

RAM SA MEDICAL HEALTHCARE

Resting ECG Report

Patient Name: M/S RINKI KUMARI 44/F

March 09, 2025

Time: 13:45:30

QT/QTc: 0.184 / 0.194 Sec

P-QRS-T Axis (16)-(-29)-(-57) deg

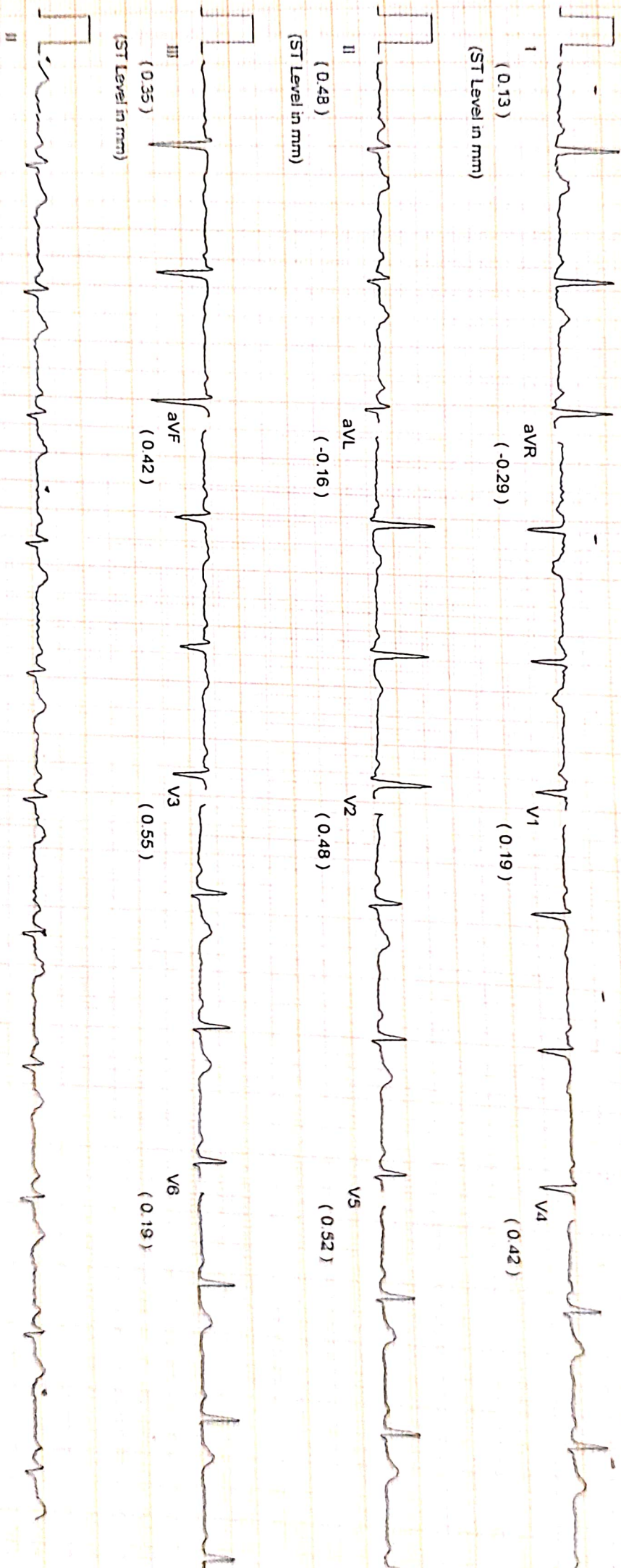
PR Interval: 0.06 sec

QRS Duration: 0.088 Sec

RR Interval: 0.89 sec

HR 71 bpm

BP 0/0 mmHg



Comments: Sinus bradycardia
Otherwise Normal ECG



Dr. Sastry Kishore
MBBS, MD (Medicine)
Reg. No.-22643

DR
MBBS MD

Name :- Pranvi Kumar
 Age :- 45 Gender :- Female

Date :- 08/06/2025
 Bill No. :-

V/A	Without Glasses		With Glasses		C/O
	DV	NV	DV	NV	
RE	6/60	N/6	6/6	N/6	H/O Diabetes Hypertension Others
LE	6/60	N/6	6/6		
RE					
I.O.P					O/E Ext.
LE					

