

MEDICAL SUMMARY

NAME:	Vishnu Granane	UHID:	4995
AGE:	36 yrs	DATE OF HEALTHCHECK:	11-2-2023
GENDER:	male	BMI	

HEIGHT:	169cm	MARITAL STATUS:	yes
WEIGHT:	70.7 kg	NO OF CHILDREN:	1

BMI- 24.8

C/O: Low back pain
Pain in upper abdomen

K/C/O: Nil

PRESENT MEDICATION: Nil

P/M/H: No

P/S/H: No

H/A: SMOKING: }
ALCOHOL: } N.
TOBACCO/PAN: }

FAMILY HISTORY FATHER: } Hypertension
MOTHER: } No

O/E: N.

LYMPHADENOPATHY: No

BP: 140/100 PULSE: 68 reg.

PALLOR/LCTERUS/CYNOSIS/CLUBBING: No

TEMPERATURE: N. SCARS: No

OEDEMA: Absent

S/E:  PEBC
RS: Coarse sounds

P/A:  Soft, Non tender

CVS: S1S2 -N.

Extremities & Spine: -N.

CNS: -N.

ENT: }
Skin: } N.

Vision:

	Without Glass		With Glass	
	Right Eye	Left eye	Right Eye	Left eye
FAR :	—————			
NEAR :	—————			
COLOUR VISION:				
ADVISE :				

• ANDHERI • COLABA • NASHIK • VASHI

OPHTHALMIC EVALUATION

UHID No.: 4925 Date: 11/02/2023

Name: Mr. Vishnu Gangane Age: 36 Gender: Male/Female

Without Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye N-6 Left Eye N-6

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye _____ Left Eye _____

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near										

Colour Vision : (BE) WNL

Anterior Segment Examination : (BE) WNL

Pupils : (BE) WNL

Fundus : (BE) WNL

Indil
Intraocular Pressure : _____

Diagnosis : (BE) WNL

Advice : _____

Re-Check on _____ (This Prescription needs verification every year)

DR. SAGORIKA DEY
MBBS, DOMS

Dr. REGN NO: 2008/04/1182
(Consultant Ophthalmologist)

Sdey

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: <u>Vishnu</u>	MR NO:
Age/Gender : <u>36 M</u>	Date: <u>11/2</u>

Medical history: Diabetes Hypertension _____

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains				
Mobility				
Caries (Cavities)				
a) Class 1 (Occlusal)				
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

NA

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: Scaling & polishing
 Orthodontic Advice for Braces: Yes / No
 Prosthetic Advice to Replace Missing Teeth: Denture Bridge Implant
 Oral Habits: Tobacco Cigarette Others since ___ years
 Advice to quit any form of tobacco as it can cause cancer.
 Other Findings: NA

dl

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Name : Mr. Vishnu Pandurang Gangane Gender : Male Age : 36 Years
 UHID : FVAH 4995. Bill No : Lab No: V-246-23
 Ref. by : SELF Sample Col.Dt : 11/02/2023 08:30
 Barcode No : 4942 Reported On : 11/02/2023 21:03


TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

CBC (Complete Blood Count)-WB (EDTA)

Haemoglobin(Colorimetric method)	16.3	g/dl	13 - 18
RBC Count (Impedance)	5.12	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	47.8	%	35 - 55
MCV:(Calculated parameter)	93.4	fl	78 - 98
MCH:(Calculated parameter)	31.8	pg	26 - 34
MCHC:(Calculated parameter)	34.1	gm/dl	30 - 36
RDW-CV:	13.5	%	11.5 - 16.5
Total Leucocyte count(Impedance)	5790	/cumm.	4000 - 10500
Neutrophils:	45	%	40 - 75
Lymphocytes:	40	%	20 - 40
Eosinophils:	10	%	0 - 6
Monocytes:	05	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.74	Lakhs/c.mm	1.5 - 4.5
MPV	8.4	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic, Normocytic		
WBCs:	Eosinophilia		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter.		

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Dr. Vinod Patwardhan
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M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

ESR(Westergren Method)

Erythrocyte Sedimentation Rate:- 02 mm/1st hr 0 - 20

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TEST

RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group:

:O:

Rh Type:

Negative

Method :

Tube Agglutination (forward and reverse)

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Apollo Clinic
VASHI

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 4.9 %
Normal <5.7 %
Pre Diabetic 5.7 - 6.5 %
Diabetic >6.5 %
Target for Diabetes on therapy < 7.0 %
Re-evaluation of therapy > 8.0 %

Mean Blood Glucose : 93.93 mg/dL

Correlation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298


Method High Performance Liquid Chromatography (HPLC).

