


 भारत सरकार  
GOVERNMENT OF INDIA

दिनेश कांवल  
Dinesh Kanwat  
जन्म वर्ष / Year of Birth : 1985  
पुरुष / Male




9908 5176 5641

आधार – आम आदमी का अधिकार

*Meena*

*U*

Dr. U. C. GUPTA  
MBBS, MD (Physician)  
RMC No. 291

 भारतीय विशिष्ट पहचान प्राधिकरण  
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

पता: S/O: हरफूल सिंह मीणा, 137, सती मंदिर, मोरिजा, चोमु, मोरिजा, जयपुर, मोरिजा, राजस्थान, 303805  
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**General Physical Examination**

Date of Examination: 11/12/2022

Name: DINESH KANWAT Age: 37 DOB: 14/08/1985 Sex: Male

Referred By: BANK OF BARODA

Photo ID: AADHAR CARD ID #: 5641

Ht: 183 (cm)

Wt: 100 (Kg)

Chest (Expiration): 117 (cm)

Abdomen Circumference: 113 (cm)

Blood Pressure: 124/88 mm Hg PR: 75 /min RR: 18 /min Temp: Afebrile

BMI 29

Eye Examination: With class RIE 6/6, N/G, NCB  
LIE 6/6, N/G, NCB

Other: N/A

On examination he/she appears physically and mentally fit:  Yes / No

Signature Of Examinee : [Signature] Name of Examinee: DINESH KANWAT

Signature Medical Examiner : [Signature] Name Medical Examiner DR. U. C. GUPTA

**Dr. U. C. GUPTA**  
MBBS, MD (Physician)  
RMC No. 291





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|                                  |                                |                    |          |
|----------------------------------|--------------------------------|--------------------|----------|
| <b>NAME :- Mr. DINESH KANWAT</b> | Patient ID :-12222574          | Date :- 01/12/2022 | 10:14:32 |
| Age :- 37 Yrs 3 Mon 19 Days      | Ref. By Doctor:-BANK OF BARODA |                    |          |
| Sex :- Male                      | Lab/Hosp :-                    |                    |          |
|                                  | Company :- Mr.MEDIWHEEL        |                    |          |

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**HAEMATOLOGY**

| Test Name | Value | Unit | Biological Ref Interval |
|-----------|-------|------|-------------------------|
|-----------|-------|------|-------------------------|

FULL BODY HEALTH CHECKUP BELOW 40 MALE

**HAEMOGARAM**

|                                     |                |                  |               |
|-------------------------------------|----------------|------------------|---------------|
| <b>HAEMOGLOBIN (Hb)</b>             | 13.9           | g/dL             | 13.0 - 17.0   |
| <b>TOTAL LEUCOCYTE COUNT</b>        | 4.10           | /cumm            | 4.00 - 10.00  |
| <b>DIFFERENTIAL LEUCOCYTE COUNT</b> |                |                  |               |
| NEUTROPHIL                          | 54.0           | %                | 40.0 - 80.0   |
| LYMPHOCYTE                          | 39.0           | %                | 20.0 - 40.0   |
| EOSINOPHIL                          | 3.0            | %                | 1.0 - 6.0     |
| MONOCYTE                            | 4.0            | %                | 2.0 - 10.0    |
| BASOPHIL                            | 0.0            | %                | 0.0 - 2.0     |
| TOTAL RED BLOOD CELL COUNT (RBC)    | 4.60           | $\times 10^6/uL$ | 4.50 - 5.50   |
| HEMATOCRIT (HCT)                    | 43.20          | %                | 40.00 - 50.00 |
| MEAN CORP VOLUME (MCV)              | 97.0           | fL               | 83.0 - 101.0  |
| MEAN CORP HB (MCH)                  | 31.1           | pg               | 27.0 - 32.0   |
| MEAN CORP HB CONC (MCHC)            | 32.2           | g/dL             | 31.5 - 34.5   |
| <b>PLATELET COUNT</b>               | 159            | $\times 10^3/uL$ | 150 - 410     |
| RDW-CV                              | 13.7           | %                | 11.6 - 14.0   |
| MENTZER INDEX                       | <b>21.65 H</b> |                  | 0.00 - 0.00   |

A complete blood picture (CBP) is a kind of blood test that is done to assess a person's overall health and diagnose a wide range of health disorders like leukemia, anemia and other infections.

A complete blood count (CBC) is a complete blood test that diagnose many components and features of a persons blood which includes: -

- \*Red Blood Cells (RBC), which carry oxygen -
- \*White Blood Cells (WBC), which help in fighting against infections -
- \*Hemoglobin, which is the oxygen carrying protein in the red blood cells -
- \*Hematocrit (HCT), the proportion of RBC to the fluid component, or plasma present in blood -
- \*Platelets, which aid in blood clotting

(CBC): Methodology: TLC,TRBC,PCV,PLT Impedance method, HB Calorimetric method,, and MCH,MCV,MCHC,MENTZER INDEX are calculated. InstrumentName: MINDRAY BC-3000 Plus 3 part automatic analyzer,