Colour Vision :-

Rx

Repeat Refraction
 after 10 days

Ophthalmoscopy

- ① Trace plus eye
1 eye 3 or
- ② Cat Ast 2
N/1 (20)



Glasses Prescribed/Acceptance :-

VA	RE			LE				
	D. Sph	D. Cyl	Axis	VA	D. Sph	D. Cyl	Axis	VA
DV	-7.00			6/6	-7.00			Dr. Ashok Kumar MBBS, DOMS Reg. No.- 23091
NV ADD	+1.75			N/6	+1.75			

Ashok Kumar
 08/06/25

फीस 15 दिनों के लिए मान्य है, 15 दिन बाद फीस पुनः लगेगी।

Beside Yadav Timber, East of Kanti Factory More, Kankarbagh Main Road, Patna-26

Contact No# ☎ +91 6122356151 📞 +91 9229245090 Email:- Ramsamedicalhealthcare@gmail.com



RAMSA

MEDICAL HEALTH CARE

DR. AMIT SINHA
B.D.S., M.D.S (DENTAL)
Reg. No : BCMR-6242/A

Name :- Rishi Kumar
Age :- 44 Gender :- M

Date :- 8/3/25
Bill No. :-

Activity

- Hbna NW 10ml twice
a day for 15 days

O/E

- Generalised
Itching & redness
Anus



Dr. Amit Sinha
B.D.S., M.D.S
Reg. No.: 6242/A

Amit Sinha
Signature

फीस 15 दिनों के लिए मान्य है, 15 दिन बाद फीस पूनः लगेगी।

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RAMSA

MEDICAL HEALTHCARE

Patient Name :- Mrs. Rinki Kumari
Bill No :- 24252822
Refer By :- Self

Gender :- Female
Date :- 08.3.2025

Age:- 45Years

DEPARTMENT OF RADIOLOGY

Whole Abdomen

LIVER : 15.0 cm

Liver is grade I mild hepatomegaly in size and echopattern .. No focal intra-hepatic lesion detected. Intra-hepatic biliary radicals are not dilated. Portal vein is normal & measures 11.5 mm in calibre.

GALL BLADDER : Gall bladder appears echofree with normal wall thickness .
Common Bile duct is not dilated & measures 4.6 mm.

PANCREAS : Pancreas is normal in size and echopattern.

SPLEEN : Spleen is mild Spleenomegaly in size & echopattern. Its measures 11.8cm.

KIDNEYS :

RIGHT KIDNEY :- Measures 9.68 x 3.8 cm.

LEFT KIDNEY :- Measures 9.63 X 4.9 cm

Both kidneys are normal in position, size and outline. Cortico-medullary differentiation of both kidneys is maintained. Central sinus echoes are compact.

URINARY BLADDER : Urinary bladder is normal in wall thickness with clear contents. No significant intra or extraluminal mass seen.

UTERUS :- Measures 7.2 × 13.0 × 5.7 cm uterus is anteverted, homogenous in echotexture. An IUCD is seen in Uterine Cavity in size. Endometrium is central and of normal thickness 5.7mm

RIGHT OVARY : 1.75 x 1.90 cm.

LEFT OVARY : 1.25 × 1.41 cm.

Both ovaries are normal in size and echopattern No free fluid detected in pouch of Douglas (POD).

OTHERS :- Visualized parts of retro-peritoneum do not reveal any lymphadenopathy.

No significant free fluid is detected.

IMPRESSION :- An IUCD is seen in Uterine Cavity.