INTERPRETATION

- * The HbA1c levels correlate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
- * This Methodology is better than the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints and uremia does not INTERFERE with the results in this methodology.
- * It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts.& every 3 - 4 months in well controlled daibetics .
- * Mean blood glucose (MBG) in first 30 days (0-30)before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

PLASMA GLUCOSE

Fasting Plasma Glucose : 91 mg/dL Normal < 100 mg/dL
Impaired Fasting glucose : 101 to 125 mg/dL
Diabetes Mellitus : ≥ 126 mg/dL
(on more than one occasion)
(American diabetes association guidelines 2016)

Post Prandial Plasma Glucose : 70 mg/dL Normal < 140 mg/dL
Impaired Post Prandial glucose : 140 to 199 mg/dL
Diabetes Mellitus : ≥ 200 mg/dL
(on more than one occasion)
(American diabetes association guidelines 2016)

Method : Hexokinase

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Lipid Profile- Serum			
S. Cholesterol(Oxidase)	158	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	98	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	19.6	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	37.1	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	101.3	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4.3		3.5 - 5
Ratio of LDL/HDL	2.7		2.5 - 3.5

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Page 6 of 10 MD(Path)
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.60	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.67	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.93	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.59		0.9 - 2
S.Total Bilirubin (DPD):	0.60	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.18	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.42	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	15	U/L	5 - 36
S.ALT (SGPT) (IFCC Kinetic with P5P):	11	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	66	U/L	40 - 129
S.GGT(IFCC Kinetic):	8	U/L	11 - 50

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	19.5 mg/dl	10.0 - 45.0
BUN (Calculated)	9.1 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.99 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	9.19	9:1 - 23:1
S.Uric Acid(Uricase Method)	4.2 mg/dl	3.4 - 7.0

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Thyroid (T3,T4,TSH)- Serum

Total T3 (Tri-iodo Thyronine) (ECLIA)	2.02	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	104.1	nmol/L	66 - 181 nmol/L
TSH (Thyroid-stimulating hormone) (ECLIA)	4.68	□IU/mL	Euthyroid :0.35 - 5.50 □IU/mL Hyperthyroid : < 0.35 □IU/mL Hypothyroid : > 5.50 □IU/mL

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	40	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	5.0		4.6 - 8.0
SPECIFIC GRAVITY	1.010		1.005 - 1.030
URINE ALBUMIN	Absent		Absent
URINE SUGAR(Qualitative)	Absent		Absent
KETONES	Absent		Absent
BILE SALTS	Absent		Absent
BILE PIGMENTS	Absent		Absent
UROBILINOGEN	Normal(<1 mg/dl)		Normal
OCCULT BLOOD	Absent		Absent
Nitrites	Absent		Absent

MICROSCOPIC EXAMINATION

PUS CELLS	Occasional		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	2 - 3 /hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

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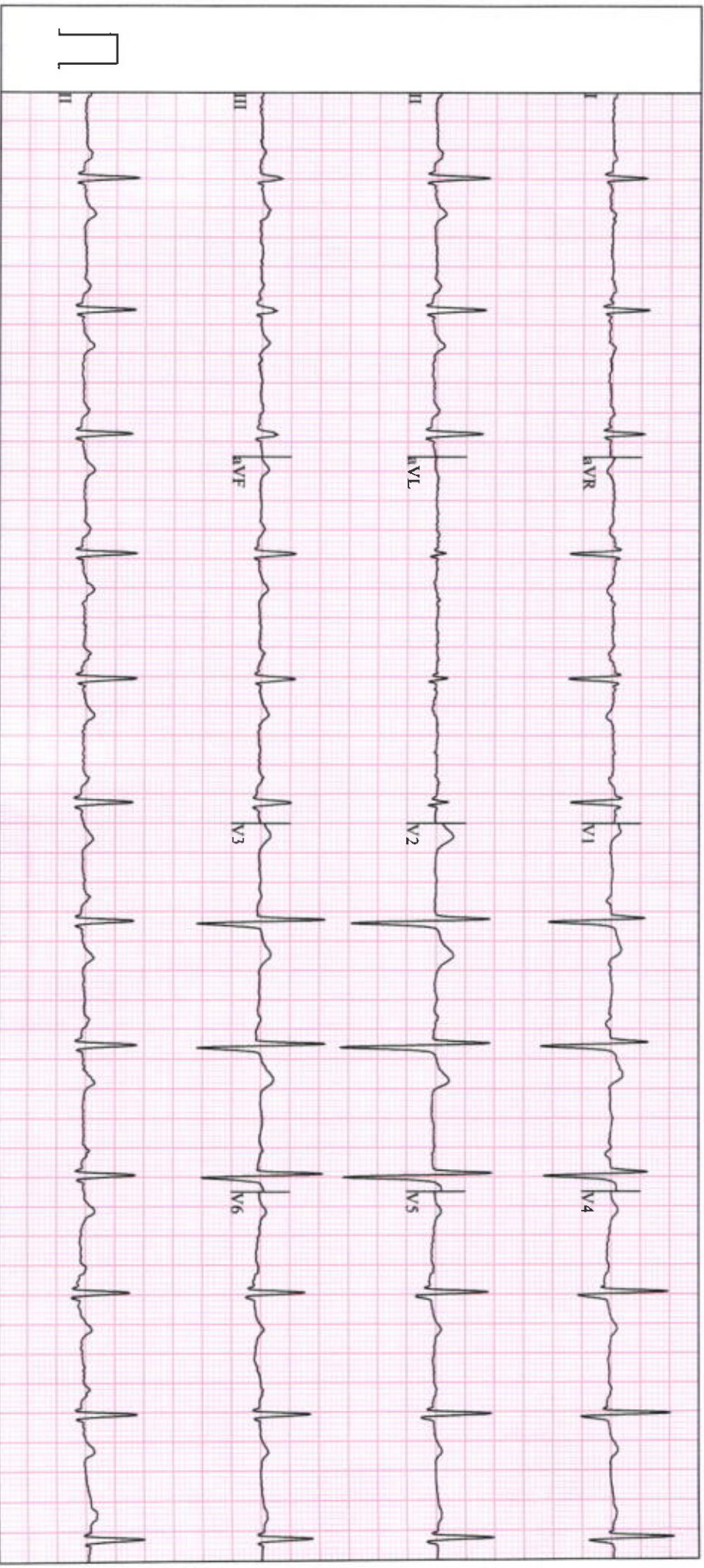
QRS : 88 ms
QT / QTcBaz : 380 / 412 ms
PR : 170 ms
P : 100 ms
RR / PP : 840 / 845 ms
P / QRS / T : 52 / 52 / 76 degrees

