MC-6135

Dr. Smita Ranveer`s

Radiance

CLINICAL DIAGNOSTIC CENTRE

COMPLETE PATHOLOGICAL SOLUTION

224074

Name	: Mrs. POOJA CHARAN AHUJA	**Collected On**	: 19/2/2025 7:59 pm
Lab ID.	: 224074	**Received On**	: 19/2/2025 8:09 pm
Age/Sex	: 34Years / Female	**Reported On**	: 19/2/2025 9:24 pm
Ref By	: COMPANY PACKAGE-JINKUSHAL	**Report Status**	: FINAL
Consulting Dr.	: DR. MAYUR JAIN		

*LIPID PROFILE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDASE)	171.0	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)	**37.0**	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	120.0	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)	24	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	110	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)	2.97		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.62		<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

24 HOURS 7

Main Center :- 2-3, 'Silver Plaza' E.S.I.S. Hospital Road, Opp. Suryadarshan Tower, Thane (W)-400 604. ☎ +91 91363 56284
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COMPLETE BLOOD COUNT

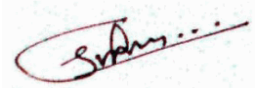
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	12.4	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	38.2	%	36 - 46
RBC COUNT	**6.73**	x10^6/uL	4.5 - 5.5
MCV	**57**	fl	80 - 96
MCH	**18.4**	pg	27 - 33
MCHC	**32**	g/dl	33 - 36
RDW-CV	**17.4**	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	8940	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	68	%	40 - 80
LYMPHOCYTES	25	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	05	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	265000	/ cumm	150 to 410
MPV	**11.8**	fl	6.5 - 11.5
PDW	15.7	%	9.0 - 17.0
PCT	0.310	%	0.200 - 0.500
RBC MORPHOLOGY	Microcytosis(+)		
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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Name : Mrs. POOJA CHARAN AHUJA
Lab ID. : 224074
Age/Sex : 34Years / Female
Ref By : COMPANY PACKAGE-JINKUSHAL
Consulting Dr. : DR. MAYUR JAIN

Collected On : 19/2/2025 7:59 pm
Received On : 19/2/2025 8:09 pm
Reported On : 19/2/2025 9:24 pm
Report Status : FINAL

*RENAL FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	17.9	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	8.36	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.60	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	4.8	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	138.8	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.61	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	100.3	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.95	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.1	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.11	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.07	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	3.04	g/dl	1.9 - 3.5
A/G RATIO calculated	1.34		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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Ref By	: COMPANY PACKAGE-JINKUSHAL	**Report Status**	: FINAL
Consulting Dr.	: DR. MAYUR JAIN		

LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.65	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.28	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.37	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	18.0	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	17.1	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	58.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	7.11	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.07	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	3.04	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.34		0 - 2

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

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

Checked By
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Consulting Dr.	: DR. MAYUR JAIN		

BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GLYCOCELATED HEMOGLOBIN (HBA1C)			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.6	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	114.0	mg/dL	65.1 - 136.3
METHOD	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	83.3	mg/dL	70 - 110
URINE GLUCOSE FASTING	Absent		
URINE KETONE FASTING	Absent		
BLOOD GLUCOSE PP	110.9	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 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

Checked By
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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE

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.

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

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

Checked By
SHAISTA Q

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Age/Sex	: 34Years / Female	**Reported On**	: 20/2/2025 2:18 pm
Ref By	: COMPANY PACKAGE-JINKUSHAL	**Report Status**	: FINAL
Consulting Dr.	: DR. MAYUR JAIN		

IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TFT (THYROID FUNCTION TEST)			
SPECIMEN	Serum		
T3	150.0	ng/dl	84.63 - 201.8
T4	8.88	µg/dl	5.13 - 14.06
TSH	2.49	µIU/ml	0.270 - 4.20

DONE ON FULLY AUTOMATED ANALYSER MAGLUMI SNIBE X3

T3 (Triiodo Thyronine)

AGE	RANGE
1-30 days	100-740
1-11 months	105-245
1-5 years	105-269
6-10 years	94-241
11-15 years	82-213
15-20 years	80-210

T4 (Thyroxine)

AGE	RANGES
1-14 Days	11.8-22.6
1-2 weeks	9.9-16.6
1-4 months	7.2-14.4
4-12months	7.8-16.5
1-5 years	7.3-15.0
5-10 years	6.4-13.3
11-15 years	5.6-11.7

TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	0.30-3.0

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

Mithila

Dr.K.B. MITHILA
M.D.PATHOLOGY
REG NO:- 2016104415

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Ref By	: COMPANY PACKAGE-JINKUSHAL	**Report Status**	: FINAL
Consulting Dr.	: DR. MAYUR JAIN		

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	15	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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

Checked By
Rajashri_Dumbre

Dr.K.B. MITHILA
M.D.PATHOLOGY
REG NO:- 2016104415

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JINKUSHAL
CARDIAC CARE
AND SUPER SPECIALITY HOSPITAL

2D ECHOCARDIOGRAPHY & COLOR DOPPLER REPORT

NAME	**MRS POOJA AHUJA**
DATE	19/2/2025
REF BY	HEALTH CHECK UP
DONE BY	**DR MAYUR JAIN (9867280303/ 9222888070)**

2D

- All cardiac chambers are normal in size.
- Concentric left ventricular hypertrophy.
- No regional wall motion abnormality.
- Normal LV systolic function. LVEF is approximately 70% 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	44	mm	**Ao**	26	mm
LVIDs	27	mm	**LA**	30	mm
EDV	90	ml			
ESV	28	ml			
EF	69	%			
IVS(d)	12	mm			
PW(d)	11	mm			

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AND SUPER SPECIALITY HOSPITAL

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

- Concentric left ventricular hypertrophy.
- Grade I LV diastolic dysfunction.
- Good LV systolic function.

Many thanks for reference

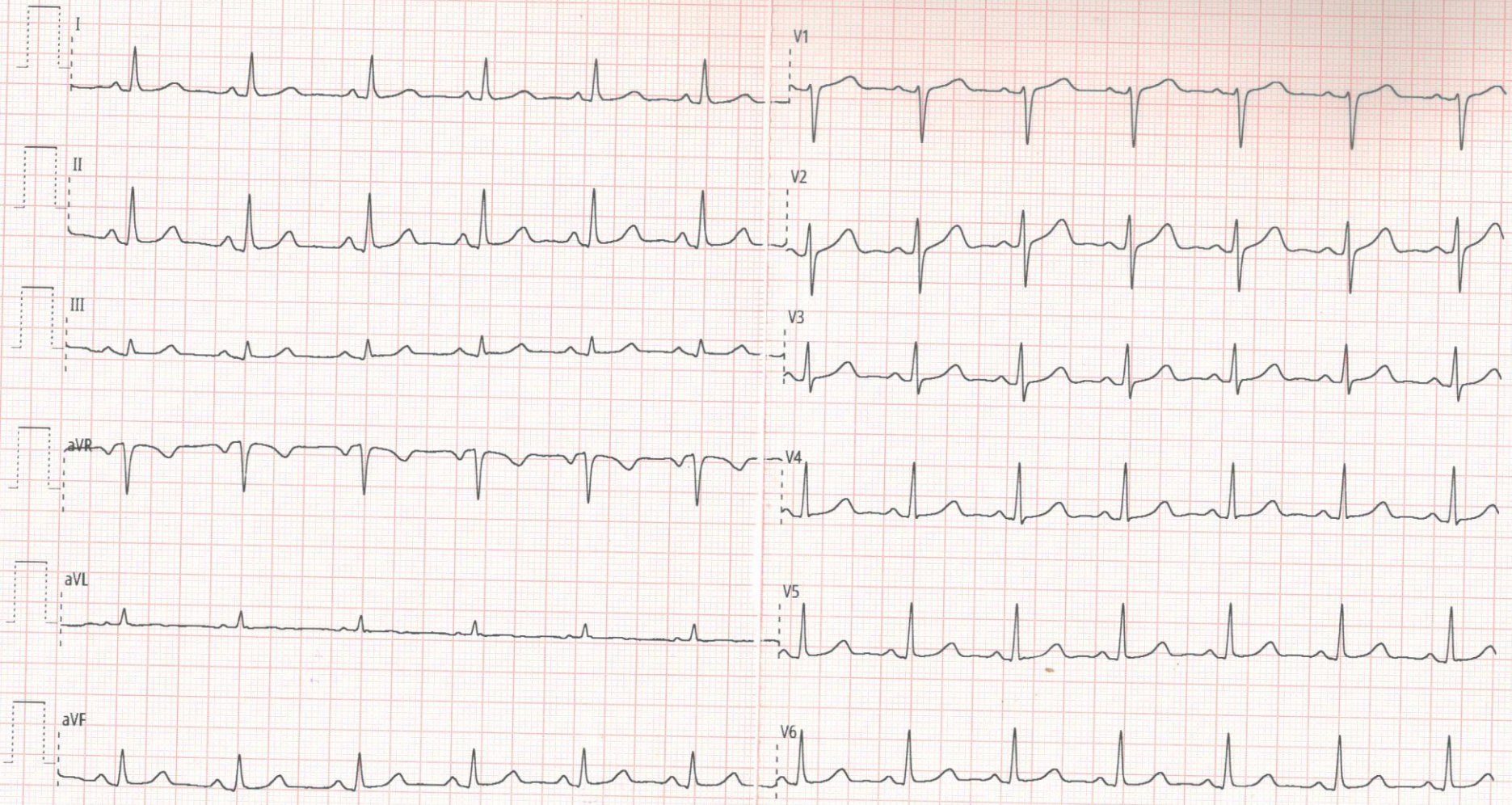
Dr, Mayur N Jain
MD DM cardiology- gold medalist
FACC, FSCAI, ICOB- USA; AFESC - UK
Consultant interventional cardiologist