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### HAEMATOLOGY

**Erythrocyte Sedimentation Rate (ESR)**

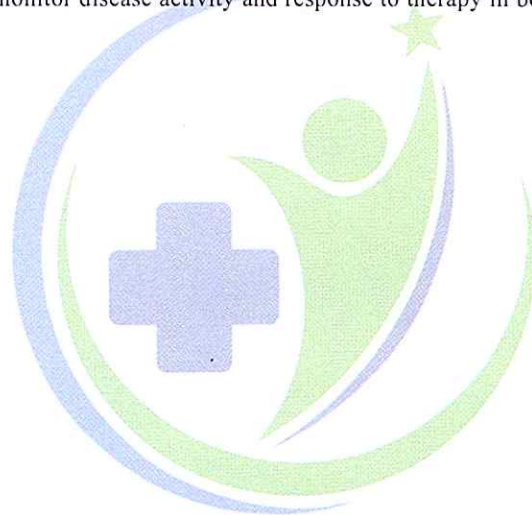
11

mm in 1st hr

00 - 15

Method:- Westergreen

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases. ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein. ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as



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|                                  | Company :- Mr.MEDIWHEEL        |                    |          |

(CBC): **Methodology:** TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and MCH,MCV,MCHC,MENTZER INDEX are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan



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| Sex :- Male                      | Lab/Hosp :-                    |                    |          |
|                                  | Company :-                     | Mr.MEDIWHEEL       |          |

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## BIOCHEMISTRY

| Test Name | Value | Unit | Biological Ref Interval |
|-----------|-------|------|-------------------------|
|-----------|-------|------|-------------------------|

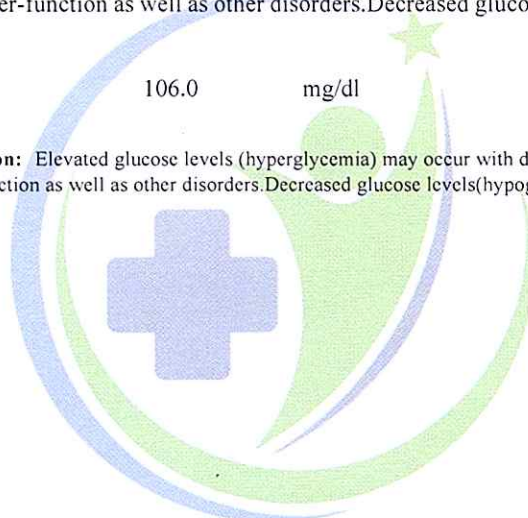
|  |       |       |              |
|--|-------|-------|--------------|
| FASTING BLOOD SUGAR (Plasma)<br>Method:- GOD POD | 101.0 | mg/dl | 70.0 - 115.0 |
|--|-------|-------|--------------|

|                                  |                 |
|----------------------------------|-----------------|
| Impaired glucose tolerance (IGT) | 111 - 125 mg/dL |
| Diabetes Mellitus (DM)           | > 126 mg/dL     |

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .

|   |       |       |              |
|---|-------|-------|--------------|
| BLOOD SUGAR PP (Plasma)<br>Method:- GOD PAP | 106.0 | mg/dl | 70.0 - 140.0 |
|---|-------|-------|--------------|

Instrument Name: HORIBA Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .



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**HAEMATOLOGY**

| Test Name | Value | Unit | Biological Ref Interval |
|-----------|-------|------|-------------------------|
|-----------|-------|------|-------------------------|

**GLYCOSYLATED HEMOGLOBIN (HbA1C)**

Method:- CAPILLARY with EDTA

5.8 mg%

Non-Diabetic < 6.0  
Good Control 6.0-7.0  
Weak Control 7.0-8.0  
Poor control > 8.0

**MEAN PLASMA GLUCOSE**

Method:- Calculated Parameter

120 mg/dL

68 - 125

**INTERPRETATION**

AS PER AMERICAN DIABETES ASSOCIATION (ADA)

Reference Group HbA1c in %

Non diabetic adults >=18 years < 5.7

At risk (Prediabetes) 5.7 - 6.4

Diagnosing Diabetes >= 6.5

**CLINICAL NOTES**

In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia. The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings. Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al.]

**1. Erythropoiesis**

- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

**2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.**

**3. Glycation**

- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

**4. Erythrocyte destruction**

- Increased HbA1c: increased erythrocyte life span: Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

**5. Others**

- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use, chronic renal failure
- Decreased HbA1c: hypertriglyceridemia, reticulocytosis, chronic liver disease, aspirin, vitamin C and E, splenomegaly, rheumatoid arthritis or drugs

**Note:**

- Shortened RBC life span—HbA1c test will not be accurate when a person has a condition that affects the average lifespan of red blood cells (RBCs), such as hemolytic anemia or blood loss. When the lifespan of RBCs in circulation is shortened, the A1c result is falsely low and is an unreliable measurement of a person's average glucose over time.
- Abnormal forms of hemoglobin – The presence of some hemoglobin variants, such as hemoglobin S in sickle cell anemia, may affect certain methods for measuring A1c. In these cases, fructosamine can be used to monitor glucose control.

**Advised:**

- To follow patient for glycemic control test like fructosamine or glycosylated albumin may be performed instead.
  - Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.
- estimated Average Glucose (eAG) : based on value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

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**BIOCHEMISTRY**

| Test Name | Value | Unit | Biological Ref Interval |
|-----------|-------|------|-------------------------|
|-----------|-------|------|-------------------------|

**LIPID PROFILE**

**TOTAL CHOLESTEROL** **248.00 H** mg/dl  
 Desirable <200  
 Borderline 200-239  
 High > 240  
 Method:- CHOD-PAP methodology

**InstrumentName:**MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.

**TRIGLYCERIDES** **181.00 H** mg/dl  
 Normal <150  
 Borderline high 150-199  
 High 200-499  
 Very high >500  
 Method:- GPO-TOPS methodology

