

Name	MRS.DHANYA ASOKAN	ID	MED110660412
Age & Gender	31Y/FEMALE	Visit Date	03/11/2021
Ref Doctor	MediWheel		

:2:

OVARIES are normal in size are normal in size and show polycystic morphology.

Right ovary shows a follicle measuring 17 x 15mm.

Ovaries measures as follows:

Right ovary: 3.3 x 2.3 x 2.6 cms, vol-10.7ml.

Left ovary: 2.9 x 1.8 x 2.4 cms, vol-6.6ml.

POD & adnexa are free.

No evidence of ascites.

Impression:

- *Cholelithiasis.*
- *Thickened endometrium.*
- *Bilateral polycystic ovaries.*

Note: No previous reports available for comparison.

CONSULTANT RADIOLOGISTS:

DR. H. K. ANAND

DR. PRAJNA SHENOY

DR. MAHESH. M. S

DR. RADHA KRISHNA. A.

DR. HIMA BINDU.P

Ms/so

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ABDOMINO-PELVIC ULTRASONOGRAPHY

LIVER is normal in shape, size and has uniform echopattern.
No evidence of focal lesion or intrahepatic biliary ductal dilatation.
Hepatic and portal vein radicals are normal.

GALL BLADDER shows a calculus measuring 13mm.
Gall bladder wall is of normal thickness.
CBD is of normal calibre.

PANCREAS has normal shape, size and uniform echopattern.
No evidence of ductal dilatation or calcification.

SPLEEN show normal shape, size and echopattern.

No demonstrable Para -aortic lymphadenopathy.

KIDNEYS move well with respiration and have normal shape, size and echopattern.
Cortico- medullary differentiations are well madeout.
No evidence of calculus or hydronephrosis.

The kidney measures as follows

	Bipolar length (cms)	Parenchymal thickness (cms)
Right Kidney	9.4	1.6
Left Kidney	9.7	1.8

URINARY BLADDER show normal shape and wall thickness.
It has clear contents. No evidence of diverticula.

UTERUS is anteverted and has normal shape and size.

It has uniform myometrial echopattern.

Endometrium is thickened and measures 18mm.

Uterus measures as follows:

LS: 7.3cms AP: 3.1cms TS: 4.7cms.

31 Years
Female

03.11.2021 11:13:52
CLUMAX DIAGNOSTICS
JAYANAGAR
BANGALORE

QRS : 84 ms
QT / QTcBaz : 388 / 442 ms
PR : 142 ms
P : 90 ms
RR / PP : 770 / 769 ms
P / QRS / T : 63 / 27 / 32 degrees

