


Patient Name : MR. SHASHI KUMAR SINHA
Age / Sex : 38Y/Male
IP/Reg.No/UHID : Reg-16949 /UHID16949
Lab No : LA25002912
Referred By : Dr.SAMANVAY HOSPITAL
Bedcategory/Bed :
Mobile No : 8737042542
UHID : UHID16949
Consultant : Mr. Samanvay Hospital
Sponsor : **MEDIWHEEL**
Barcode No. : 47704,47705,47706,47707

Bill No : OPB/1/24/17298
Sample Collected : Mar 8 2025 11:21AM
Sample Received : Mar 8 2025 11:22AM
Report On : Mar 8 2025 11:37AM
Bill Creation Date : Mar 8 2025 10:57AM
Bar Code : 
Reg No : Reg-16949
IPNo :
Passport No. :
Verified On : **Mar 8 2025 1:42PM**

Test Name

Results

Units

Bio. Ref. Interval

MICRO

URINE ANALYSIS

PHYSICAL EXAMINATION

VOLUME : 20 ML
COLOUR : PALE YELLOW
APPEARANCE : CLEAR

CHEMICAL EXAMINATION

PH : 6.0 : 4.5 - 8.0
SPECIFIC GRAVITY : 1.025 : 1.000 - 1.030
PROTEIN : Negative
GLUCOSE : Negative
KETONE : Negative
BLOOD : Negative
UROBILINOGEN : Negative
BILE PIGMENTS : Negative
BILE SALT : Negative
NITRITE : Negative
LEUKOCYTE ESTERASE : Negative

MICROSCOPIC EXAMINATION

PUS CELLS : 0--1 : CELLS/HPF : 0 - 5
RBC : NIL : RBC'S/HPF : 0 - 2
EPITHELIAL CELLS : 1--2 : OCC/HPF : 0 - 5
CASTS : NIL
CRYSTALS : NIL

HPLC

HBA1C/ GLYOCO HB

GLYCOCYLATED HAEMOGLOBIN(HBA1C) : 5.3 : % : 4.0 - 6.0
Method :- HPLC



Dr. Sweta Patel
MD (Pathology)
Verified By

Mrs. Rachana Parsottambhai Dayma

Prepared by

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AVERAGE BLOOD SUGAR	105.41	mg/dl	0 - 140.0
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BIOCHEMISTRY

LIPID PROFILE

CHOLESTROL (TOTAL)	145.0	mg/dl	0.0 - 200.0
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Method :- CHOD-PAP

Desirable blood cholesterol : <200 mg/dl
Borderline high blood cholesterol : 200-239 mg/dl
High blood cholesterol : >239 mg/dl

TRIGLYCERIDE	103.7	mg/dl	0 - 161.0
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Method :- GPO-METHOD

NORMAL : <161 MG/DL
HIGH : 161-199 MG/DL
HYPERTRIGLYCERIDEMIC : 200-499 MG/DL

HDL CHOLESTEROL	↓ 29.1	mg/dl	35.3 - 79.5
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Method :- DIRECT METHOD

CHOLESTROL (TOTAL)/HDL RATIO	↑ 4.98		3.30 - 4.40
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Method :- CALCULATED

VLDL	20.74		0 - 30.0
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LDL CHOLESTEROL(CALCULATED)	115.9		0 - 130.0
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LDL/HDL RATIO	3.98		
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CREATININE (BLOOD)	0.81	mg/dl	0.7 - 1.3
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Method :- ENZYMATIC

BUN	13.50	mg/dl	5.0 - 21.0
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Method :- UREASE-GLDH

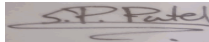
URIC ACID	4.9	mg/dl	3.5 - 7.2
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BUN CREATININE RATIO	16.66	mg/dl	10.0 - 20
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Method :- CALCULATED

UREA	28.9	mg/dl	21.0 - 43.0
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Method :- UREASE-GLDH