**InstrumentName:**MISPA PLUS **Interpretation :** Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.

**DIRECT HDL CHOLESTEROL** **88.90** mg/dl  
 Male 35-80  
 Female 42-88  
 Method:- Selective inhibition Method

**Instrument Name:**MISPA PLUS **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.

**LDL CHOLESTEROL** **128.93** mg/dl  
 Optimal <100  
 Near Optimal/above optimal 100-129  
 Borderline High 130-159  
 High 160-189  
 Very High > 190  
 Method:- Calculated Method

**VLDL CHOLESTEROL** **36.20** mg/dl  
 Method:- Calculated  
 0.00 - 80.00

**T.CHOLESTEROL/HDL CHOLESTEROL RATIO** **2.79**  
 Method:- Calculated  
 0.00 - 4.90

**LDL / HDL CHOLESTEROL RATIO** **1.45**  
 Method:- Calculated  
 0.00 - 3.50

**TOTAL LIPID** **761.40** mg/dl  
 Method:- CALCULATED  
 400.00 - 1000.00

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. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended
3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.

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## BIOCHEMISTRY

**Comments:** 1- ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all atherogenic lipoproteins ( mainly LDL & VLDL). The Non HDL Cholesterol is used as a secondary target of therapy in persons with triglycerides  $\geq 200$  mg/dL. The goal for Non HDL Cholesterol in those with increased triglyceride is 30 mg/dL above that set for LDL Cholesterol.  
2 -For calculation of CHD risk, history of smoking, any medication for hypertension & current B.P. levels are required.



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**BIOCHEMISTRY**

**LIVER PROFILE WITH GGT**

|  |                |        |  |
|--|----------------|--------|--|
| SERUM BILIRUBIN (TOTAL)<br>Method:- DMSO/Diazo   | 0.51           | mg/dL. | Infants : 0.2-8.0 mg/dL<br>Adult - Up to - 1.2 mg/dL |
| SERUM BILIRUBIN (DIRECT)<br>Method:- DMSO/Diazo  | 0.29           | mg/dL. | Up to 0.40 mg/dL                                     |
| SERUM BILIRUBIN (INDIRECT)<br>Method:- Calculated  | 0.22           | mg/dl  | 0.30-0.70  |
| SGOT<br>Method:- IFCC  | <b>90.0 H</b>  | U/L    | Men- Up to - 37.0<br>Female - Up to - 31.0           |
| SGPT<br>Method:- IFCC  | <b>138.0 H</b> | U/L    | Men- Up to - 40.0<br>Female- Up to - 31.0            |
| SERUM ALKALINE PHOSPHATASE<br>Method:- DGKC - SCE  | 57.90          | U/L.   | 53.00 - 141.00                                       |
| SERUM GAMMA GT<br>Method:- Szasz methodology<br>Instrument Name Randox Rx Imola<br>Interpretation Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis. | 22.40          | U/L    | 10.00 - 45.00  |
| SERUM TOTAL PROTEIN<br>Method:- Direct Biuret Reagent  | 7.00           | g/dl   | 5.10 - 8.00  |
| SERUM ALBUMIN<br>Method:- Bromocresol Green  | 3.98           | g/dl   | 2.80 - 4.50  |
| SERUM GLOBULIN<br>Method:- CALCULATION   | 3.02           | gm/dl  | 2.20 - 3.50  |
| A/G RATIO  | 1.32           |        | 1.30 - 2.50  |

**Interpretation :** Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

**Note :-** These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A, B, C, paracetamol toxicity etc. Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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**BIOCHEMISTRY**

**RFT / KFT WITH ELECTROLYTES**

SERUM UREA 28.80 mg/dl 10.00 - 50.00  
Method:- Urease/GLDH

InstrumentName: HORIBA CA 60 Interpretation : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE 1.23 mg/dl Males : 0.6-1.50 mg/dl  
Method:- Jaffe's Method Females : 0.6 -1.40 mg/dl

Interpretation : Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID 4.72 mg/dl 2.40 - 7.00

InstrumentName: HORIBA YUMIZEN CA60 Daytona plus Interpretation: Elevated Urate: High purine diet, Alcohol, Renal insufficiency, Drugs, Polycythaemia vera, Malignancies, Hypothyroidism, Rare enzyme defects, Down's syndrome, Metabolic syndrome, Pregnancy, Gout.

SODIUM 136.9 mmol/L 135.0 - 150.0  
Method:- ISE

Interpretation: Decreased sodium - Hyponatraemia Causes include: fluid or electrolyte loss, Drugs, Oedematous states, Legionnaire's disease and other chest infections, pseudonatremia, Hyperlipidaemias and paraproteinaemias, endocrine diseases, SIADH.

POTASSIUM 4.52 mmol/L 3.50 - 5.50  
Method:- ISE

Interpretation: A. Elevated potassium (hyperkalaemia) Artefactual, Physiologic, Medication, Drugs, Pathological states, Renal failure Adrenocortical insufficiency, metabolic acidoses, very high platelet or white cell counts B. Decreased potassium (hypokalaemia) Drugs, Liquoric, Diarrhoea and vomiting, Metabolic alkalosis, Corticosteroid excess, Oedematous state, Anorexia nervosa/bulimia

CHLORIDE 101.3 mmol/L 94.0 - 110.0  
Method:- ISE

Interpretation: Used for Electrolyte monitoring.