ECG report

ID	: 20250219100931	HR	: 83 bpm
Name	: ahuja,pooja	PR	: 142 ms
Gender	: F	QRS	: 82 ms
Age	: 34 Years	QT/QTc	: 380/420 ms
Dept	:	P/QRS/T	: 57/44/60 °
Bed No.	:	RV5/SV1	: 0.894/0.846 mv
		RV5+SV1	: 1.740 mv

<<Interpretations >>
Sinus rhythm
Normal ECG

Confirm and sign:



0.05Hz - 25Hz - AC OFF 25mm/s 10mm/mv V1.0.26 Sequential

Examination time: 2025-02-19 10:13:02

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CARDIAC CARE
AND SUPER SPECIALITY HOSPITAL

NAME : MRS. POOJA AHUJA	AGE : 34YRS / FEMALE
REF. BY : HEALTH CHECKUP	DATE : 26.02.2025

FULL ABDOMEN USG

LIVER: Normal in size and shows homogenous echotexture. No focal lesion is seen. Hepatic vasculature appears normal. No evidence of intrahepatic biliary radical dilatation seen.

PORTAL VEIN / SPLENIC VEIN: is 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: Is normal in size and shows normal homogeneous echotexture. No focal lesion is seen. Pancreatic duct is normal in caliber.

KIDNEYS: **Right kidney: 8.7 x 4.2 cm** **Left kidney: 11.6 x 5.2 cm**
Both kidneys are normal in size, shape, position, and echotexture. Both kidneys show normal cortico-medullary differentiation. No calculi or HN/HU seen.

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

UTERUS: Is normal in size 6.5 x 4.6 x 5.1 cm anteverted and shows normal echotexture. Central Endometrial eco-complex measures 10.1 mm. Cervix appears normal.

OVARIES: Bilateral adnexa are clear.

PERITONEAL CAVITY: No ascites or enlarged lymph nodes.

OPINION:

- **NO SIGNIFICANT ABNORMALITY IS DETECTED.**

Dr. Patil

DR. DEVENDRA PATIL (MD Radiology)
CONSULTANT RADIOLOGIST
Please co-relate the findings with clinical examination, history & blood investigations.