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LIVER FUNCTION TEST

BILIRUBIN-TOTAL	1.00	mg/dl	0.00 - 2.0
Method :- DIAZO			
BILIRUBIN-DIRECT	0.36	mg/dl	0.00 - 0.4
Method :- DIAZO			
BILIRUBIN-INDIRECT	0.64	mg/dl	0.00 - 1.10
Method :- DIAZO			
SGOT	28.9	U/L	0 - 35
Method :- IFCC WITHOUT PYRIDOXAL PHOSPHATE			
SGPT	37.9	U/mL	0 - 45
Method :- IFCC WITHOUT PYRIDOXAL PHOSPHATE			
ALKALINE PHOSPHATASE(ALKP04)*	98.0	U/L	53 - 128
Method :- AMP-METHOD			
PROTEIN (SERUM)	6.76	g/dl	6.40 - 8.30
Method :- BIURET			
ALBUMIN	4.27	g/dl	3.5 - 5.2
Method :- BCG			
GLOBULIN	2.49	g/dl	2.3 - 3.7
Method :- CALCULATED			
A/G RATIO	1.71	Ratio	1.0 - 2.0
Method :- CALCULATED			
GAMMA GT	↑ 65.6	U/L	0.0 - 58.0
Method :- GLUPA C METHOD			

IMMUNOLOGY

T3 T4 TSH

TOTAL T3	↑ 2.12	ng/ml	0.6 - 1.8
Method :- CHEMILUMINESCENCE / CLIA			
TOTAL T4	7.73	ug/dl	4.5 - 12.7
Method :- CHEMILUMINESCENCE / CLIA			
TSH	2.77	μIU/mL	0.35 - 4.78
Method :- CHEMILUMINESCENCE / CLIA			




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Nr. St. Kabir School, Opp. Raneshwar Temple, Vasna Road, Vadodara-15

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Interpretation : 1. TSH results between 4.5 to 15.0 show considerable physiologic and seasonal variation, suggest clinical correlation or repeat testing with fresh sample.
2.TSH results between 0.1 to 0.45 requires correlation with patient age and clinical symptoms. As with increasing age, there are marked changes in thyroid hormone production, metabolism and its action resulting in an increase prevalence of sub-clinical thyroid disease.
3. TSH values may be transiently altered because of non- thyroidal illness like severe infections, liver diseases, renal and heart failure, severe burns, trauma and surgery etc.
4.Drugs that decreased TSH values e.g. L-dopa, glucocorticoid. Drugs that increase TSH values e.g .Iodine, Lithium and amiodarone.

BIOCHEMISTRY

FASTING BLOOD GLUCOSE*

FASTING BLOOD GLUCOSE(FBS) 94.6 mg/dl 74.0 - 100.0

Method :- GOD-POD

FASTING URINE GLUCOSE

NIL

HEMATOLOGY

CBC WITH ESR

RBCS PARAMETER

HAEMOGLOBIN 14.2 g/dl 13.0 - 17.0

Method :- SLS METHOD

RBC COUNT 4.52 10⁶/uL 4.50 - 5.50

Method :- IMPEDENCE

PCV (HEAMATOCRIT) 44.0 % 40.0 - 50.0

Method :- IMPEDENCE

MCV 97.3 fl 80.0 - 100.0

Method :- CALCULATED

MCH 31.4 pg 27.0 - 33.0

Method :- CALCULATED

MCHC 32.3 g/dl 32.0 - 36.0

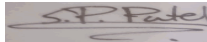
Method :- CALCULATED

RDW-CV 13.8 % 11.6 - 14.0

Method :- PARTICLE COUNTER(CALCULATED)

RDW-SD ↑ 50.0 fl 39 - 46

Method :- PARTICLE COUNTER(CALCULATED)