SERUM CALCIUM 11.50 mg/dl 8.10 - 11.50  
Method:- Colorimetric method

InstrumentName: Rx Daytona plus Interpretation: Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia. Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN 7.00 g/dl 5.10 - 8.00  
Method:- Direct Biuret Reagent

Technologist  
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*Tanu*

**DR. TANU RUNGTA**  
MD (Pathology)  
RMC No. 17226

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|                                  |                                |                    |          |
|----------------------------------|--------------------------------|--------------------|----------|
| <b>NAME :- Mr. DINESH KANWAT</b> | Patient ID :-12222574          | Date :- 01/12/2022 | 10:14:32 |
| Age :- 37 Yrs 3 Mon 19 Days      | Ref. By Doctor:-BANK OF BARODA |                    |          |
| Sex :- Male                      | Lab/Hosp :-                    |                    |          |
|                                  | Company :- Mr.MEDIWHEEL        |                    |          |

Final Authentication : 01/12/2022 15:36:34

**BIOCHEMISTRY**

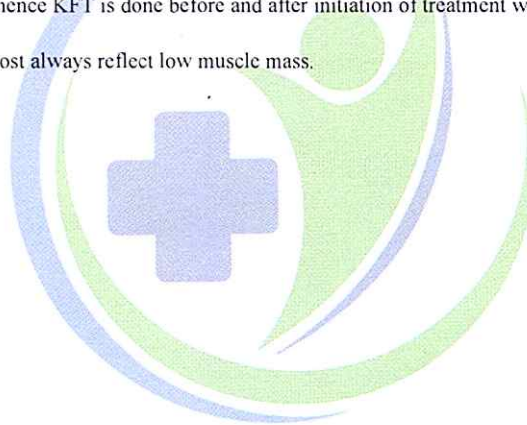
|   |      |       |             |
|---|------|-------|-------------|
| SERUM ALBUMIN<br>Method:- Bromocresol Green | 3.98 | g/dl  | 2.80 - 4.50 |
| SERUM GLOBULIN<br>Method:- CALCULATION      | 3.02 | gm/dl | 2.20 - 3.50 |
| A/G RATIO                                   | 1.32 |       | 1.30 - 2.50 |

**Interpretation** : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

**INTERPRETATION**

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR .in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare; they almost always reflect low muscle mass.



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| Sex :- Male                      | Company :- Mr.MEDIWHEEL        |                    |          |

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**CLINICAL PATHOLOGY**

URINE SUGAR (FASTING)  
Collected Sample Received

Nil

Nil



ADIYTA

**Technologist**  
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| Sex :- Male                      | Lab/Hosp :-                    |                    |          |
|                                  | Company :- Mr.MEDIWHEEL        |                    |          |

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**TOTAL THYROID PROFILE**

**IMMUNOASSAY**

| Test Name  | Value | Unit  | Biological Ref Interval |
|--|-------|-------|-------------------------|
| <b>THYROID-TRIIODOTHYRONINE T3</b><br>Method:- ECLIA | 1.07  | ng/mL | 0.70 - 2.04             |

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by serum T3 & T4 values along with TSH level. 2.Low TSH, high FT4 and TSH receptor antibody (TRAb) +ve seen in patients with Graves disease 3.Low TSH, high FT4 and TSH receptor antibody (TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.High TSH, Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.High TSH, Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH, Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism 7.Primary hypothyroidism is accompanied by serum T3 and T4 values & serum TSH levels 8.Normal T4 levels accompanied by T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9.Normal or T3 & T4 10.Normal T3 & T4 along with TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & T4 along with TSH is seen in Hypothyroidism .12.Normal T3 & T4 levels with TSH indicate Mild / Subclinical Hypo

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved. TSH is an important marker for the diagnosis of thyroid dysfunction. Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age. This is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly. \*\*\* 5.10 - 14.10

**THYROID-THYRONINE (T4)**  
Method:- ECLIA

6.42 uIU/mL

5.10 - 14.10

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by serum T3 & T4 values along with TSH level. 2.Low TSH, high FT4 and TSH receptor antibody (TRAb) +ve seen in patients with Graves disease 3.Low TSH, high FT4 and TSH receptor antibody (TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.High TSH, Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.High TSH, Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH, Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism 7.Primary hypothyroidism is accompanied by serum T3 and T4 values & serum TSH levels 8.Normal T4 levels accompanied by T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9.Normal or T3 & T4 10.Normal T3 & T4 along with TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & T4 along with TSH is seen in Hypothyroidism .12.Normal T3 & T4 levels with TSH indicate Mild / Subclinical Hypo

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**TSH**  
Method:- ECLIA

2.846 uIU/mL

0.350 - 5.500

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

ADITYA  
INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by serum T3 & T4 values along with TSH level.

**Technologist**  
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*Tanu*  
**DR. TANU RUNGTA**  
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| Sex :- Male                      | Lab/Hosp :-                    |                    |          |
|                                  | Company :-                     | Mr.MEDIWHEEL       |          |

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**IMMUNOASSAY**

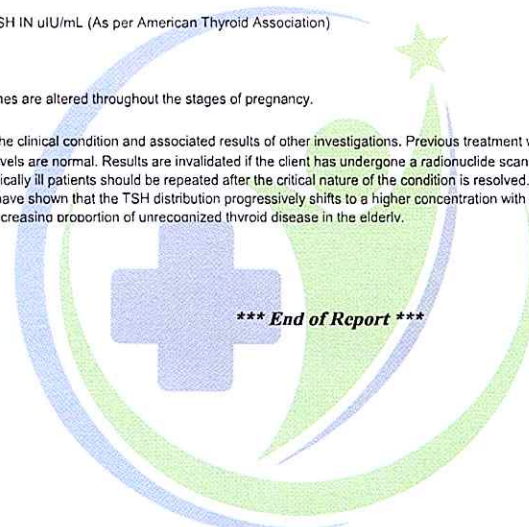
- 2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease
- 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter
- 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis
- 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency
- 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
- 7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
- 8 Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
- 9.Normal or↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis ( problem is conversion of T4 to T3)
- 10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism .
- 11.Normal T3 & ↓ T4 along with ↓ TSH is seen in Hypothyroidism .
- 12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism .
- 13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propranolol.
- 14.Although ↑ TSH levels are nearly always indicative of Primary Hypothyroidism ,rarely they can result from TSH secreting pituitary tumours .

**DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)**

- 1st Trimester : 0.10-2.50 uIU/mL
- 2nd Trimester : 0.20-3.00 uIU/mL
- 3rd Trimester : 0.30-3.00 uIU/mL

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

**REMARK**-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.



\*\*\* End of Report \*\*\*

ADIYTA

**Technologist**  
Page No: 15 of 15

**DR.TANU RUNGTA**  
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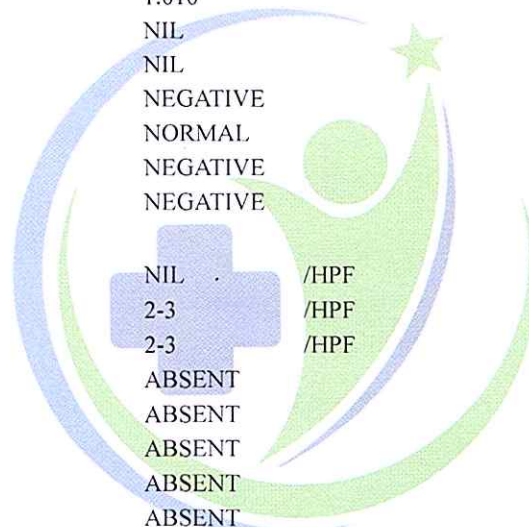


|                                  |                                |                    |          |
|----------------------------------|--------------------------------|--------------------|----------|
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| Age :- 37 Yrs 3 Mon 19 Days      | Ref. By Doctor:-BANK OF BARODA |                    |          |
| Sex :- Male                      | Lab/Hosp :-                    |                    |          |
|                                  | Company :-                     | Mr.MEDIWHEEL       |          |

Final Authentication : 01/12/2022 15:36:34

**CLINICAL PATHOLOGY**

| Test Name                            | Value       | Unit | Biological Ref Interval |
|--------------------------------------|-------------|------|-------------------------|
| <b>Urine Routine</b>                 |             |      |                         |
| <b><u>PHYSICAL EXAMINATION</u></b>   |             |      |                         |
| COLOUR                               | PALE YELLOW |      | PALE YELLOW             |
| APPEARANCE                           | Clear       |      | Clear                   |
| <b><u>CHEMICAL EXAMINATION</u></b>   |             |      |                         |
| REACTION(PH)                         | 5.0         |      | 5.0 - 7.5               |
| SPECIFIC GRAVITY                     | 1.010       |      | 1.010 - 1.030           |
| PROTEIN                              | NIL         |      | NIL                     |
| SUGAR                                | NIL         |      | NIL                     |
| BILIRUBIN                            | NEGATIVE    |      | NEGATIVE                |
| UROBILINOGEN                         | NORMAL      |      | NORMAL                  |
| KETONES                              | NEGATIVE    |      | NEGATIVE                |
| NITRITE                              | NEGATIVE    |      | NEGATIVE                |
| <b><u>MICROSCOPY EXAMINATION</u></b> |             |      |                         |
| RBC/HPF                              | NIL         | /HPF | NIL                     |
| WBC/HPF                              | 2-3         | /HPF | 2-3                     |
| EPITHELIAL CELLS                     | 2-3         | /HPF | 2-3                     |
| CRYSTALS/HPF                         | ABSENT      |      | ABSENT                  |
| CAST/HPF                             | ABSENT      |      | ABSENT                  |
| AMORPHOUS SEDIMENT                   | ABSENT      |      | ABSENT                  |
| BACTERIAL FLORA                      | ABSENT      |      | ABSENT                  |
| YEAST CELL                           | ABSENT      |      | ABSENT                  |
| OTHER                                | ABSENT      |      | ABSENT                  |



ADIYTA

**Technologist**  
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*Tanu Rungta*

**DR.TANU RUNGTA**  
MD (Pathology)  
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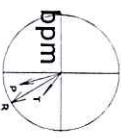


