

Dr. Vimmi Goel
MBBS, MD (Internal Medicine)
Sr. Consultant Non Invasive Cardiology
Reg. No: MMC- 2014/01/0113

Medi-wheel



Name: Mrs. Ranjana Deshpande Date: 25/03/23

Age: 39 Sex: M/F Weight: 46.6 kg Height: 154.5 Inc BMI: 19.5

BP: 120/80 mmHg Pulse: 76 bpm RBS: _____ mg/dl

SPO₂ - 99%

Lmp - 13/03/23

Mrs. Rajyara Deshpande 39/6 25/3/23

For Health check up

No gynec complaints

O/A: P₂L₂AC Both LSCU
TR Not Done

M/H: LMP - 13/3/23
PANC - 4-5 d / 28-30 d / Reg

P/H: Nil

Sx/H: 2 LSCS & 2 S&E.

F/H: ~~At~~ HTN

OSG: wt (N), ET - 5mm
No adnexal lesion seen

Adv: PAP smear Test - Taken on 25/3/23.

Breasts: soft wnc

PIA: soft NT

PIU: CX] Healthy
v g]

PIV: wt (N) w/ IAF
B/L fornices free NT

Dr. Monika
KOTPALLIWAR
MBBS, MD, DNB, MNAMS, MRCOG,
Consultant-Obstetrics and Gynecologist,
Reg. No.: MMC-2013/03/0477



MC-4807

**DEPARTMENT OF PATHOLOGY**

Patient Name : Mrs. RANJANA DESHPANDE	Age / Gender : 39 Y(s)/Female
Bill No/ UMR No : BIL2223024932/UMR2223139018	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 25-Mar-23 09:43 am	Report Date : 25-Mar-23 12:08 pm

HAEMOGRAM

Parameter	Specimen	Results	Biological Reference	Method
Haemoglobin	Blood	10.8	12.0 - 15.0 gm%	Photometric
Haematocrit(PCV)		33.0	36.0 - 46.0 Vol%	Calculated
RBC Count		4.69	3.8 - 4.8 Millions/cumm	Photometric
Mean Cell Volume (MCV)		70	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		22.9	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		32.6	31.5 - 35.0 g/l	Calculated
RDW		15.6	11.5 - 14.0 %	Calculated
Platelet count		361	150 - 450 10^3 /cumm	Impedance
WBC Count		9300	4000 - 11000 cells/cumm	Impedance

DIFFERENTIAL COUNT

Neutrophils	60.9	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes	33.9	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils	3.4	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes	1.8	2 - 10 %	Flow Cytometry/Light microscopy
Basophils	0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count	5663.7	2000 - 7000 /cumm	Calculated
Absolute Lymphocyte Count	3152.7	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count	316.2	20 - 500 /cumm	Calculated
Absolute Monocyte Count	167.4	200 - 1000 /cumm	Calculated



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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
PERIPHERAL SMEAR				
Microcytosis		Microcytosis +(Few)		
Hypochromasia		Hypochromia +(Few)		
Anisocytosis		Anisocytosis +(Few)		
WBC		As Above		
Platelets		Adequate		
ESR		05	0 - 20 mm/hr	Automated Westergren's Method
*** End Of Report ***				

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100245

Test results related only to the item tested.

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**Dr. VAIDEHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. RANJANA DESHPANDE	Age / Gender : 39 Y(s)/Female
Bill No/ UMR No : BIL2223024932/UMR2223139018	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 25-Mar-23 09:43 am	Report Date : 25-Mar-23 12:04 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	77	< 100 mg/dl	GOD/POD, Colorimetric

Interpretation:

Clinical Decision Value as per ADA Guidelines 2021

- Diabetes Mellites If,
- Fasting \geq 126 mg/dl
- Random/2Hrs. OGTT \geq 200 mg/dl
- Impaired Fasting = 100-125 mg/dl
- Impaired Glucose Tolerance = 140-199 mg/dl

Post Prandial Plasma Glucose	70	< 140 mg/dl	GOD/POD, Colorimetric
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Interpretation:

Clinical Decision Value as per ADA Guidelines 2021

- Diabetes Mellites If,
- Fasting \geq 126 mg/dl
- Random/2Hrs. OGTT \geq 200 mg/dl
- Impaired Fasting = 100-125 mg/dl
- Impaired Glucose Tolerance = 140-199 mg/dl

GLYCOSYLATED HAEMOGLOBIN (HbA1c)

HbA1c	5.4	Non-Diabetic : \leq 5.6 %	HPLC
		Pre-Diabetic : 5.7 - 6.4 %	
		Diabetic : \geq 6.5 %	



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LIPID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	155	< 200 mg/dl
Triglycerides		75	< 150 mg/dl
HDL Cholesterol Direct		66	> 50 mg/dl
LDL Cholesterol Direct		76.72	< 100 mg/dl
VLDL Cholesterol		15	< 30 mg/dl
Tot Chol/HDL Ratio		2	3 - 5

Enzymatic

<u>Intiate therapeutic</u>		<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	>130, optional at 100-129	<100
Multiple major risk factors conferring 10 yrs CHD risk >20%			
Two or more additional major risk factors, 10 yrs CHD risk <20%	>130	10 yrs risk 10-20 % >130 10 yrs risk <10% >160	<130
No additional major risk or one additional major risk factor	>160	>190, optional at 160-189	<160

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100026

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Dr. Anuradha Deshmukh, MBBS,MD**CONSULTANT MICROBIOLOGIST**



DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. RANJANA DESHPANDE **Age / Gender** : 39 Y(s)/Female
Bill No/ UMR No : BIL2223024932/UMR2223139018 **Referred By** : Dr. Vimmi Goel MBBS,MD
Received Dt : 25-Mar-23 09:43 am **Report Date** : 25-Mar-23 12:04 pm

LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Billirubin	Serum	0.55	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Billirubin		0.25	0.1 - 0.3 mg/dl	Calculated
Indirect Billirubin		0.30	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric pNPP/AMP buffer
Alkaline Phosphatase		65	38 - 126 U/L	Kinetic with pyridoxal 5 phosphate
SGPT/ALT		15	13 - 45 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		17	13 - 35 U/L	Biuret (Alkaline cupric sulphate)
Serum Total Protein		6.94	6.3 - 8.2 gm/dl	Bromocresol green Dye Binding
Albumin Serum		3.72	3.5 - 5.0 gm/dl	Calculated
Globulin		3.22	2.0 - 4.0 gm/	
A/G Ratio		1.15		

*** End Of Report ***

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Dr. Anuradha Deshmukh, MBBS,MD

CONSULTANT MICROBIOLOGIST



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

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Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 25-Mar-23 09:43 am
Report Date : 25-Mar-23 12:04 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
RFT				
Blood Urea	Serum	14	15.0 - 36.0 mg/dl	Urease with indicator dye
Creatinine		0.52	0.52 - 1.04 mg/dl	Enzymatic (creatinine amidohydrolase)
GFR		121.1		Calculation by CKD-EPI 2021
Sodium		142	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.84	3.5 - 5.1 mmol/L	Direct ion selective electrode
URINE SUGAR				
Urine Glucose		Negative		
THYROID PROFILE				
T3		1.39	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.10	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.24	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY**

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Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 25-Mar-23 10:43 am
Report Date : 25-Mar-23 12:25 pm

Parameter	Specimen	Results	Method
URINE MICROSCOPY			
PHYSICAL EXAMINATION			
Volume	Urine	30 ml	
Colour.		Pale yellow	
Appearance		Clear	
CHEMICAL EXAMINATION			
Reaction (pH)	Urine	5.0	4.6 - 8.0
Specific gravity		1.010	1.005 - 1.025
Urine Protein		Negative	Indicators
Sugar		Negative	ion concentration
Bilirubin		Negative	protein error of pH
Ketone Bodies		Negative	indicator
Nitrate		Negative	GOD/POD
Urobilinogen		Negative	Diazonium
MICROSCOPIC EXAMINATION			
Epithelial Cells	Urine	0-1	Legal's est Principle
R.B.C.		Absent	Ehrlich's Reaction
Pus Cells		0-1	0 - 4 /hpf
Casts		Absent	0 - 4 /hpf
Crystals		Absent	0 - 4 /hpf
Others		Absent	Manual
USF(URINE SUGAR FASTING)			
Urine Glucose	Urine	Negative	Manual
			GOD/POD