Normal sinus rhythm
Normal ECG

W.C.

DR. ANIRBAN DASGUPTA
M.B., B.S., D.N.B. Medicine
Diploma Cardiology
MMC - 2005/02/0920

NORMAL ECG



Apollo Clinic
The Emerald, Plot No-195/B, Sector-12,
Neel Siddhi Towers, Vashi-400703

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: VISHNU, GANGANE
Patient ID: 4995
Height:
Weight:

DOB: 02.01.1987
Age: 36yrs
Gender: Male
Race: Asian

Study Date: 11.02.2023
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR. ANIRBAN DASGUPTA
Technician: Anu Salve

Medications:
NIL

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	00:08	0.00	0.00	61	140/90	
	STANDING	00:18	0.00	0.00	70	140/90	
	HYPERV.	00:18	0.00	0.00	66	140/90	
EXERCISE	WARM-UP	00:09	0.70	0.00	65	140/90	
	STAGE 1	03:00	1.70	10.00	102	140/90	
	STAGE 2	03:00	2.50	12.00	126	140/90	
	STAGE 3	03:00	3.40	14.00	160	160/100	
RECOVERY	STAGE 4	00:26	4.20	16.00	169	160/100	
		01:04	0.00	0.00	136	170/90	

The patient exercised according to the BRUCE for 9:26 min:s, achieving a work level of Max. METS: 11.40. The resting heart rate of 61 bpm rose to a maximal heart rate of 171 bpm. This value represents 92 % of the maximal, age-predicted heart rate. The resting blood pressure of 140/90 mmHg, rose to a maximum blood pressure of 170/90 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: none.
Overall impression: Normal stress test.

Conclusions

TMT IS NEGATIVE FOR INDUCIBLE MYOCARDIAL ISCHAEMIA AT THE WORKLOAD ACHIEVED.

Physician-DR. ANIRBAN DASGUPTA

Anirban Dasgupta

Dr. ANIRBAN DASGUPTA
M.B., B.S., D.N.B. Medicine
Diploma Cardiology
MMC -2005/02/0920

PATIENT'S NAME	VISHNU P GANGANE	AGE : 36 Y/ MALE
UHID NO	4995	DATE :- 11-02-23

X-RAY CHEST PA VIEW

OBSERVATION:

Bilateral lung fields are clear.
Both hila are normal.
Bilateral cardiophrenic and costophrenic angles are normal.
The trachea is central.
Aorta appears normal.
The mediastinal and cardiac silhouette are normal.
Soft tissues of the chest wall are normal.
Bony thorax is normal.

IMPRESSION:

➤ No significant abnormality seen.



DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

• ANDHERI • COLABA • NASHIK • VASHI

PATIENT'S NAME	VISHNU P GANGANE	AGE :- 36 y/M
UHID NO	4995	11 Feb 2023

USG WHOLE ABDOMEN

LIVER is normal in size, shape and shows bright echotexture .No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

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

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen. **RIGHT KIDNEY** measures 9.7 x 4.2 cm. **LEFT KIDNEY** measures 9.2 x 4.2 cm.

Urinary Bladder is adequately distended; no e/o any obvious wall thickening or mass or calculi seen.

PROSTATE is normal in size, shape & echotexture. It measures approximately 17 gms.

Visualised bowel loops appear normal. There is no free fluid seen.

IMPRESSION –

- **Grade I fatty liver.**
- **No other significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

Name: Mr. Vishnu Gargane Age: 36 Date of Health check-up: 11/02/2023

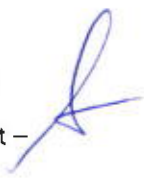
Findings and Recommendation:

Findings:-

Grade I Falb/ur

Recommendation:-

-> No Out/cur

Signature: 
Consultant -

DR. ANIRBAN DASGUPTA
MBBS, D.N.B MEDICINE
DIPLOMA CARDIOLOGY
MMC- 2005/02/0920