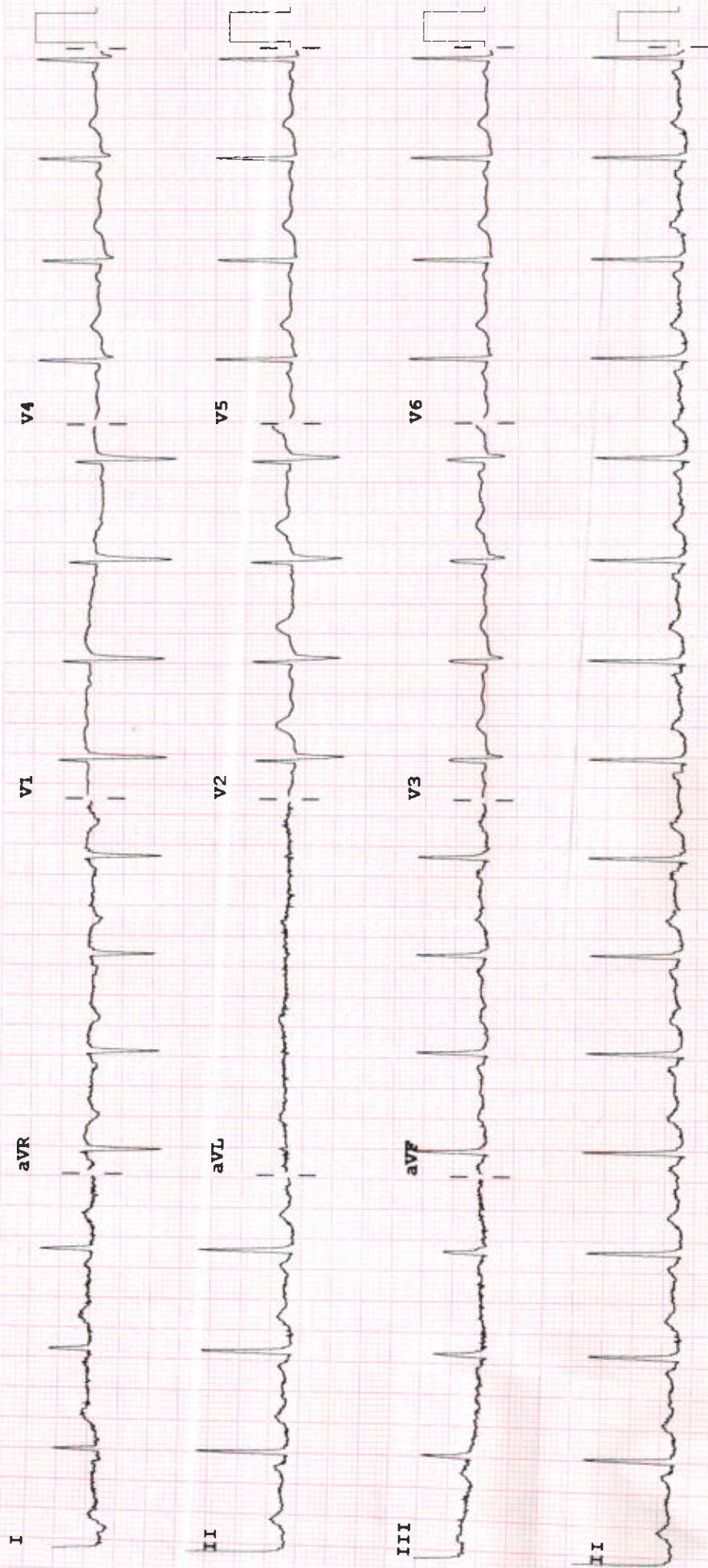
Rate 91

PR	128
QRSD	76
QT	352
QTc	434

--AXIS--

P	45
QRS	60
T	3

12 Lead; Standard Placement



Device:

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50~ 0.50-150 Hz W

PB09

P?



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CONSULTANT RADIOLOGIST

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2D-ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT

NAME: LAJUMIBEN N PARMAR

DATE: 10/03/2025

AGE/SEX: 38 YRS/FEMALE

REF BY: DIRECT

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- NORMAL PERICARDIUM.

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LVPW: 10/13MM

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DR.NIRAV BHALANI
[CARDIOLOGIST]

DR.ARVIND SHARMA
[CARDIOLOGIST]



Examination By Ophthalmologist

Name :	LAJUMIBEN N PARMAR	Age :	38/FEMALE
Reg.No :	20250308657	DOE :	10-03-2025

Present Complaints :	EYE CHEAK UP
Medical History :	NAD
Examination Of Eye :	NAD

External Examination :	WNL	WNL
Ati Seg Examination :	AS WNL	AS WNL
Schiotz Tonometry IOP :		
Fundus :	WNL	WNL

Without Glass	Distant Vision :6/6	6/6
	Near Vision : N6	N6
With Glass	Distant Vision :	
	Near Vision : N6	N6
Colour Vision (With Ishihara Chart) :	WNL	
(BE) READS ALL PLATES		
Impression:	REFRACTIVE ERROR	
Advice :	CT WITH FLAM ,F/UP 6 MONTH	

DR KUNTAL SHAH





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PHYSICIAN EXAMINATION

Name :	LAJUMIBEN N PARMAR	Age :	38/FEMALE
Reg.No :	20250308657	DOE :	10-03-2025

Physical Examination:

Height:	151	Weight:	52KG	PULSE:	88	Temperature:	NORMAL
	CM						

BMI :	22.8	BP :	124/82	SPO2	99%
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Chief Complaint : NAD

Past History : NAD

General Examination : NAD

Systemic Examination: NAD

INVESTIGATION : RBS:96MG/DL
ECG:WNL

ADVICE : AVOID OILY FOOD,EXERCISE,REPEAT
LIPID PROFILE , AFTER 6 MONTH

DR KANCHI DESAI