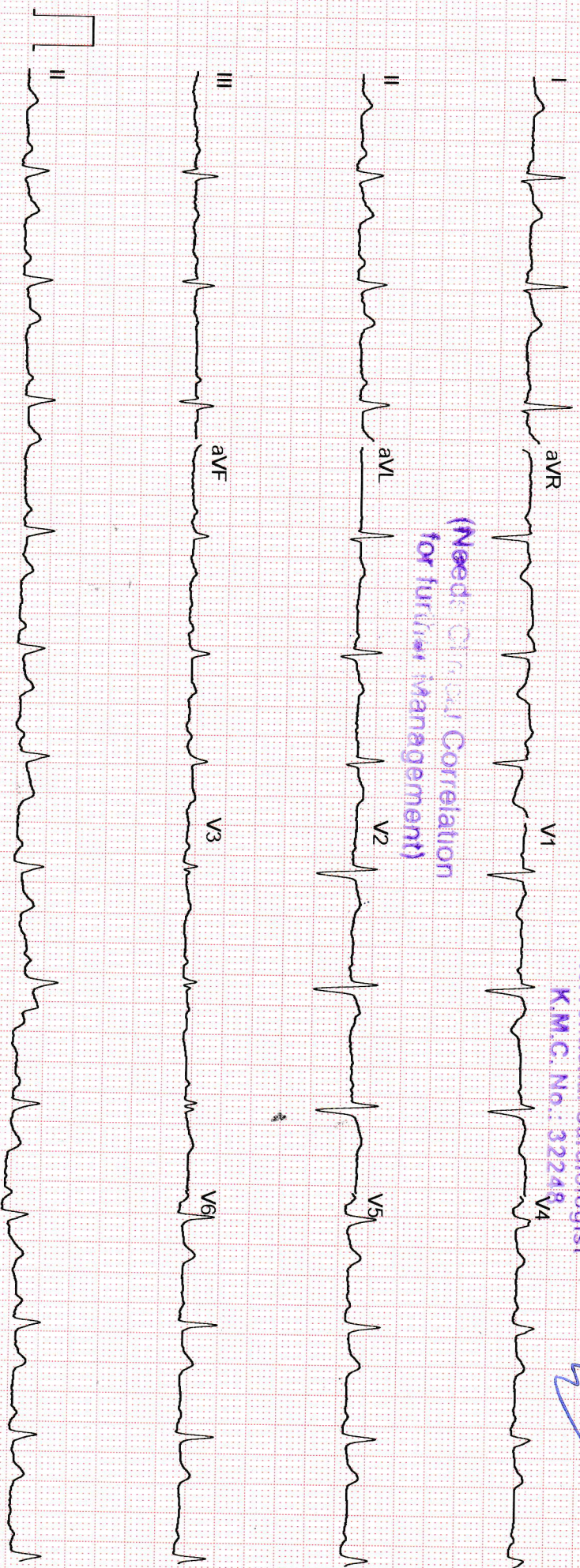


(Need Clinical Correlation
for further management)

DR. SRIDHAR L
MD (Med), DM (Cardio), FICG
Interventional Cardiologist
K.M.C. No.: 32249

HR - 78bpm
WR
WMS + 40°
Normal STV WMS
Normal STV

Technician: koms
Ordering Ph: MEDI WEEL
Referring Ph: MEDI WEEL
Attending Ph:



GE MAC2000 1.1 12SL™ V241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz 4x2.5x3_25_R1 Unconfirmed

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2D ECHOCARDIOGRAPHIC STUDY

M mode measurement:

AORTA	:	2.65	cms
LEFT ATRIUM	:	2.65	cms
AVS	:	1.22	cms
LEFT VENTRICLE (DIASTOLE)	:	3.39	cms
(SYSTOLE)	:	2.29	cms
VENTRICULAR SEPTUM (DIASTOLE)	:	0.86	cms
(SYSTOLE)	:	1.59	cms
POSTERIOR WALL (DIASTOLE)	:	0.98	cms
(SYSTOLE)	:	1.76	cms
EDV	:	47	ml
ESV	:	17	ml
FRACTIONAL SHORTENING	:	32	%
EJECTION FRACTION	:	62	%
EPSS	:		cms
RVID	:	1.92	cms

DOPPLER MEASUREMENTS:

MITRAL VALVE	: 'E' -0.85m/s 'A' -0.55m/s	NO MR
AORTIC VALVE	:1.27 m/s	NO AR
TRICUSPID VALVE	: 'E' - 0.68 m/s 'A' - m/s	NO TR
PULMONARY VALVE	: 0.84 m/s	NO PR

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2D ECHOCARDIOGRAPHY FINDINGS:

Left Ventricle	:	Normal size, Normal LV function, No regional wall motion abnormalities.
Left Atrium	:	Normal
Right Ventricle	:	Normal
Right Atrium	:	Normal.
Mitral valve	:	Normal, No mitral valve prolapse.
Aortic valve	:	Normal, Trileaflet .
Tricuspid valve	:	Normal.
Pulmonary valve	:	Normal.
IAS	:	Intact.
IVS	:	Intact.
Pericardium	:	No Pericardial effusion.

IMPRESSION :

- NORMAL SIZED CARDIAC CHAMBERS
- NORMAL LV SYSTOLIC FUNCTION. EF : 62 %
- NO REGIONAL WALL MOTION ABNORMALITIES
- NORMAL VALVES
- NO CLOTS / PERICARDIAL EFFUSION / VEGETATION.