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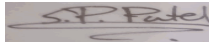
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Test Name	Results	Units	Bio. Ref. Interval
WBCS PARAMETER			
TOTAL COUNT	5800	/uL	4000 - 10000
Method :- FLOW CYTOMETRY			
DLC			
NEUTROPHILS	↑ 72	%	40 - 70
Method :- FLOW CYTOMETRY			
LYMPHOCYTES	20	%	20 - 40
Method :- FLOW CYTOMETRY			
MONOCYTES	06	%	2 - 8
Method :- FLOW CYTOMETRY			
EOSINOPHILS	02	%	1 - 4
Method :- FLOW CYTOMETRY			
BASOPHILS	00	%	0.0 - 1.0
Method :- FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	4170.0	10 ³ /uL	2000.0 - 7000.0
Method :- CALCULATED			
ABSOLUTE LYMPHOCYTE COUNT	1100.0	10 ³ /uL	1000.0 - 3000.0
Method :- CALCULATED			
ABSOLUTE MONOCYTE COUNT	350.0	10 ³ /uL	200.0 - 1000.0
Method :- CALCULATED			
ABSOLUTE EOSINOPHIL COUNT	140.0	10 ³ /uL	20.0 - 500.0
Method :- CALCULATED			
PLATELETS PARAMETER			
PLATELET COUNT	↓ 130000	/uL	150000 - 450000
Method :- IMPEDENCE			
ESR	12	mm/hr	0 - 20

-----End of the Report-----

Mrs. Rachana Parsottambhai Dayma

Prepared by



Dr. Sweta Patel
MD (Pathology)