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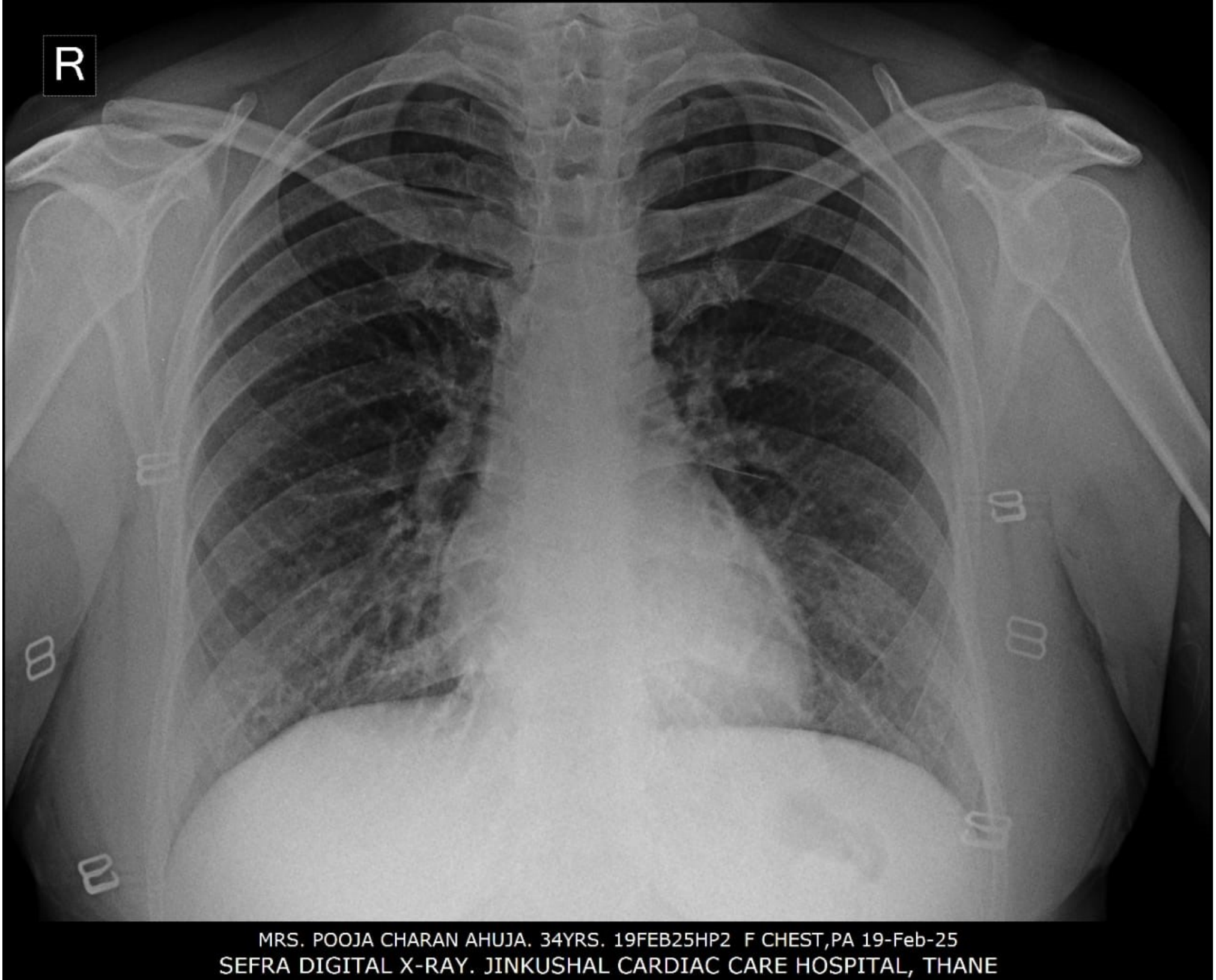
022 - 40615511 / 22


R
MRS. POOJA CHARAN AHUJA. 34YRS. 19FEB25HP2 F 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 : MRS. POOJA CHARAN AHUJA	**AGE / SEX 34 YRS / F**
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. Devendra Patil
MD Radiology

Mrs. Pooja Chandan Ahuja

34/F

HTN (+)

No DM / IHD.

C/o – Breathing after food.

No fever / cough / cold

No Chest pain / Palpitation / DOE

O/E PR-94/min

BP-110/70 mm

SpO2-99% on RA

CNS:- GCS-15/15 (E4V5M6)

M - B/L BS, clear.

CVS - S1S2 (+), no murmur

P/A - Soft, NT, BS (+)

26/02/2025

Wt:- 69 kg

19/2/25

Hb=12.4, TLC=8940

Plt=265, LYM=0.60

Neut=13B.B, Mono=4.6%

Eos=9.1, Baso=7.

RBS=107

LFT=WNL.

HbA1c=5.6.

HDL=37.

TSH=2.49.

EGFR=15.

19/2/25: 2DEC=EHO

EF=70%.

Adv

Cap. Velpanocid-20 mg 1-0-1

30 min before food.

Syp. Sporacid 10 ml

1-1-1

(5) days

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