(KINDLY CORRELATE CLINICALLY AND WITH ECG)

DR.SRIDHAR.L MD,DM,FICC.
CONSULTANT CARDIOLOGIST

Ls/ml

Dr. SRIDHAR .L

MD,(Med), DM(Cardio), FICC
Interventional Cardiologist

K.M.C. No.: 32248

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X - RAY CHEST PA VIEW

Bilateral lung fields appear normal.

Cardiac size is within normal limits.

Bilateral hilar regions appear normal.

Bilateral domes of diaphragm and costophrenic angles are normal.

Visualised bones and soft tissues appear normal.

Impression: Essentially normal study.

DR. H.K. ANAND

DR. SHWETHA S

DR. PRAJNA SHENOY

DR. MAHESH M S

CONSULTANT RADIOLOGISTS

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Investigation Observed Value Unit Biological Reference Interval


HAEMATOLOGY

Complete Blood Count With - ESR

Haemoglobin (EDTA Blood/Spectrophotometry)	13.7	g/dL	12.5 - 16.0
Packed Cell Volume(PCV)/Haematocrit (EDTA Blood/Derived from Impedance)	41.8	%	37 - 47
RBC Count (EDTA Blood/Impedance Variation)	5.11	mill/cu.mm	4.2 - 5.4
Mean Corpuscular Volume(MCV) (EDTA Blood/Derived from Impedance)	82.0	fL	78 - 100
Mean Corpuscular Haemoglobin(MCH) (EDTA Blood/Derived from Impedance)	26.8	pg	27 - 32
Mean Corpuscular Haemoglobin concentration(MCHC) (EDTA Blood/Derived from Impedance)	32.8	g/dL	32 - 36
RDW-CV (EDTA Blood/Derived from Impedance)	14.1	%	11.5 - 16.0
RDW-SD (EDTA Blood/Derived from Impedance)	40.47	fL	39 - 46
Total Leukocyte Count (TC) (EDTA Blood/Impedance Variation)	11100	cells/cu.mm	4000 - 11000
Neutrophils (EDTA Blood/Impedance Variation & Flow Cytometry)	60.3	%	40 - 75
Lymphocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	31.3	%	20 - 45
Eosinophils (EDTA Blood/Impedance Variation & Flow Cytometry)	2.2	%	01 - 06


Dr SONAL H K MD
CONSULTANT PATHOLOGIST
KMC No - 110249

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DR SHAMIM JAVED
MD PATHOLOGY
KMC 88902

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Monocytes (EDTA Blood/Impedance Variation & Flow Cytometry)	5.6	%	02 - 10
Basophils (EDTA Blood/Impedance Variation & Flow Cytometry)	0.6	%	00 - 02
Absolute Neutrophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	6.69	10 ³ / μ l	1.5 - 6.6
Absolute Lymphocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	3.47	10 ³ / μ l	1.5 - 3.5
Absolute Eosinophil Count (AEC) (EDTA Blood/Impedance Variation & Flow Cytometry)	0.24	10 ³ / μ l	0.04 - 0.44
Absolute Monocyte Count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.62	10 ³ / μ l	< 1.0
Absolute Basophil count (EDTA Blood/Impedance Variation & Flow Cytometry)	0.07	10 ³ / μ l	< 0.2
Platelet Count (EDTA Blood/Impedance Variation)	535	10 ³ / μ l	150 - 450
MPV (EDTA Blood/Derived from Impedance)	7.6	fL	8.0 - 13.3
PCT (EDTA Blood/Automated Blood cell Counter)	0.41	%	0.18 - 0.28
ESR (Erythrocyte Sedimentation Rate) (EDTA Blood/Modified Westergren)	10	mm /1st hr	0 - 20