Greetings of good health from RAMSA Medical Healthcare Patna. We sincerely thanks for the referred


Technologist


Pawan Kumar Shah DMRD
Radiologist



RAMSA

MEDICAL HEALTHCARE

Patient Name :-Mrs.Rinki Kumari
Bill No :- 24252822
Refer By :- Self

Gender :-Female Age:- 45 Years
Date:- 08.03.2025

2D Echocardiogram Report

ECHOGENICITY :- Is Adequate.

DIMENSIONS	NORMAL	DIMENSIONS	NORMAL
AO(ed):- 2.4 cm	(2.0 – 4.0 cm)	IVS (Ed):- 1.0 cm	(0.6 – 1.1 cm)
LA(es):- 3.1 cm	(2.0 – 4.0cm)	LVPW (Ed):- 1.0 cm	(0.6 – 1.1 cm)
RVID (ed) :- 2.1 cm	(1.5 – 2.4 cm)	EF:- 60 %	(55-65%)
LVID(ed):- 4.1 cm	(3.3 – 5.4 cm)	% FD:- 32 %	(28% - 42 %)
LVID(es):- 2.7 cm	(2.0 – 4.0 cm)		

MORPHOLOGICAL DATA

Mitral Valve:-	AML Mettalic	Interatrial septum :-	Normal
	PML Mettalic	Interventricular septum :-	Normal.
Aortic Valves:-	Normal	Pulmonary artery :-	Normal.
Tricuspid valve :-	Normal	Aorta :-	Normal.
Pulmonary valve :-	Normal.	Right atrium :-	Normal.
Right ventricle :-	Normal	Left atrium :-	Normal.

Left ventricle:- LV WALL MOTION ANALYSIS- No RWMA.
Pericardium:- No echo free space.
Doppler studies:- Normal flow across valves.
MV – 90/70 cm/Sec PG – mmHg
AV – 120 cm/Sec

Impression:-

NO R.W.M.A
VALVES ARE NORMAL,NORMAL IVC,
NORMAL PA PRESSURE, NO CARDIAC SHUNT
NORMAL LV/RV SIZE & SYSTOLIC FUNCTION, LVEF=60%
NO PE/Veg/ CLOT/Mass

Consultant Cardiology



RAMSA

MEDICAL HEALTHCARE

Patient Name :-Mrs. RINKI KUMARI
Age/Gender :-44 Year(s)/Female
Referred By :- SELF,



Bill No# :-BL/2425/2822
Collection Date :-08/03/2025
Reporting Date :-08/03/2025
Contact No :-7903676765

DEPARTMENT OF RADIOLOGY
Mediwheel Full Body Health Annual Plus Check

X-RAY CHEST- PA VIEW

Bilateral Lung fields are clear.
Both cardiophrenic & costophrenic angles are clear.
Cardiac size & bony cage is normal.

Greetings of good health from Ram Sa Medical Healthcare Patna. We sincerely thanks for the referral.


Technician


DR. Pawan Kumar Shah
DMRD, Radiologist

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Bill No# :-BL/2425/2822
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Reporting Date :-09/03/2025
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HAEMATOLOGY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Blood Group & Rh Factor			
Blood Group	"B"		
Rh Factor	Negative		

Interpretation:-

When and if following bone marrow or liver transplantation there is disagreement between the results of ABO or Rh results based on testing of RBCs ("forward" testing) and results based on testing of plasma ("reverse" testing), the discrepancy will be reported.

If baby and mother are both Rh Negative on initial testing, weak D testing should be performed on the cord sample and confirm.

Erythrocyte Sedimentation Rate (Westergen Method)

First Hour	↑	22	mm/hr	0 - 20
Second Hour		48	mm/hr	
Ratio		23		

Interpretation:-

The erythrocyte sedimentation rate increases with age; the upper limit is not clearly defined for patients > 60 years old.

Technician / Technologist


Dr. Manish Jaipuriyar
MD. (Pathology)



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HAEMATOLOGY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
COMPLETE BLOOD COUNT (C. B. C.)			
Total Leucocyte Count (TLC)	8100	cells/Cu. mm	4000 - 11000
Differential Leucocyte Count (DLC)			
Neutrophil	75	%	60 - 75
Lymphocyte	22	%	20 - 35
Monocyte	01	%	1.0 - 6.0
Eosinophil	02	%	1.0 - 6.0
Basophil	00	%	0.0 - 1.0
Haemoglobin	↓ 10.2	gm/dl	11.0 - 15.5
Haemoglobin %	69.56	%	
Red Blood Cells (RBC) Count	↓ 3.68	million/Cu mm	3.8 - 4.8
PCV / Haematocrit (HCT)	↓ 29.2	%	36 - 46
Mean Cell Volume (MCV)	↓ 79.35	fl	80.0 - 99.0
Mean Cell Haemoglobin (MCH)	27.72	pg	26.5 - 33.5
Mean Cell Hb. Concentration (MCHC)	34.93	g/dl	32.0 - 36.0
Platelet Count	1.52	Lakh Cell/cum	1.5 - 4.5

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BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Blood Sugar Fasting	96	mg/dl	70 - 110
Blood Sugar Post Prandial (PP)	102	mg/dl	80 - 150

Interpretation:-

The Glucose Fasting test is done in the morning after an 8 to 12 hour overnight fast whereas the Glucose Postprandial test is done after a period of 2 hours from the start of the last meal. A healthcare professional will draw a blood sample from a vein in the arm.

Glycosylated Hemoglobin HbA1C 5.1 % 4.0 - 7.0

Interpretation:-

Management of Diabetes: When using HbA1c assay, the ADA recommended goal for A1c control for adult diabetic patients in general is < 7%. In diabetic patients who have experienced recent blood loss, hemolysis, or have elevated reticulocyte counts for other reasons, the HgBA1c level may be lowered and may not reflect actual glycemic control. In pregnant patients with diabetes, the ADA recommends aiming for the range < 6% if it can be achieved without excessive hypoglycemia.

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BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Kidney / Renal Function Test			
Blood Urea	20	mg/dl	13.0 - 45.0
Serum Creatinine	0.70	mg/dl	0.5 - 1.2
Serum Uric Acid	↑ 6.2	mg/dl	2.5 - 6.0
Sodium (Na)	138	mcg Eq/L	136 - 143
Potassium (K)	3.9	mcg Eq/L	3.5 - 5.6
Chloride (Cl)	101	mcg Eq/L	97.0 - 108.0

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BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Liver Function Test			
Bilirubin Total	0.82	mg/dl	0.0 - 1.3
Bilirubin Direct (Conjugated)	0.32	mg/dl	0.0 - 0.60
Bilirubin Indirect (Un Conjugated)	0.5	mg/dl	0.0 - 0.90
Alanine Transaminase (ALT/SGPT)	28	U/L	0.0 - 40.0
Aspartate Transaminase (AST/SGOT)	26	IU/L	0.0 - 37.0
Alkaline Phosphatase	67	U/L	39 - 118
Total Protein	6.4	g/dl	6.0 - 8.3
albumin	3.9	gm/dl	3.5 - 5.0
Globulin	2.5	gm/dl	2.3 - 3.3
A:G Ratio	1.56		0.9 - 2.0

Interpretation:-

Aspartate Aminotransferase (AST) Aspartate Aminotransferase (AST) catalyses conversion of nitrogenous portion of amino acid, essential to energy production in Krebs cycle. AST is released into serum in proportion to cellular damage and most elevated in acute phase of cellular necrosis. Useful in the detection and differential diagnosis of hepatic disease.

Alanine Aminotransferase (ALT) Alanine Aminotransferase catalyses reversible amine group transfer in Krebs cycle. Unlike AST, it is mainly in liver cells and is a relatively specific indicator of Hepatocellular damage. It is released early in liver damage and remain elevated for weeks.