**P3 HEALTH SOLUTIONS LLP**

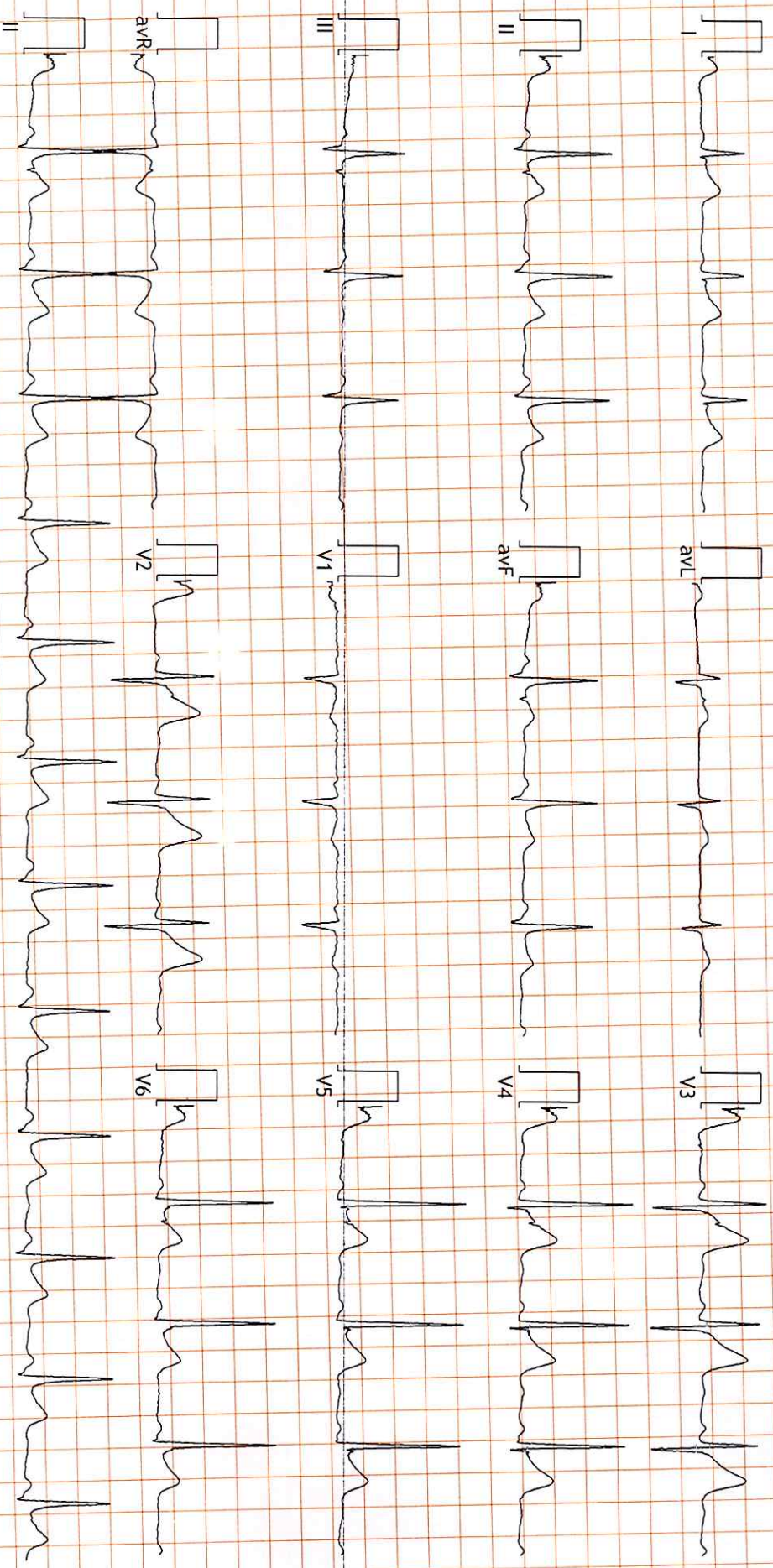
B-14, Vidhyanager Nagar, Enclave, Phase-2, Jaipur  
 12229451322594/Mr. Dinesh Kanwat 37Yrs-02Months/Male  
 Ref.: BANK OF BARODA Test Date: 01-Dec-2022(10:53:10) Notch: 50Hz

Kgs/ Cms BP: \_\_\_/\_\_\_ mmHg  
 10mm/mV 25mm/Sec

HR: 73 bpm



PR Interval: 140 ms  
 QRS Duration: 76 ms  
 QT/QTc: 353/391ms  
 P-QRS-T Axis: 73 - 58 - 38 (Deg)



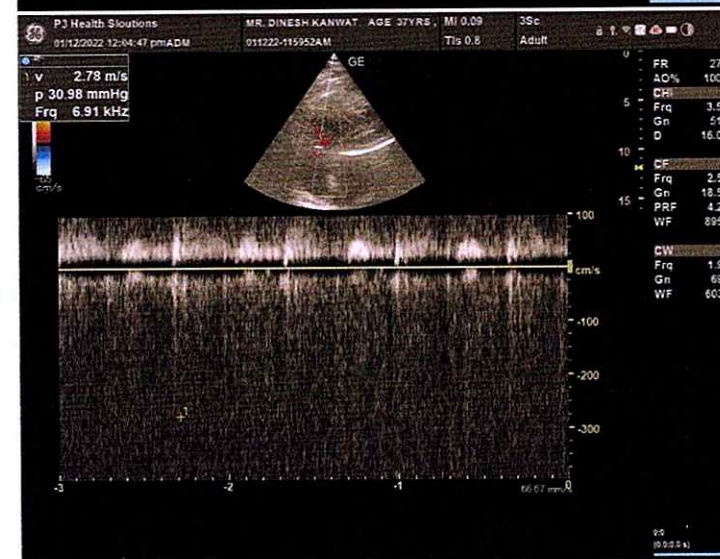
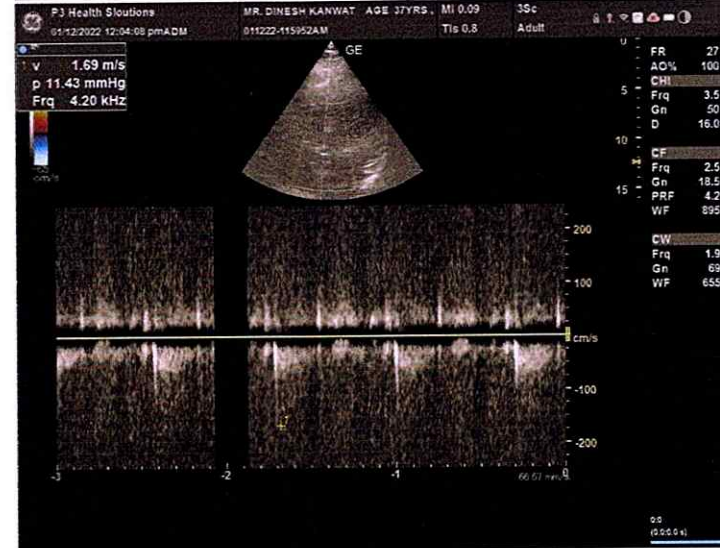
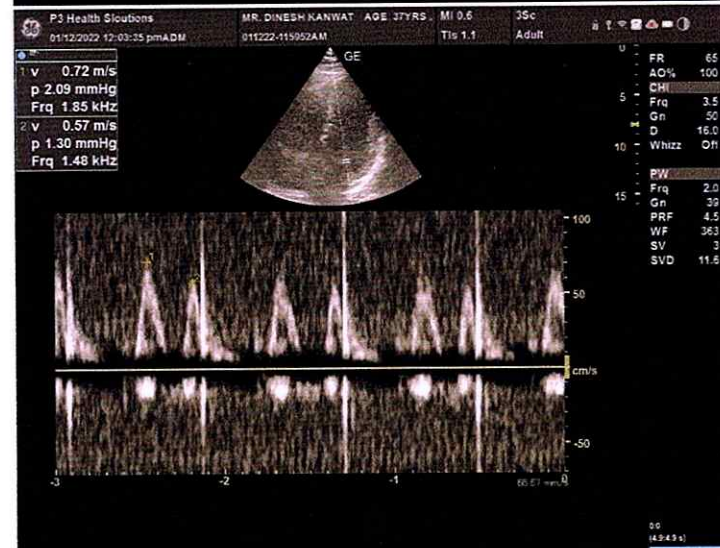
**FINDINGS: Normal Sinus Rhythm**  
 Vent Rate : 73 bpm; PR Interval : 140 ms; QRS Duration: 76 ms; QT/QTc Int : 353/391 ms  
 P-QRS-T axis: 73•58•38• (Deg)  
 Comments :

*(Handwritten signature)*

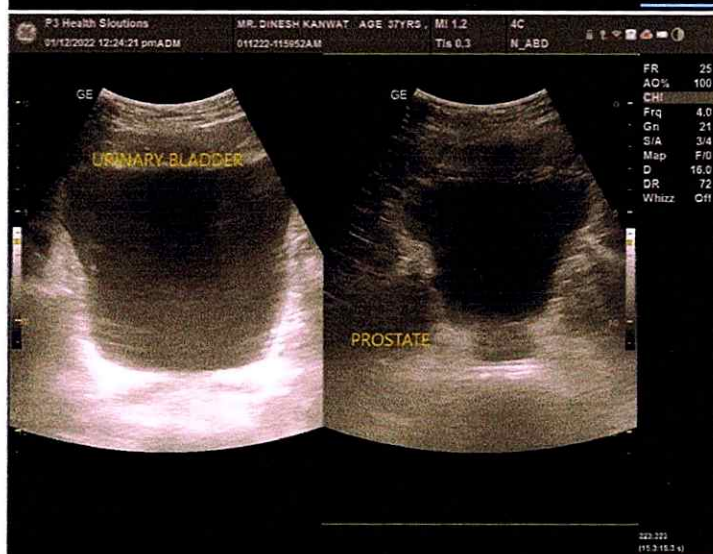
**TUNL**

Dr. Kumar Mohanka  
 (ESCORTS)  
 35703  
 (ESCORTS)











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|        |                   |      |            |
|--------|-------------------|------|------------|
| NAME:  | MR. DINESH KANWAT | AGE  | 37 YRS/M   |
| REF.BY | BANK OF BARODA    | DATE | 01/12/2022 |

**CHEST X RAY (PA VIEW)**

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

**IMPRESSION:** No significant abnormality is detected.

**DR.SHALINI GOEL**  
M.B.B.S, D.N.B (Radiodiagnosis)  
RMC No.: 21954





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|                                      |                                |
|--------------------------------------|--------------------------------|
| <b>MR. DINESH KANWAT</b>             | <b>37 Y/Male</b>               |
| <b>Registration Date: 01/12/2022</b> | <b>Ref. by: BANK OF BARODA</b> |

**2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:**  
FAIR TRANSTHORACIC ECHOCARDIOGRAPHIC WINDOW MORPHOLOGY:

|              |        |                 |        |
|--------------|--------|-----------------|--------|
| MITRAL VALVE | NORMAL | TRICUSPID VALVE | NORMAL |
| AORTIC VALVE | NORMAL | PULMONARY VALVE | NORMAL |

**M.MODE EXAMINATION:**

|        |        |    |        |     |    |        |     |    |
|--------|--------|----|--------|-----|----|--------|-----|----|
| AO     | 2.8    |    | LA     | 2.8 | cm | IVS-D  | 1.1 | cm |
| IVS-S  | 1.3    | cm | LVID   | 3.9 | cm | LVSD   | 2.9 | cm |
| LVPW-D | 1.1    | cm | LVPW-S | 1.3 | cm | RV     |     | cm |
| RVWT   |        | cm | EDV    |     | ml | LVVS   |     | ml |
| LVEF   | 55-60% |    | RWMA   |     |    | ABSENT |     |    |

**CHAMBERS:**

|             |        |        |        |
|-------------|--------|--------|--------|
| LA          | NORMAL | RA     | NORMAL |
| LV          | NORMAL | RV     | NORMAL |
| PERICARDIUM |        | NORMAL |        |