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BIOCHEMISTRY

Liver Function Test

Bilirubin(Total) (Serum/Diazotized Sulfanilic Acid)	0.8	mg/dL	0.1 - 1.2
Bilirubin(Direct) (Serum/Diazotized Sulfanilic Acid)	0.3	mg/dL	0.0 - 0.3
Bilirubin(Indirect) (Serum/Derived)	0.5	mg/dL	0.1 - 1.0
Total Protein (Serum/Biuret)	7.0	g/dL	6.0 - 8.3
Albumin (Serum/Bromocresol green)	4.2	g/dL	3.5 - 5.2
Globulin (Serum/Derived)	2.8	g/dL	2.3 - 3.5
A : G Ratio (Serum/Derived)	1.5		1.5 - 2.5
SGOT/AST (Aspartate Aminotransferase) (Serum/IFCC Kinetic)	20	U/L	5 - 40
SGPT/ALT (Alanine Aminotransferase) (Serum/IFCC / Kinetic)	27	U/L	5 - 41
Alkaline Phosphatase (SAP) (Serum/IFCC Kinetic)	107	U/L	42 - 98
GGT(Gamma Glutamyl Transpeptidase) (Serum/SZASZ standarised IFCC)	23	U/L	< 38


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KMC NO: 38205
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<u>Lipid Profile</u>			
Cholesterol Total (Serum/Cholesterol oxidase/Peroxidase)	187	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/Glycerol phosphate oxidase / peroxidase)	69	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >= 500

INTERPRETATION: The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the "usual" circulating level of triglycerides during most part of the day.

HDL Cholesterol (Serum/Immunoinhibition)	40	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 50 - 59 High Risk: < 50
LDL Cholesterol (Serum/Calculated)	133.2	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/Calculated)	13.8	mg/dL	< 30
Non HDL Cholesterol (Serum/Calculated)	147.0	mg/dL	Optimal: <130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >=220

INTERPRETATION: 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol.
2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.


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Total Cholesterol/HDL Cholesterol Ratio (Serum/Calculated)	4.7		Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/Calculated)	1.7		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0
LDL/HDL Cholesterol Ratio (Serum/Calculated)	3.3		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0


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<u>Investigation</u>	<u>Observed Value</u>	<u>Unit</u>	<u>Biological Reference Interval</u>
<u>Glycosylated Haemoglobin (HbA1c)</u>			
HbA1C (Whole Blood/HPLC)	5.7	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: \geq 6.5

INTERPRETATION: If Diabetes - Good control : 6.1 - 7.0 % , Fair control : 7.1 - 8.0 % , Poor control \geq 8.1 %

Estimated Average Glucose 116.89 mg/dL
(Whole Blood)

INTERPRETATION: Comments

HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency, hypertriglyceridemia, hyperbilirubinemia, Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values.

Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly, Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.


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IMMUNOASSAY

THYROID PROFILE / TFT

T3 (Triiodothyronine) - Total (Serum/CMIA)	0.87	ng/mL	0.7 - 2.04
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INTERPRETATION:

Comment :

Total T3 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T3 is recommended as it is Metabolically active.

T4 (Thyroxine) - Total (Serum/CMIA)	8.26	µg/dL	4.2 - 12.0
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INTERPRETATION:

Comment :

Total T4 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T4 is recommended as it is Metabolically active.

TSH (Thyroid Stimulating Hormone) (Serum/Chemiluminescent Microparticle Immunoassay(CMIA))	1.25	µIU/mL	0.35 - 5.50
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INTERPRETATION:

Reference range for cord blood - upto 20

1 st trimester: 0.1-2.5

2 nd trimester 0.2-3.0

3 rd trimester : 0.3-3.0

(Indian Thyroid Society Guidelines)

Comment :

1.TSH reference range during pregnancy depends on Iodine intake, TPO status, Serum HCG concentration, race, Ethnicity and BMI.

2.TSH Levels are subject to circadian variation, reaching peak levels between 2-4am and at a minimum between 6-10PM.The variation can be of the order of 50%,hence time of the day has influence on the measured serum TSH concentrations.