MC-4807



DEPARTMENT OF IMMUNO HAEMATOLOGY

Patient Name : Mrs. RANJANA DESHPANDE **Age / Gender** : 39 Y(s)/Female
Bill No/ UMR No : BIL2223024932/UMR2223139018 **Referred By** : Dr. Vimmi Goel MBBS,MD
Received Dt : 25-Mar-23 09:43 am **Report Date** : 25-Mar-23 12:55 pm

BLOOD GROUPING AND RH

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
BLOOD GROUP.	EDTA Whole Blood & Plasma/ Serum	" O "	Gel Card Method
Rh (D) Typing.		" Positive "(+Ve)	
*** End Of Report ***			

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Dr. VAIDEHEE NAIK, MBBS,MD

CONSULTANT PATHOLOGIST

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	RANJANA DESHPANDE	STUDY DATE	25-03-2023 10:03:42
AGE/ SEX	39Y2M2D / F	HOSPITAL NO.	UMR2223139018
ACCESSION NO.	BIL2223024932-10	MODALITY	DX
REPORTED ON	25-03-2023 11:05	REFERRED BY	Dr. Vimmi Goel

X-RAY CHEST PA VIEW

Both the lung fields are clear.

Heart and Aorta are normal.

Both hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

IMPRESSION -No pleuro-parenchymal abnormality seen.



DR. MILU PARIKH

MD, DNB

CONSULTANT RADIOLOGIST

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Phone: +91 0712 6789100
CIN: U74999MH2018PTC303510

N.B: This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations. Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

NAME OF PATIENT:	RANJANA DESHPANDE	AGE & SEX:	39 Y/ F
UMR NO	2223139018		
REF BY:	DR. VIMMI GOEL	DATE:	25/03/2023

USG ABDOMEN AND PELVIS

LIVER is normal in size and echotexture.

No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated.

PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No stones or sludge seen within it.
Wall thickness is within normal limits.

PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in size, shape and echotexture. No focal lesion seen.

Right kidney measures 9.3 x 3.6 cm. Left kidney measures 9.2 x 4.4 cm.

Both kidneys are normal in size, shape and echotexture.

No evidence of calculus or hydronephrosis seen.

URETERS are not dilated.

URINARY BLADDER is well distended. No calculus or mass lesion seen.

Uterus appears normal. No focal myometrial lesion seen.


Endometrial echo-complex appear normal. Et- 5 mm.

No adnexal lesion seen.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

- No significant abnormality.



DR. AMEYA KAWTHALKAR
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FELLOWSHIP IN MUSCULOSKELETAL IMAGING AND
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RADIOLOGIST.

Kingsway Hospitals
44 Kingsway, Mohan Nagar,
Near Kasturchand Park, Nagpur

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Mrs. Ranjana, Deshpande
Patient ID: 139018
Height:
Weight:
Study Date: 25.03.2023
Test Type: Treadmill Stress Test
Protocol: BRUCE

DOB: 22.01.1984
Age: 39yrs
Gender: Female
Race: Indian
Referring Physician: Mediwheel HCU
Attending Physician: Dr. Vimmi Goel
Technician: --

Medications:

Medical History:

NIL

Reason for Exercise Test:

Screening for CAD

Exercise Test Summary:

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	01:39	0.00	0.00	99	120/80	
	HYPERV.	00:01	0.00	0.00	100		
	WARM-UP	00:16	0.00	0.00	92		
EXERCISE	STAGE 1	03:00	1.70	10.00	133	120/80	
	STAGE 2	03:00	2.50	12.00	146	130/80	
	STAGE 3	02:56	3.40	14.00	166	140/80	
RECOVERY		01:00	0.00	0.00	121	130/80	
		02:00	0.00	0.00	108	120/80	
		00:19	0.00	0.00	108		

The patient exercised according to the BRUCE for 8:56 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 99 bpm rose to a maximal heart rate of 169 bpm. This value represents 93% of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 140/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation:

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: appropriate.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

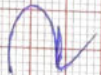
ST Changes: Insignificant ST-T change seen..