Gamma Glutamyl Transferase (GGT) Gamma Glutamyl Transferase (GGT) is associated with transfer of amino acids across cell membranes. GGT is most useful when looking for Hepatocellular damage. Increased production of GGT as ductal enzymosis, with increased enzymes produced in response to Hepatocellular damage.

Total and Direct Bilirubin determination in Serum is used for the diagnosis, differentiation and follow-up of Jaundice & assess liver function. Elevated Unconjugated Bilirubin occur in hemolytic jaundice. The Conjugated Bilirubin is predominately increased in obstructive jaundice due to regurgitation. Hepatic jaundice is associated with increase in both conjugated and Unconjugated Bilirubin.

Total Protein is increased in hypergammaglobulinemias (monoclonal or polyclonal) and hypovolemic states. It is decreased in nutritional deficiency, severe liver damage. Increased loss in Renal, GI disease, severe skin disease and blood loss. Albumin levels generally parallel total protein levels.

The liver **Alkaline Phosphatase** is increased in biliary obstruction. ALP is involved in bone calcification. So elevated level indicate liver or bone diseases or Pregnancy.

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Bill No// 1-BL/2425/2022
Collection Date 1-08/03/2025
Reporting Date 1-09/03/2025
Contact No 1-7903676765

BIO-CHEMISTRY EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
LIPID PROFILE			
Total Cholesterol	188	mg/dl	110 - 240
Serum Triglycerides	140	mg/dl	60 - 160
HDL Cholesterol	44.0	mg/dl	30 - 85
LDL Cholesterol	116	mg/dl	60 - 130
VLDL Cholesterol	28	mg/dl	5 - 40
Total : HDL Cholesterol Ratio	4.27	Ratio	

Interpretation:-

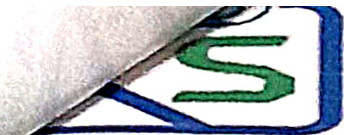
NLA - 2014 Recommendation	Total Cholesterol	Triglyceride	LDL Cholesterol	Non HDL Cholesterol	Total : HDL Ratio
Optimal / Low Risk	< 200	< 150	< 100	< 130	3.3 - 4.4
Above Optimal / Average Risk	-	-	100 - 129	130 - 159	4.5 - 7.1
Borderline High / Moderate Risk	200 - 239	150 - 199	130 - 159	160 - 189	7.2 - 11.0
High Risk	>=240	200 - 499	160 - 189	190 - 219	>11.0
Very High Risk	> 400	>=500	>=190	>=220	

- Note:** 1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
2. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
3. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved.
4. Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement.
5. A variety of genetic conditions are associated with accumulation in plasma of specific class of lipoprotein particles, are critical first step, as per Frederickson classification. It is important to consider & rule out secondary causes of hypertriglyceridemia (Obesity, Type 2 DM, Alcoholism, Renal failure, Cushing's syndrome etc.) before making the diagnosis of FHTG.

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ELISA ASSEY EXAMINATION

Investigations

Investigations	Observed Value	Unit	Reference - Range
Serum Tri-Iodothyronine (T3)	1.3	ng/ml	0.50 - 2.00
Serum Thyroxine (T4)	8.2	µg/dl	4.5 - 11
Serum Thyroid Stimulating Hormon (TSH)	1.4	µIU/ml	0.28 - 6.80

Interpretation:-

Wallach's reference range for Thyroid for Male & Non Pregnant

Age	TSH (µIU/ml)		T4(µg/dl)		T3(ng/ml)	
	From	To	From	To	From	To
1-4 Days	1.0	39.0	11.08	21.61	0.97	7.42
1-4 Weeks	1.7	9.1	8.29	17.24	1.04	3.45
1-12 Months	0.8	8.2	5.93	16.38	1.04	2.47
1-5 Years	0.7	5.7	7.33	15.04	1.04	2.66
6-10 Years	0.7	5.7	6.40	13.33	0.91	2.40
11-15 Years	0.7	5.7	5.54	11.78	0.84	2.14
15-18 Years	0.7	5.7	4.21	11.86	0.78	2.0