3.Values&lt;0.03 µIU/mL need to be clinically correlated due to presence of rare TSH variant in some individuals.


DR SHAMIM JAVED
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CLINICAL PATHOLOGY

PHYSICAL EXAMINATION


Colour (Urine)	Pale yellow		
Volume (Urine)	10	mL	
Appearance (Urine)	Slightly hazy		Clear

CHEMICAL EXAMINATION(Automated-Urineanalyser)

pH (Urine/AUTOMATED URINANALYSER)	5.0		4.5 - 8.0
Specific Gravity (Urine)	1.025		1.002 - 1.035
Protein (Urine)	Negative	mg/dL	Negative
Glucose (Urine)	Negative	mg/dL	Negative
Ketones (Urine)	Negative	mg/dL	Negative
Leukocytes (Urine)	Negative	leuco/uL	Negative
Nitrite (Urine/AUTOMATED URINANALYSER)	Negative		Negative
Bilirubin (Urine/AUTOMATED URINANALYSER)	Negative	mg/dL	Negative
Blood (Urine/AUTOMATED URINANALYSER)	Negative	Ery/uL	Negative


Dr BIDISHA DE MD
CONSULTANT PATHOLOGIST
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Urobilinogen (Urine/AUTOMATED URINANALYSER)	0.2	mg/dL	0.2 - 1.0
<u>MICROSCOPY(URINE DEPOSITS)</u>			
Pus Cells (Urine/Flow cytometry)	2 - 3	/hpf	3-5
Epithelial Cells (Urine)	8 - 10	/hpf	1-2
RBCs (Urine/Flow cytometry)	Nil	/hpf	2-3
Others (Urine)	Bacteria present		Nil


Dr BIDISHA DE MD
CONSULTANT PATHOLOGIST
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PHYSICAL EXAMINATION


Colour (Stool)	Brownish		
Consistency (Stool)	Semi solid		Semi solid to solid
Mucus (Stool)	Absent		Absent
Blood (Stool)	Absent		Absent

CHEMICAL EXAMINATION


Reducing Substances (Stool)	Negative		Negative
Reaction (Stool)	Alkaline		Alkaline

MICROSCOPIC EXAMINATION(STOOL COMPLETE)

Ova (Stool)	Not Found		Not Found
Cysts (Stool)	Not Found		Not Found
Trophozoites (Stool)	Not Found		Not Found
Pus Cells (Stool/Microscopy)	0-1	/hpf	Nil
RBCs (Stool/Microscopy)	Nil	/hpf	Nil
Others (Stool)	Nil		Nil


Dr BIDISHA DE MD
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BIOCHEMISTRY

BUN / Creatinine Ratio	11		6 - 22
Glucose Fasting (FBS) (Plasma - F/GOD - POD)	123	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126

INTERPRETATION: Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level.

Glucose Fasting - Urine (Urine - F)	Negative		Negative
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Glucose Postprandial (PPBS) (Plasma - PP/GOD - POD)	130	mg/dL	70 - 140
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INTERPRETATION:

Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level. Fasting blood glucose level may be higher than Postprandial glucose, because of physiological surge in Postprandial Insulin secretion, Insulin resistance, Exercise or Stress, Dawn Phenomenon, Somogyi Phenomenon, Anti- diabetic medication during treatment for Diabetes.

Blood Urea Nitrogen (BUN) (Serum/Urease-GLDH)	8	mg/dL	7.0 - 21
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Creatinine (Serum/Jaffe Kinetic)	0.7	mg/dL	0.6 - 1.1
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INTERPRETATION: Elevated Creatinine values are encountered in increased muscle mass, severe dehydration, Pre-eclampsia, increased ingestion of cooked meat, consuming Protein/ Creatine supplements, Diabetic Ketoacidosis, prolonged fasting, renal dysfunction and drugs such as cefoxitin ,cefazolin, ACE inhibitors ,angiotensin II receptor antagonists, N-acetylcysteine, chemotherapeutic agent such as flucytosine etc.