**COLOUR DOPPLER:**

|                         |        |        |                   |  |       |
|-------------------------|--------|--------|-------------------|--|-------|
| <b>MITRAL VALVE</b>     |        |        |                   |  |       |
| E VELOCITY              | 0.72   | m/sec  | PEAK GRADIENT     |  | Mm/hg |
| A VELOCITY              | 0.57   | m/sec  | MEAN GRADIENT     |  | Mm/hg |
| MVA BY PHT              |        | Cm2    | MVA BY PLANIMETRY |  | Cm2   |
| MITRAL REGURGITATION    | ABSENT |        |                   |  |       |
| <b>AORTIC VALVE</b>     |        |        |                   |  |       |
| PEAK VELOCITY           | 1.69   | m/sec  | PEAK GRADIENT     |  | mm/hg |
| AR VMAX                 |        | m/sec  | MEAN GRADIENT     |  | mm/hg |
| AORTIC REGURGITATION    | ABSENT |        |                   |  |       |
| <b>TRICUSPID VALVE</b>  |        |        |                   |  |       |
| PEAK VELOCITY           |        | m/sec  | PEAK GRADIENT     |  | mm/hg |
| MEAN VELOCITY           |        | m/sec  | MEAN GRADIENT     |  | mm/hg |
| VMax VELOCITY           |        |        |                   |  |       |
| TRICUSPID REGURGITATION | MILD   |        |                   |  |       |
| <b>PULMONARY VALVE</b>  |        |        |                   |  |       |
| PEAK VELOCITY           | 0.79   | M/sec. | PEAK GRADIENT     |  | Mm/hg |
| MEAN VELOCITY           |        |        | MEAN GRADIENT     |  | Mm/hg |
| PULMONARY REGURGITATION | ABSENT |        |                   |  |       |

**Impression—**

- NORMAL LV SIZE & CONTRACTILITY.
- NO RWMA, LVEF 55-60%.
- MILD TR/ PAH (RVSP 30 MMHG+ RAP).
- NORMAL DIASTOLIC FUNCTION
- MILD CONCENTRIC LVH
- NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.

  
(Cardiologist)



|                                      |                                |
|--------------------------------------|--------------------------------|
| <b>MR.DINESH KANWAT</b>              | <b>AGE- 37 Y/Male</b>          |
| <b>Registration Date: 01/12/2022</b> | <b>Ref. by: BANK OF BARODA</b> |

**ULTRASOUND OF WHOLE ABDOMEN**

**Liver is mildly enlarged in size (16.3 cm) with increased echotexture obscuring periportal echogenicity.** No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

**Gall bladder** is well distended. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

**Pancreas** is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

**Spleen** is of normal size and shape (9.1 cm). Echotexture is normal. No focal lesion is seen.

**Kidneys** are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. Collecting system does not show any calculus or dilatation.

**Right kidney** is measuring approx. 11.6 x 4.1 cm.

**Left kidney** is measuring approx. 12.8 x 5.4 cm.

**Urinary bladder** does not show any calculus or mass lesion.

**Prostate** is normal in size with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.  
No significant free fluid is seen in pelvis.

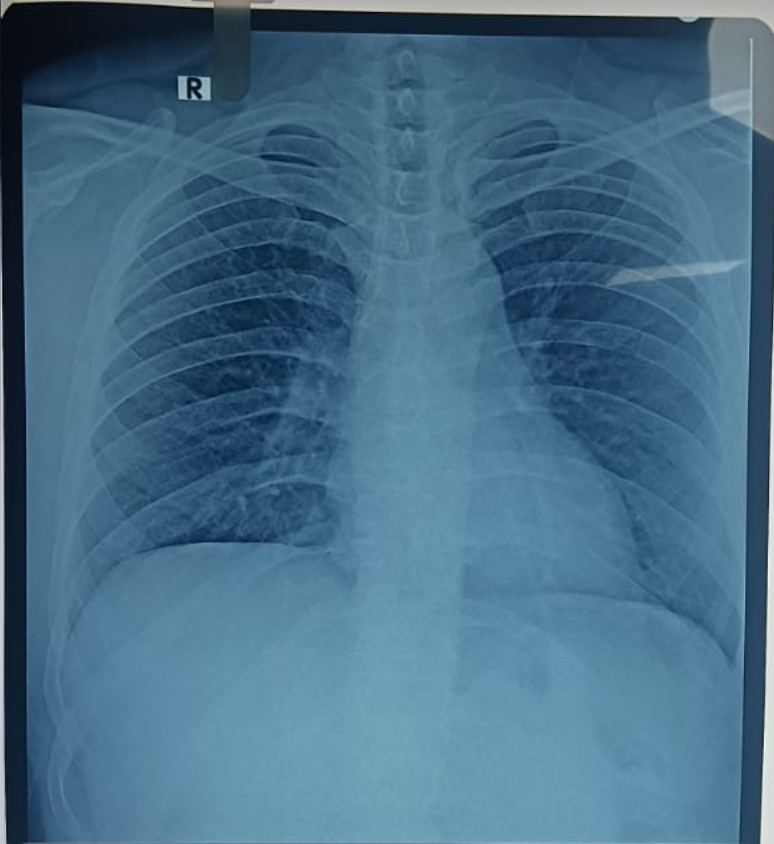
**IMPRESSION:**

- **Mild hepatomegaly with grade 2 fatty liver as described above.**

**DR.SHALINI GOEL**

**M.B.B.S, D.N.B (Radiodiagnosis)**





12222574 MR.DINESH KANWAT 37YRS BANK OF BARODA M  
01 DEC 2022  
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)