Verified By

Nr. St. Kabir School, Opp. Raneshwar Temple, Vasna Road, Vadodara-15



UNCONFIRMED REPORT

SINUS RHYTHM
LEFT ATRIAL ABNORMALITY

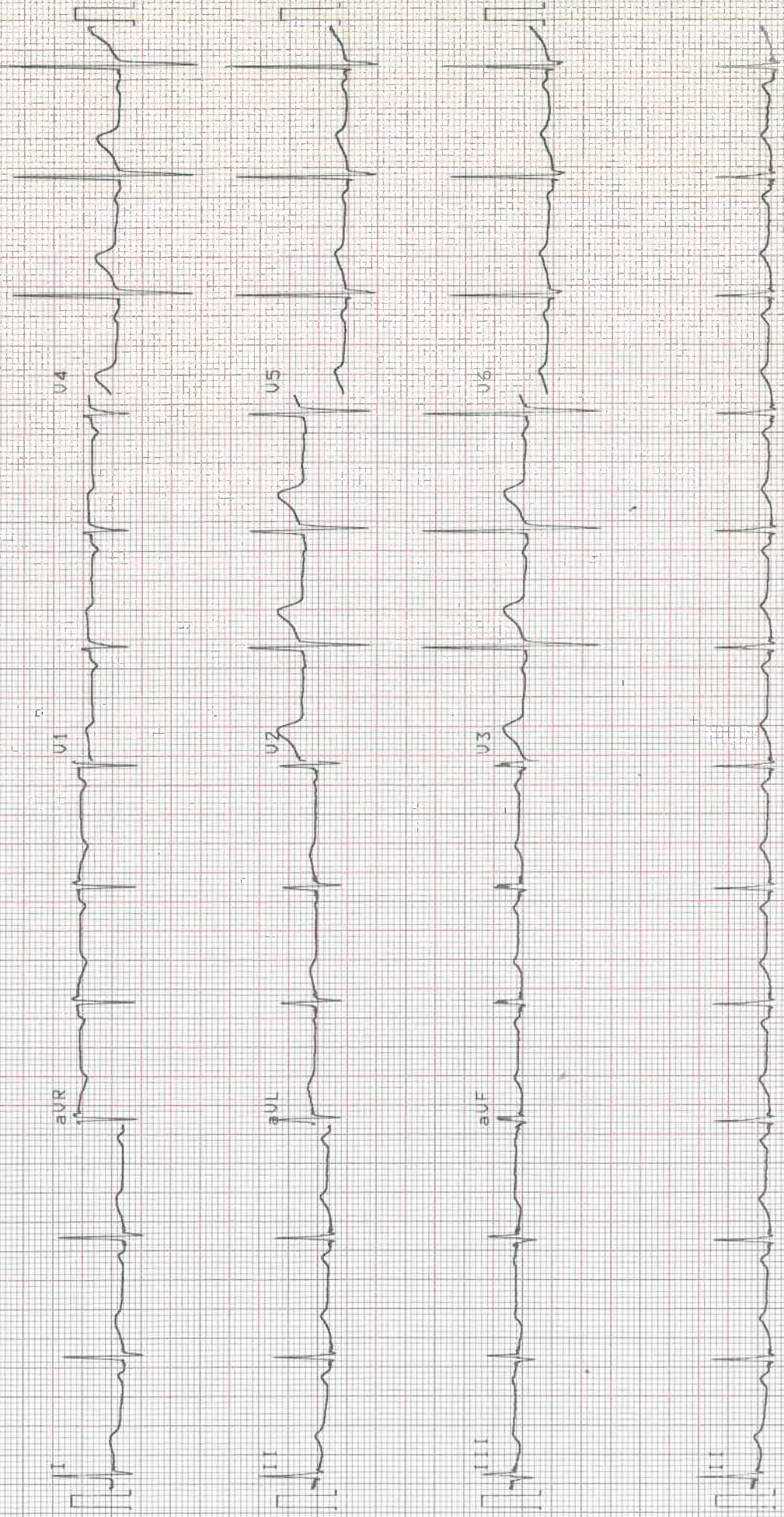
Axis:
P 42°
QRS 19°
T 17°

HR 74/min
Intervals:
RR 807 ms
P 110 ms
PR 154 ms
QRS 78 ms
QT 378 ms
QTc 425 ms

P (II) 0.13 mV
S (V1) -0.64 mV
R (V5) 1.91 mV
Sokol. 3.04 mV

10 mm/mV

10 mm/mV



10 mm/mV

25 mm/s

DR. PAVAN ROY
MD, DM (CC), DNB (CC), DNB (CV)
CONSULTANT CARDIOLOGIST
REG. NO. G-2350
M. No. 157017M
Sankar Hospital, Vadodra

F50 55F 59S 5a 08-MAR-25 10:02:12

SCHILLER

Part No. 2.157017M

R BE

Saturday, March 08, 2025
SHASHIKUMAR SINHA
38 YEARS/MALE

CHEST X RAY PA VIEW

Both the lung fields appear normal.

Both costophrenic angles appear clear.

Cardiac silhouette appear normal.

Both hila appears normal.

Bony thorax appears normal.

No evidence of free gas seen under dome of diaphragm.

COMMENTS:

- **NORMAL BOTH LUNG FIELDS.**
- **NORMAL CARDIAC SIZE.**



DR SARJAN VASAVA
M.B.B.S., D.M.R.D.
Reg. No. G-26527
SAMANVAY HOSPITALS

Digitally signed by
DR SARJAN VASAVA,
CONSULTANT RADIOLOGIST.



2812 x 2280
WL: 128 WW: 256

R

L/R

Shashi Kumar Sinha 38Yrs 90 (-, -)
Chest

R

107%
1.1/1
Uncompressed
Position: PA



08/03/25, 10:50:02 AM
Samarthy Hospital
Noida, India

SINHA SHASHI KUMAR

M / 38 YEARS

DATE: 08/03/2025

REAL TIME SONOGRAPHY OF THE ABDOMEN & PELVIS

LIVER - It is normal in size (15.0 cm). It shows bright echo pattern. No evidence of solid or cystic focal lesion is seen. The intrahepatic biliary system is normal and shows no dilatation of the radicles. The portal vein, CBD and hepatic veins appear normal.

GALL BLADDER - It is distended and appears normal. No evidence of sludge or calculus is seen. The wall appears normal.

PANCREAS - It is visualized and appears normal.

SPLEEN - It appears normal in size (10.7 cm), normal in shape and echotexture. No focal lesions.

KIDNEYS - . Both the kidneys appear normal in size, shape and show normal corticomedullary differentiation. Normal echogenicity of both kidneys.

Right kidney measures 9.2 x 3.9 cm. Left kidney measures 10.0 x 4.9 cm.

No calculus or hydronephrosis is seen on either side.

Urinary bladder is distended and appears normal. No cystitis or mass lesion noted.

Prostate appears normal in size vol - 15 cc . No focal lesion.

No evidence of any lymphadenopathy or ascites is noted.

No evidence of dilated bowel loops or bowel wall thickening noted.

IMPRESSION:

FATTY LIVER GRADE-I.



DR. SARJAN VASAVA,
CONSULTANT RADIOLOGIST.