Uric Acid (Serum/Uricase/Peroxidase)	5.0	mg/dL	2.6 - 6.0
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IMMUNOHAEMATOLOGY

BLOOD GROUPING AND Rh TYPING
(EDTA Blood/Agglutination)

'A' 'Positive'

A handwritten signature in black ink, appearing to read "Bidisha".

Dr BIDISHA DE MD
CONSULTANT PATHOLOGIST
KMC NO:110691

VERIFIED BY

A handwritten signature in black ink, appearing to read "Shamim Javed".

DR SHAMIM JAVED
MD PATHOLOGY
KMC 88902

APPROVED BY

-- End of Report --

PATIENT SUMMARY

Page 1 of 1

Patient : DHANYA ASOKAN - 31/Years
Address : CLUMAX
Phone : +919497470389

OP Number : KA-PEC2021/340152

03/11/2021

OPTOMETRIST FINDINGS (-12:04:04)

WITH EXISTING GLASS DIST 6/6 RE 6/6 LE

WITH EXISTING GLASS NEAR N6 RE N6 LE

COLOR VISION RE Normal LE Normal

Sleeping with Contact Lens NO

DOCTOR ADVICE (DR.KEERTI MUKESH - 12:05:16)

PRESENTING COMPLAINTS clumax screening camp

LIDS & ADNEXA RE: NORMAL; LE: NORMAL

PUPIL RE: RRR; LE: RRR

CORNEA RERE: CLEAR; LE: CLEAR

LENS RERE: CLEAR; LE: CLEAR

CONJUNCTIVA RERE: NORMAL; LE: NORMAL

ANTERIOR CHAMBER RE:NORMAL; LE: NORMAL

Printed On 3/11/21 12:24:31 PM

***** END *****

Thanking you for giving us an opportunity to provide you eye care services.



Sign-up & Health Assessment Form

To be filled by Customer

Name: Mr/Ms/Mrs **D H A N Y A A S O K A N**

Gender: Male Female Age: **31** years DOB: **19 / 12 / 1989**

Mobile: **9497470389** Pincode: **560004**

Bar code

Vitals

To be filled by Technician

Height: **156** cms

Waist: **38** in.

Wrist: **43** in.

Weight: **72.7** kg

Heart rate: **40.3** %

Body Fat: **71.0** %

BMI: **1413** cal

Body Mass Index: **29.9** kg/m²

Body Age: **53** years

Resting BP: **108** mmHg

Diastolic BP: **79** mmHg

PULSE-91

To be filled by Customer

Medical History

Have you been previously diagnosed with?

Diabetes (Sugar) Yes No *Pre diabetic*

Hypertension (BP) Yes No

Cardiovascular Disease (Heart) Yes No

Asthma/Allergies (Dust, Pollen, Food, Animals, etc.) Yes No *Dust*

Neurological Problems (Nerve) Yes No

Are you currently taking medications for?

Diabetes (Sugar) Yes No

Hypertension (BP) Yes No

Cardiovascular Disease (Heart) Yes No

Liver Disease Yes No

Cancer Yes No

Tuberculosis (TB) Yes No

Family History

Is there a history of below diseases in your family?

Diabetes (Sugar) Yes No

Hypertension (BP) Yes No

Cardiovascular Disease (Heart) Yes No

Cancer Yes No

Lifestyle

Do you exercise regularly? Yes No

Do you consume alcohol more than 2 times a week? Yes No

Do you smoke/chew tobacco? Yes No

Are you vegetarian? Yes No

General

Do you see a doctor at least once in 6 months? Yes No

Do you undergo a health checkup every year? Yes No

How would you rate your overall Health? Excellent Good Normal Poor Very Poor

Women's Health

Is there a family history of Breast Cancer? Yes No

Is there a family history of Endometrial (Uterus) Cancer? Yes No

Is there a family history of Ovarian Cancer? Yes No

Do you have irregular periods? Yes No

Do you have heavy bleeding during periods? Yes No

Do you have scanty periods? Yes No

Have you attained Menopause? Yes No