Wallach's reference range for Thyroid for Pregnant Female

Pregnancy	TSH		T4		T3	
	From	To	From	To	From	To
1 st Trimester	0.3	4.5	0.81	1.90	7.80	14.77
2 nd Trimester	0.5	4.6	1.00	2.60	7.14	19.58
3 rd Trimester	0.8	5.2	1.00	2.60	8.32	17.02

The **Tri-Iodothyronine (T3)** level may be elevated in the < 5% of hyperthyroid patients in whom the FT4 level is normal (T3 toxicosis). Measurement of T3 is of no value in the diagnosis of hypothyroidism. Total T3 can be affected by changes in thyroid binding protein levels. Measurements of Free T3 better reflect biologically active hormone levels than measurements of total T3.

Thyroxine (T4) is the major secretory hormone of the thyroid. Only 0.03% of T4 is unbound and free for exchange with tissues. Thyroid function may be assessed with thyroid stimulating hormone (TSH) and free T4 measured. Although free T4 is generally preferred over total T4 when monitoring thyroid function, the total T4 measurement may be preferred for monitoring of pregnant patients where total T4 reference ranges are available. The total T4 concentrations tend to be stable throughout pregnancy at 150% of the values in non-pregnant subjects and can be useful when the levels are evaluated according to pregnancy specific total T4 reference ranges which are approx. 1.5 times greater than non-pregnant ranges.

Thyroid Stimulating Hormon (TSH) is primarily responsible for the synthesis and release of Thyroid hormones is an early and sensitive indicator of decrease in Thyroid reserve is the diagnostic of primary hypothyroidism. The expected increase in TSH demonstrates the classical feedback mechanism between pituitary and thyroid gland. Additionally TSH measurement is equally important in differentiating secondary and tertiary (hypothalamic) hypothyroidism. The increase in total T4 and T3 is associated with pregnancy, oral contraceptive and estrogen therapy results into masking of abnormal thyroid function only because of alteration of TBG Concentration, Which can be monitored by Calculating Free Thyroxine Index (FTI) or Thyroid Hormone Binding Ratio (THBR).

- TSH stimulates the thyroid gland to produce the main thyroid hormones T3 and T4.
- In cases of hyperthyroidism TSH level is severely inhibited and may even be undetectable.
- In rare forms of high-origin hyperthyroidism, the TSH level is not reduced, since the NFB control of the thyroid hormones has no effect.
- In cases of primary hypothyroidism, TSH levels are always much higher than normal and thyroid hormone levels are low.
- The TSH assay aids in diagnosing thyroid or hypophysial disorders.
- The T4 assay aids in assessing thyroid function, which is characterized by a decrease in thyroxine levels and an increase in patients with hyperthyroidism.
- The T3 plays an important part in maintaining euthyroidism.
- TSH, T4 & T3 determination may be associated with other tests such as FT4 & FT3 assay, as well as with the clinical examination of the

Technician / Technologist

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 MD. (Pathology)

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URINE EXAMINATION

Investigations	Observed Value	Unit	Reference - Range
Urine Sugar Fasting	Nil		
Urine Sugar Post Prandial (PP)	Nil		

Technician / Technologist


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SPECIAL TEST

Pap Smear Analysis

PAP SMEAR EXAMINATION.

RECEIVED AIR DRIED SMEAR.

SMEAR SHOW EPITHELIAL CELL
WITH HEAVY INFILTRATION OF INFLAMMATORY CELL.
NO DYSPLASTIC CELL SEEN IN THIS SMEAR.

IMP-- NON SPECIFIC CERVICITIS.
SHE MAY BE PUT ON CALL RECALL PROTOCOL.

Technician / Technologist

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