DR SARJAN VASAVA
M.B.B.S., D.M.R.D.
Reg. No. G-26527
SAMANVAY HOSPITALS

Patient

Exam

ID 08032025-010457PM
Name SINHA SHASHI KUMAR M/38
Birth Date
Gender

Accession #
Exam Date 08-03-2025
Description
Operator



2D ECHOCARDIOGRAPHY AND COLOUR DOPPLER STUDY

NAME : MR.SINHA SHASHI

DATE :08-03-25

AGE/SEX : 38 YRS /M WARD :HCP REF BY :SAMANVAY HOSPITAL

OBSERVATION:

- NORMAL LV SIZE WITH NORMAL LV SYSTOLIC FUNCTION
- LVEF 56%, NO RWMA AT REST
- E/O NO LV DIASTOLIC DYSFUNCTION, NORMAL LA SIZE
- AORTIC VALVE, NO AR, NO AS
- MITRAL VALVE, TRIVIAL MR, NO MS
- TRIVIAL TR,NO PAH, RVSP 20 MMHG
- NORMAL SIZED RA, RV WITH NORMAL RV FUNCTION
- PULMONARY VALVE- NO PR, NO PS, NORMAL SIZED PA & ITS BRANCHES
- IAS, IVS ARE INTACT
- NO INTRACARDIAC CLOT, VEGETATION
- PERICARDIUM NORMAL, NO PERICARDIAL EFFUSION
- IVC NORMAL

MEASUREMENTS:

M MODE: AORTA: 22 MM LA: 32 MM LV DD/DS: 43/22 MM IVS/PW: 11/10 MM
DOPPLER: MV RATIO E/A: 0.7/0.5 M/S AV VMAX: 1.1 M/S PV VMAX: 0.6 M/S

CONCLUSION:

NORMAL LV SIZE AND LV SYSTOLIC FUNCTION
LVEF 56%, NO RWMA AT REST
TRIVIAL MR, TRIVIAL TR, NO PAH
E/O NO LV DIASTOLIC DYSFUNCTION



DR. PAVAN ROY
MD, DM (CARDIOLOGY)
CONSULTANT CARDIOLOGIST
REG. NO. G-23390
M No. 9305988158

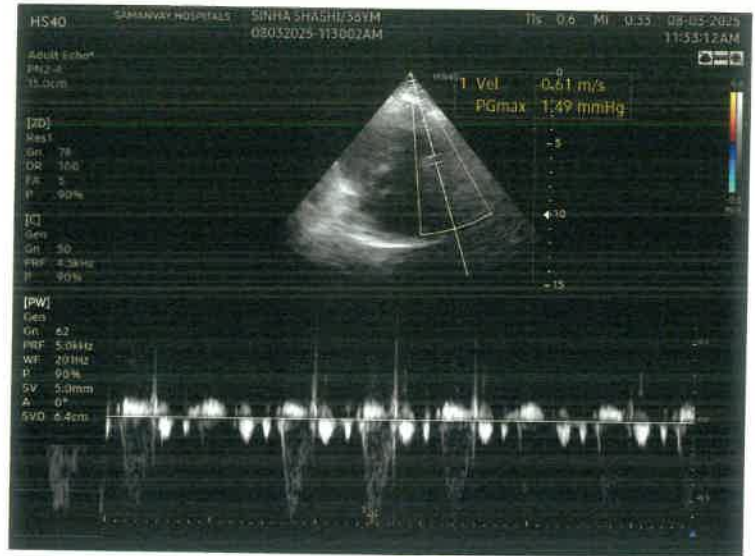
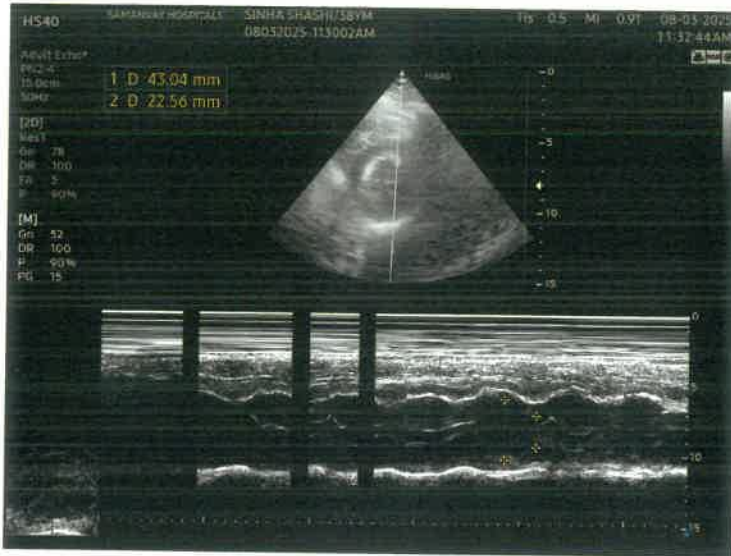
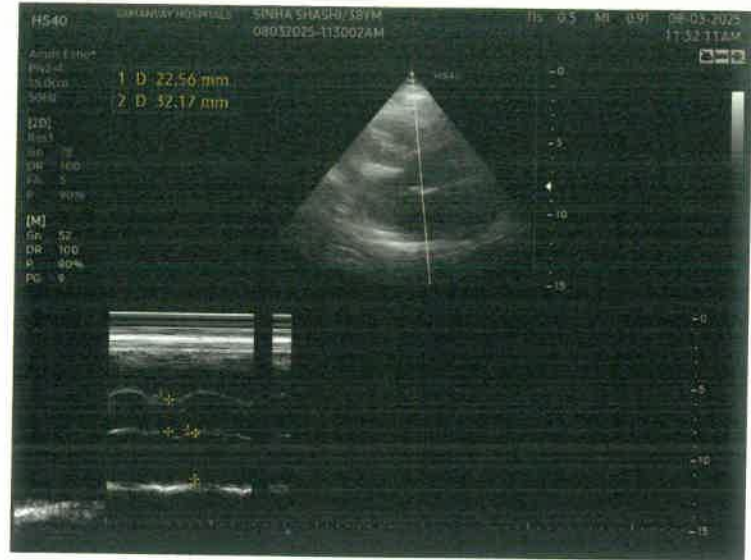
DR. PAVAN ROY
MD, DM (CARDIOLOGY), REG NO. G-23390
CONSULTANT INTERVENTIONAL CARDIOLOGIST

Patient

ID 08032025-113002AM
Name SINHA SHASHI/38YM
Birth Date
Gender

Exam

Accession #
Exam Date 08-03-2025
Description
Operator





COMPREHENSIVE HEALTH CHECK UP

Case No. : _____ Date : 8/3/25

Name : Mr. Simha Shubhi Kumar Age/Sex : 38/M

MEDICAL HISTORY : _____

PERSONAL HISTORY : _____

Appetite : _____ Smoking : -

Sleep : _____ H/O Alcohol : -

Bladder : _____ Lifestyle : Sedentary

Bowel : _____ Exercise : - None

DRUG HISTORY : _____

PAST HISTORY : _____

FAMILY HISTORY : _____

GENERAL PHYSICAL EXAMINATION :

Built and Nourishment :

Height : 158 cm

SpO2 95%

B. P. : 120/80 mm of Hg

Weight : 84.3 Kg

Character : _____

Pulse : 77 / Min

Nails : _____

Odema : _____

Tonsils : _____

Skin : _____

Tongue : _____

Sclera : _____

Eat. & Joints : _____

Glands : _____



Dermatology opia

Adv

(10/11) -> TB, Ataxia, iron
- Venous pressure UA



EYE CHECK UP

Reg. No. : _____ Date : _____

Name : _____ Age / Sex : _____

	RIGHT EYE	LEFT EYE
DISTANCE : (With / Without Glasses)	6/6	6/6
NEAR VISION : (With / Without Glasses)	N6	N6
ANTERIOR SEGMENT :	— WNL —	—
I O P (MM of Hg)	— digitally WNL —	
FUNDUS :	— WNL —	
COLOR VISION :	— WNL —	
CLINICAL IMPRESSION :	— WNL —	
ADVICE :	① Refresh tears eye drops 0-0-00 ①	




Doctor's Signature : _____

8-3-2025

Mr. Simku Shushi Kumar

Age:- 38

Adv: Horizontal 

- Stain + Calculus +

- Missing 

Adv:  - IOPA

- Ex^m 

- Scaling