Overall impression: Normal stress test.

Conclusions:

TMT is negative for inducible ischemia.

Insignificant ST-T change seen.


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MRS RANJANA DESHPANDE

25-Mar-23 9:01:24 AM

KIMS-KINGSWAY HOSPITALS

Female

39 Years

PHC DEPT.

Rate 68 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 152
QRSD 90
QT 400
QTC 426

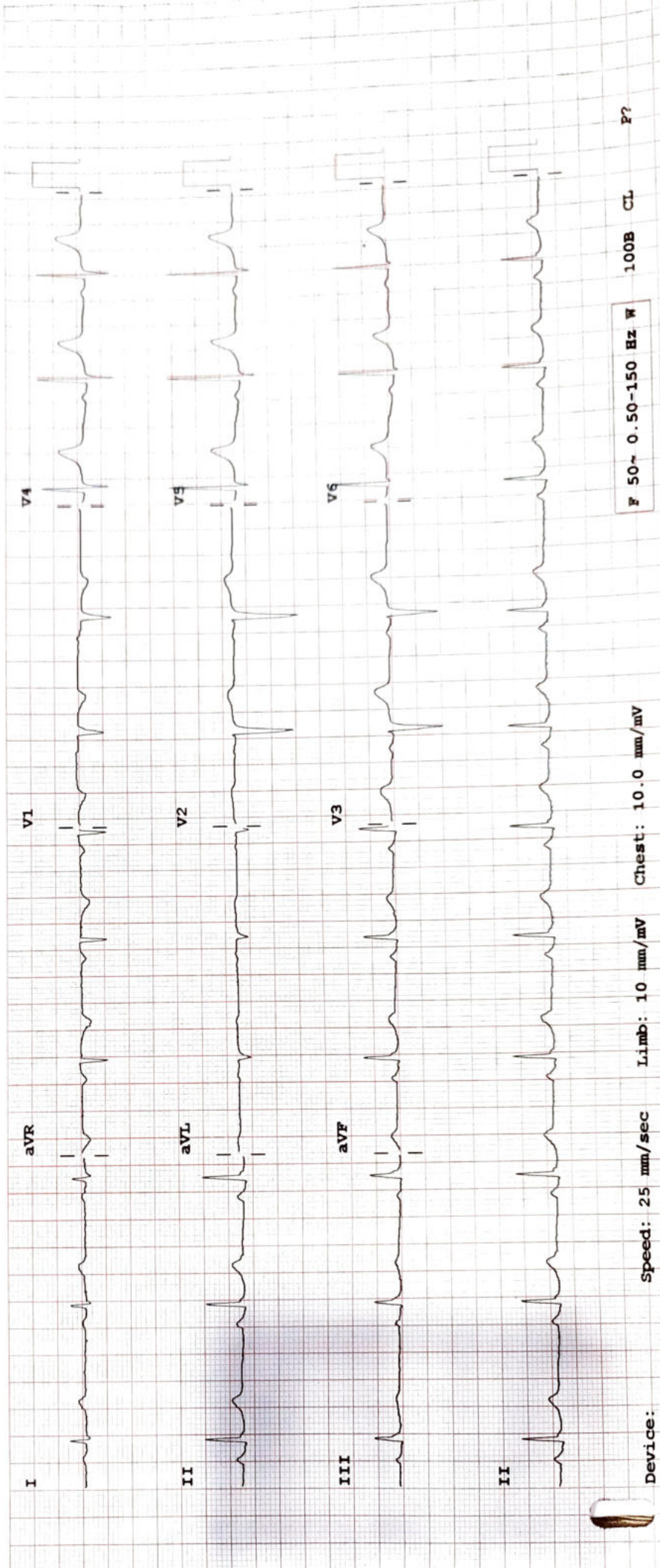
--AXIS--

P 59
QRS 78
T 52

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



F 50~ 0.50-150 Hz W

100B CL

P?

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

Device: