

भारत सरकार
Government of India



मुकेश कुमार सैनी
Mukesh Kumar Saini
जन्म तिथि/DOB: 02/05/1983
पुरुष/ MALE

8666 7896 5400
VID : 9123 9822 4933 9308

मेरा आधार, मेरी पहचान

Gum

Piyush Goyal
Dr. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No.-037041

भारतीय विश्वविद्यालय पहचान प्राधिकरण
Unique Identification Authority of India



पता:
S/O: राम चंद्र सैनी, धरौं जंताला, मवाड़ा कालन, सिकर,
राजस्थान - 332711

Address:
S/O: Ram Chandra Saini, dhari jantala,
Mowarda Kalan, Sikar,
Rajasthan - 332711

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General Physical Examination

Date of Examination: 28/10/23

Name: MUNESHKUMAR SAINI Age: 40YRS DOB: 02/06/1983 Sex: Male

Referred By: BANK OF BARODA

Photo ID: AADHAR CARD#: 5400

Ht: 178 (cm)

Wt: 89 (Kg)

Chest (Expiration): 105 (cm)

Abdomen Circumference: 86 (cm)

Blood Pressure: 120/80 mm Hg PR: 79/min RR: 18/min Temp: Afebrile

BMI 28.1

Eye Examination: R/E - BIC. NIG. NCB
L/E - BIC. NIG. NCB

Other: No

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

Signature Of Examinee: [Signature]

Name of Examinee: MUNESHKUMAR SAINI

Signature Medical Examiner: [Signature]

Name Medical Examiner: DR. PIYUSH GOYAL

Dr. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No.-037041



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NAME :- Mr. MUKESH KUMAR SAINI

Age :- 40 Yrs 4 Mon 28 Days

Sex :- Male

Patient ID :-42233840

Date :- 28/10/2023

12:17:49

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 28/10/2023 17:26:30

HAEMOGARAM

HAEMATOLOGY

| Test Name | Value | Unit | Biological Ref Interval |
|--|-------|---------------------------|-------------------------|
| FULL BODY HEALTH CHECKUP BELOW 40 MALE | | | |
| HAEMOGLOBIN (Hb) | 15.8 | g/dL | 13.0 - 17.0 |
| TOTAL LEUCOCYTE COUNT | 6.40 | /cumm | 4.00 - 10.00 |
| DIFFERENTIAL LEUCOCYTE COUNT | | | |
| NEUTROPHIL | 62.0 | % | 40.0 - 80.0 |
| LYMPHOCYTE | 32.0 | % | 20.0 - 40.0 |
| EOSINOPHIL | 2.0 | % | 1.0 - 6.0 |
| MONOCYTE | 4.0 | % | 2.0 - 10.0 |
| BASOPHIL | 0.0 | % | 0.0 - 2.0 |
| TOTAL RED BLOOD CELL COUNT (RBC) | 5.43 | $\times 10^6/\mu\text{L}$ | 4.50 - 5.50 |
| HEMATOCRIT (HCT) | 49.40 | % | 40.00 - 50.00 |
| MEAN CORP VOLUME (MCV) | 91.0 | fL | 83.0 - 101.0 |
| MEAN CORP HB (MCH) | 29.1 | pg | 27.0 - 32.0 |
| MEAN CORP HB CONC (MCHC) | 32.0 | g/dL | 31.5 - 34.5 |
| PLATELET COUNT | 231 | $\times 10^3/\mu\text{L}$ | 150 - 410 |
| RDW-CV | 14.3 | % | 11.6 - 14.0 |

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)

Method - Westergren

12

mm in 1st hr

00 - 15

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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(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 :- | | |
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BIOCHEMISTRY

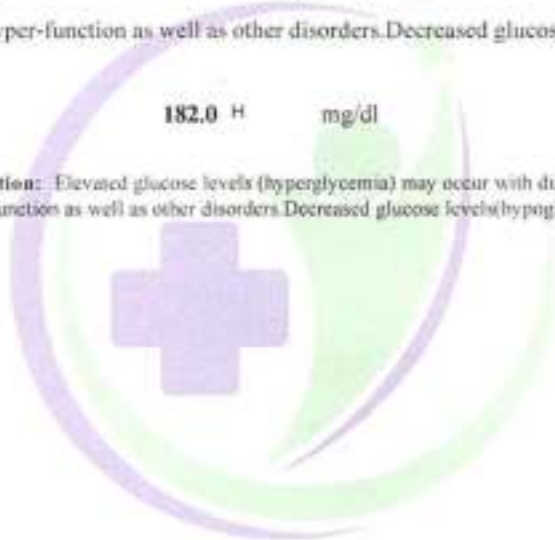
| Test Name | Value | Unit | Biological Ref Interval |
|---|-----------------|-------|-------------------------|
| FASTING BLOOD SUGAR (Plasma) <small>Method - GOD POD</small> | 93.8 | mg/dl | 70.0 - 115.0 |
| Impaired glucose tolerance (IGT) | 111 - 125 mg/dL | | |
| Diabetes Mellitus (DM) | > 126 mg/dL | | |

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)
Method - GOD PAP

182.0 H 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-functions as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases.



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

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HAEMATOLOGY

| Test Name | Value | Unit | Biological Ref Interval |
|--|-------|-------|--|
| GLYCOSYLATED HEMOGLOBIN (HbA1C) Method - CAPILLARY with EDTA | 5.6 | 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 | 110 | 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: alkalosis, chronic renal failure, decreased intracellular 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 arthrosvreals, NSAIDs & diuretics.

5. Others

- Increased HbA1c: hypochromic anemia, carbamylated hemoglobin, alkalosis, 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:

1. 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.
2. 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:

1. To follow patient for glycemic control test like fructosamine or glycated albumin may be performed instead.
2. Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.

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NAME :- Mr. MUKESH KUMAR SAINI

Age :- 40 Yrs 4 Mon 28 Days

Sex :- Male

Patient ID :-42233840

Date :- 28/10/2023

12:17:49

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

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HAEMATOLOGY

BLOOD GROUP ABO

Method:- Haemagglutination reaction

"B" POSITIVE



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| Age :- 40 Yrs 4 Mon 28 Days | Ref. By Doctor:-BANK OF BARODA | | |
| Sex :- Male | Lab/Hosp :- | | |
| | Company :- | Mr.MEDIWHEEL | |

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BIOCHEMISTRY

| Test Name | Value | Unit | Biological Ref Interval |
|---|--------|-------|--|
| LIPID PROFILE | | | |
| TOTAL CHOLESTEROL Method:- CHOD-PAP methodology | 112.00 | mg/dl | Desirable <200 Borderline 200-239 High > 240 |
| <i>InstrumentName:MISPA PLUS Interpretation: Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.</i> | | | |
| TRIGLYCERIDES Method:- GPO-PAP | 132.00 | mg/dl | Normal <150 Borderline high 150-199 High 200-499 Very high >500 |
| <i>InstrumentName:Randox Rx Imola 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.</i> | | | |
| DIRECT HDL CHOLESTEROL Method - Direct clearance Method | 35.50 | mg/dl | MALE- 30-70 FEMALE - 30-85 |
| <i>Instrument Name:Rx Daytona 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.</i> | | | |
| LDL CHOLESTEROL Method - Calculated Method | 54.50 | mg/dl | Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190 |
| VLDL CHOLESTEROL Method:- Calculated | 26.40 | mg/dl | 0.00 - 80.00 |
| T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method:- Calculated | 3.15 | | 0.00 - 4.90 |
| LDL / HDL CHOLESTEROL RATIO Method:- Calculated | 1.54 | | 0.00 - 3.50 |
| TOTAL LIPID Method:- CALCULATED | 403.68 | mg/dl | 400.00 - 1000.00 |
| I. 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. | | | |

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NAME :- Mr. MUKESH KUMAR SAINI

Age :- 40 Yrs 4 Mon 28 Days

Sex :- Male

Patient ID :-12233840

Date :- 28/10/2023 12:17:49

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BIOCHEMISTRY

- 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.
- 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.

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 ≥ 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) <small>Method - DMSO/Diaz</small> | 0.60 | mg/dL | Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL |
| SERUM BILIRUBIN (DIRECT) <small>Method - DMSO/Diaz</small> | 0.21 | mg/dL | Up to 0.40 mg/dL |
| SERUM BILIRUBIN (INDIRECT) <small>Method - Calculated</small> | 0.39 | mg/dl | 0.30-0.70 |
| SGOT <small>Method - IFCC</small> | 23.8 | U/L | 0.0 - 40.0 |
| SGPT <small>Method - IFCC</small> | 39.6 | U/L | 0.0 - 40.0 |
| SERUM ALKALINE PHOSPHATASE <small>Method - DGKC - SCE</small> | 89.60 | U/L | 53.00 - 141.00 |
| SERUM GAMMA GT <small>Method - Sruar methodology Instrument Name Rankin Rn lineal</small> | 32.20 | U/L | 10.00 - 45.00 |
| <small>Interpretation: Elevation in GGT levels occurs earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and resistant alcoholism. It may reach 7 to 70 times normal levels in pre- or post- hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 7 times normal) are observed with infectious hepatitis</small> | | | |
| SERUM TOTAL PROTEIN <small>Method - Direct Buret Reaction</small> | 6.35 | g/dl | 6.00 - 8.40 |
| SERUM ALBUMIN <small>Method - Bromocresol Green</small> | 4.10 | g/dl | 3.50 - 5.50 |
| SERUM GLOBULIN <small>Method - CALCULATION</small> | 2.25 | gm/dl | 2.20 - 3.50 |
| A/G RATIO | 1.82 | | 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 39.60 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 1.33 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 6.22 mg/dl 2.40 - 7.00

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

SODIUM 138.3 mmol/L 135.0 - 150.0
 Method :- IST
 Interpretation:

Electrolytes are minerals that are found in body tissues and blood in the form of dissolved salts. As electrically charged particles, electrolytes help move nutrients into and wastes out of the body's cells, maintain a healthy water balance, and help stabilize the body's acid/base (pH) level. The electrolyte panel measures the blood levels of the main electrolytes in the body -

* Sodium—most of the body's sodium is found in the fluid outside of the body's cells, where it helps to regulate the amount of water in the body. -

POTASSIUM 4.26 mmol/L 3.50 - 5.50
 Method - IST

* Potassium—this electrolyte is found mainly inside the body's cells. A small but vital amount of potassium is found in the plasma, the liquid portion of the blood. Potassium plays an important role in regulating muscle contraction. Monitoring potassium is important as small changes in the potassium level can affect the heart's rhythm and ability to contract.

CHLORIDE 98.6 mmol/L 94.0 - 110.0
 Method - ISL

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BIOCHEMISTRY

* **Chloride**—this electrolyte moves in and out of the cells to help maintain electrical neutrality (concentrations of positively charged cations and negatively charged anions must be equal) and its level usually mirrors that of sodium. Due to its close association with sodium, chloride also helps to regulate the distribution of water in the body

| | | | |
|---------------|------|--------|--------------|
| SERUM CALCIUM | 9.63 | mg/dl. | 8.80 - 10.20 |
|---------------|------|--------|--------------|

Method - Arsenazo III Method

InstrumentName:MISPA 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 | 6.35 | g/dl | 6.00 - 8.40 |
|---------------------|------|------|-------------|

Method - Direct Biuret Reagent

| | | | |
|---------------|------|------|-------------|
| SERUM ALBUMIN | 4.10 | g/dl | 3.50 - 5.50 |
|---------------|------|------|-------------|

Method - Bromocresol Green

| | | | |
|----------------|------|-------|-------------|
| SERUM GLOBULIN | 2.25 | gm/dl | 2.20 - 3.50 |
|----------------|------|-------|-------------|

Method - CALCULATION

| | | | |
|-----------|------|--|-------------|
| A/G RATIO | 1.82 | | 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-hour collections 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 blood increases. 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.

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

Technologist
VIKARAN TSI
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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
☎️ +91 141 4824885 📧 maxcarediagnostics1@gmail.com



| | | | |
|---------------------------------------|--------------------------------|--------------------|----------|
| NAME :- Mr. MUKESH KUMAR SAINI | Patient ID :-42233840 | Date :- 28/10/2023 | 12:17:49 |
| Age :- 40 Yrs 4 Mon 28 Days | Ref. By Doctor:-BANK OF BARODA | | |
| Sex :- Male | Lab/Hosp :- | | |
| | Company :- Mr.MEDIWHEEL | | |

Final Authentication : 28/10/2023 17:26:30

TOTAL THYROID PROFILE

IMMUNOASSAY

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

THYROID-TRIHODOTHYRONINE T3
Method - ECLIA

1.17 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 30% hence time of the day has influence on the measured 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) are seen in patients with Graves disease. 3. Low TSH, high FT4 and TSH receptor antibody (TRAb) are seen in patients with Toxic adenoma/Toxic Multinodular goiter. 4. High TSH, Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's 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.

DURING PREGNANCY - REFERENCE RANGE for TSH in uIU/mL (As per American Thyroid Association): 1st Trimester - 0.10-0.25 uIU/mL, 2nd Trimester - 0.20-3.00 uIU/mL, 3rd Trimester - 0.30-0.60 uIU/mL. The production, circulation, and distribution 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 radioiodine 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

THYROID-THYROXINE (T4) due to a real change with age or an increasing proportion of unmonitored thyroid disease in the elderly. ** 5.10 - 14.10
Method - ECLIA

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 30% hence time of the day has influence on the measured 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) are seen in patients with Graves disease. 3. Low TSH, high FT4 and TSH receptor antibody (TRAb) are seen in patients with Toxic adenoma/Toxic Multinodular goiter. 4. High TSH, Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's 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.

DURING PREGNANCY - REFERENCE RANGE for TSH in uIU/mL (As per American Thyroid Association): 1st Trimester - 0.10-0.25 uIU/mL, 2nd Trimester - 0.20-3.00 uIU/mL, 3rd Trimester - 0.30-0.60 uIU/mL. The production, circulation, and distribution 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 radioiodine 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 unmonitored thyroid disease in the elderly.

TSH 1.215 uIU/ml. 0.350 - 5.500
Method - ECLIA

4th Generation Assay. Reference ranges vary between laboratories

[Signature]

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

Technologist
VIKARANTSI
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P3 HEALTH SOLUTIONS LLP

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- Central Spine, Vidhyadhar Nagar, Jaipur - 302023
- +91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mr. MUKESH KUMAR SAINI

Age :- 40 Yrs 4 Mon 28 Days

Sex :- Male

Patient ID :-12233840

Date :- 28/10/2023 12:17:49

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 28/10/2023 17:26:30

CLINICAL PATHOLOGY

| Test Name | Value | Unit | Biological Ref Interval |
|-------------------------------|-------------|------|-------------------------|
| Urine Routine | | | |
| PHYSICAL EXAMINATION | | | |
| COLOUR | PALE YELLOW | | PALE YELLOW |
| APPEARANCE | Clear | | Clear |
| CHEMICAL EXAMINATION | | | |
| REACTION(PH) | 6.5 | | 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 |
| MICROSCOPY EXAMINATION | | | |
| 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 |

Technologist
VIKARAN JOSHI
Page No. 12 of 17

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





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| | |
|-------------------------------|-------------------------|
| MR. MUKESH KUMAR SAINI | 40 Y/M |
| Registration Date: 28/10/2023 | Ref. by: BANK OF BARODA |

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (143 mm) with bright parenchymal echotexture. 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. Wall is not thickened. 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. 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. 106 mm.

Left kidney is measuring approx. 98 mm.

Urinary bladder is normally distended and shows normal wall thickness. No calculus or mass lesion.

Prostate is normal in size (18.3 mL) 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:

- Grade I hepatic steatosis.
- No free fluid or lymphadenopathy.

Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437

Dr. MUKESH SHARMA
M.B.B.S., M.D.(Radiodiagnosis)
RMC No. : 43418/17437
P3 Health Solutions



P3 HEALTH SOLUTIONS LLP
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| | | | |
|--------|------------------------|------|------------|
| NAME: | MR. MUKESH KUMAR SAINI | AGE | 40 YRS/M |
| REF.BY | BANK OF BARODA | DATE | 28/10/2023 |

CHEST X RAY (PA VIEW)

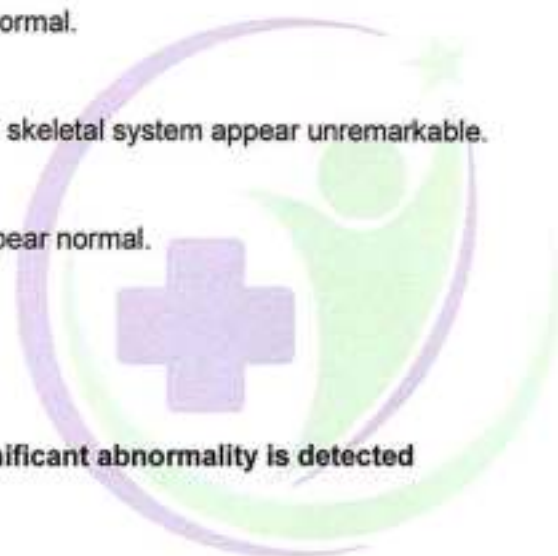
Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

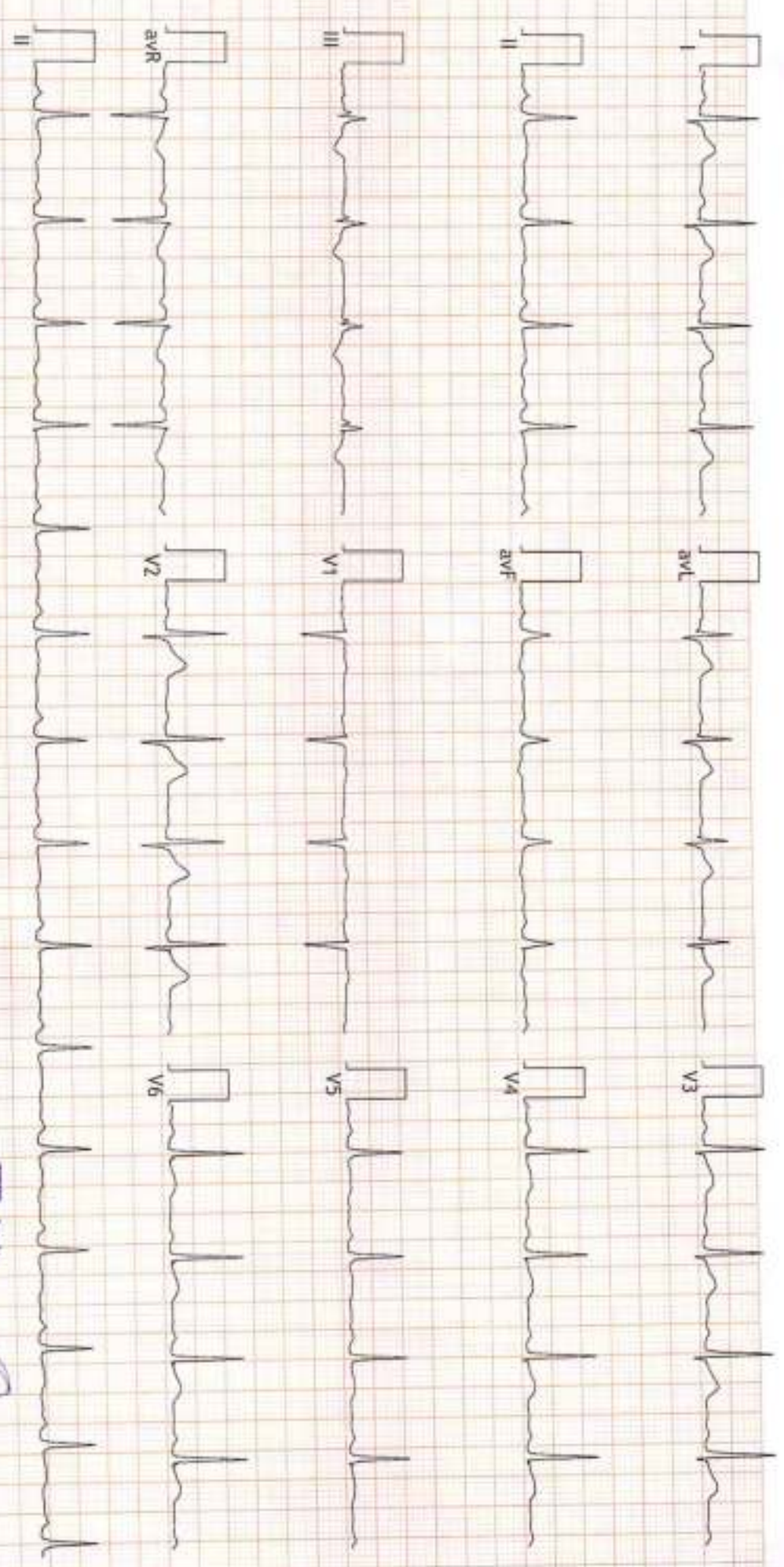
Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.



IMPRESSION: No significant abnormality is detected

Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437



FINDINGS: Normal Sinus Rhythm
Vent Rate : 87 bpm; PR Interval : 166 ms; QRS Duration: 84 ms; QT/QTc Int : 322/389 ms
P-QRS-T axis: 41 • 50 • -3 • (Deg)
Comments :

Dr. Naresh Kumar Mohanka

TRNL

[Signature]

Dr. Naresh Kumar Mohanka
RMC No.: 95703
MBBS, DIP. CARDIO (ESCORTS)
D.E.M. (RCGP-UK)

R3 HEALTH SOLUTIONS LLP
 B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur
 12213831/MR NARESH KUMAR SAINI 40 Yrs/Male 0 Kg/0 Cms
 Date: 28-Oct-2023 02:08:09 PM
 Ref By : BANK OF BARODA
 Medication : NIL
 Objective :

Protocol : BRUCE
 History : NIL

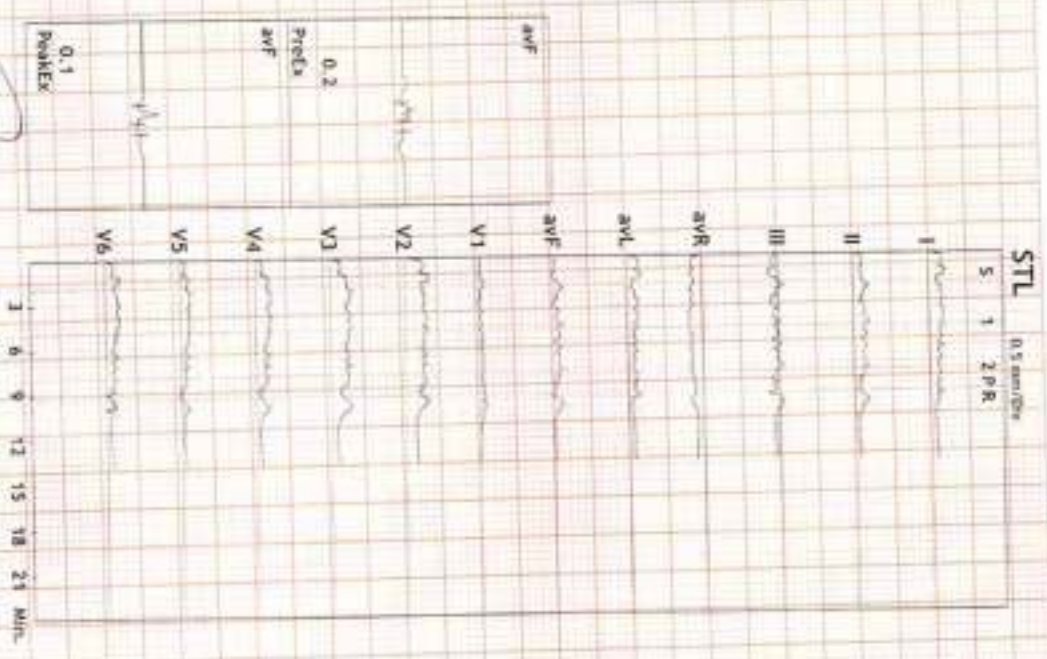
| Stage | StageTime | PhaseTime | Speed | Grade | METS | H.R. | B.P. | R.P.P. | PVC | Comments |
|----------|-----------|-----------|---------|-------|------|---------|--------|--------|-----|----------|
| | MetSec1 | metSec1 | metSec1 | RI | | MetSec1 | mmHg | atSec1 | | |
| Supine | | | | | 1.0 | 90 | 120/80 | 108 | - | |
| Standing | | | | | 1.0 | 90 | 120/80 | 108 | - | |
| HV | | | | | 1.0 | 108 | 120/80 | 129 | - | |
| ExStart | | | | | 1.0 | 111 | 120/80 | 133 | - | |
| Stage 1 | 3:01 | 3:02 | 1.7 | 10.0 | 4.7 | 128 | 130/80 | 166 | - | |
| Stage 2 | 3:01 | 6:02 | 2.5 | 12.0 | 7.1 | 148 | 140/85 | 207 | - | |
| PeakEx | 1:26 | 7:27 | 3.4 | 14.0 | 8.6 | 160 | 150/85 | 240 | - | |
| Recovery | 1:00 | | 0.0 | 0.0 | 1.2 | 118 | 150/85 | 176 | - | |
| Recovery | 2:00 | | 0.0 | 0.0 | 1.0 | 107 | 160/85 | 171 | - | |
| Recovery | 3:00 | | 0.0 | 0.0 | 1.0 | 102 | 150/85 | 153 | - | |
| Recovery | 4:00 | | 0.0 | 0.0 | 1.0 | 98 | 140/85 | 137 | - | |

Findings :

Exercise Time : 07:26
 Max HR Attained : 160 bpm 89% of Max Predictable HR 180
 Max BP : 160/85(mmHg)
 Max Workload attained : 8.6(Fair Effort Tolerance)

TTT is negative for RMI.

Dr. Naresh Kumar Mohanka



Dr. Naresh Kumar Mohanka
 RMC No. 35703
 MBBS, DIP. CARDIO (ESCORTS)
 D.E.M. (RCGP-UK)

Advice/Comments:



P3 HEALTH SOLUTIONS LLP
B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur
12233331/88 MURESH KUMAR SAINI
40 Yrs/Male
0 Kg/0 Cms
Date: 28-Oct-2023 02:08:09 PM

HR: 90 bpm
METS: 1.0
BP: 120/80

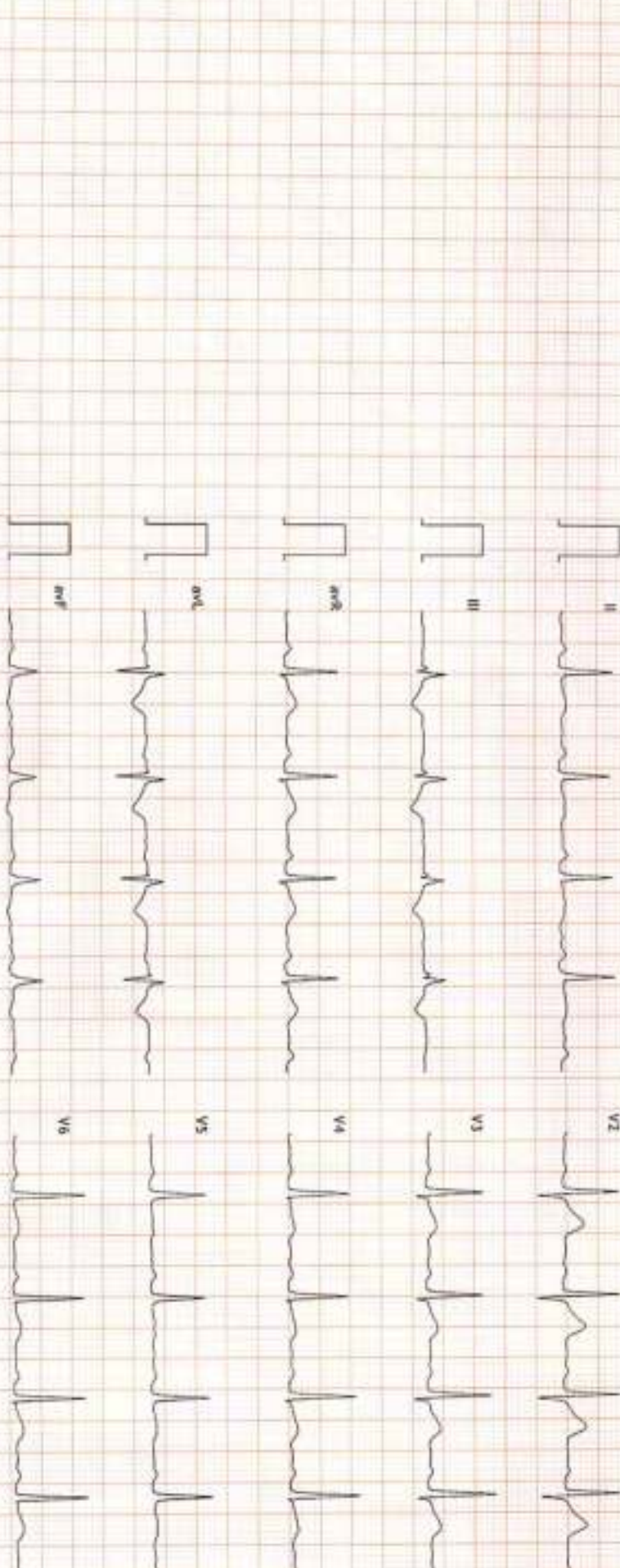
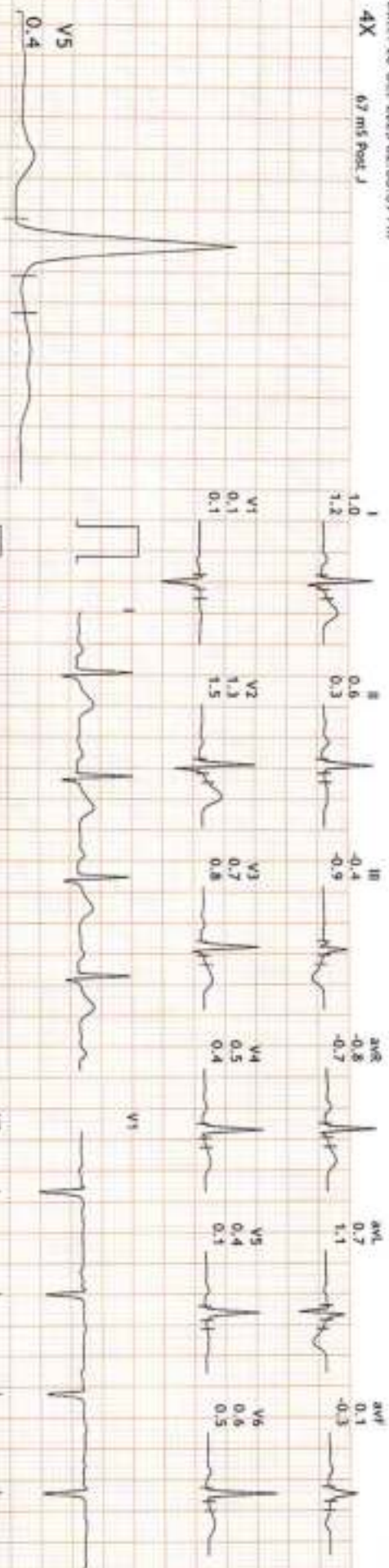
APHR: 50% of 180
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 00:31
BLC : On
Notch : On

Supine
10.0 mm/mV
25 mm/Sec

4X 67 ms Post J



B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur

1223831/MR MUKESH KUMAR SAINI

40 Yrs/Male

0 Kg/0 Cms

Date: 28-Oct-2023 02:08:09 PM

4X 67 ms Post J

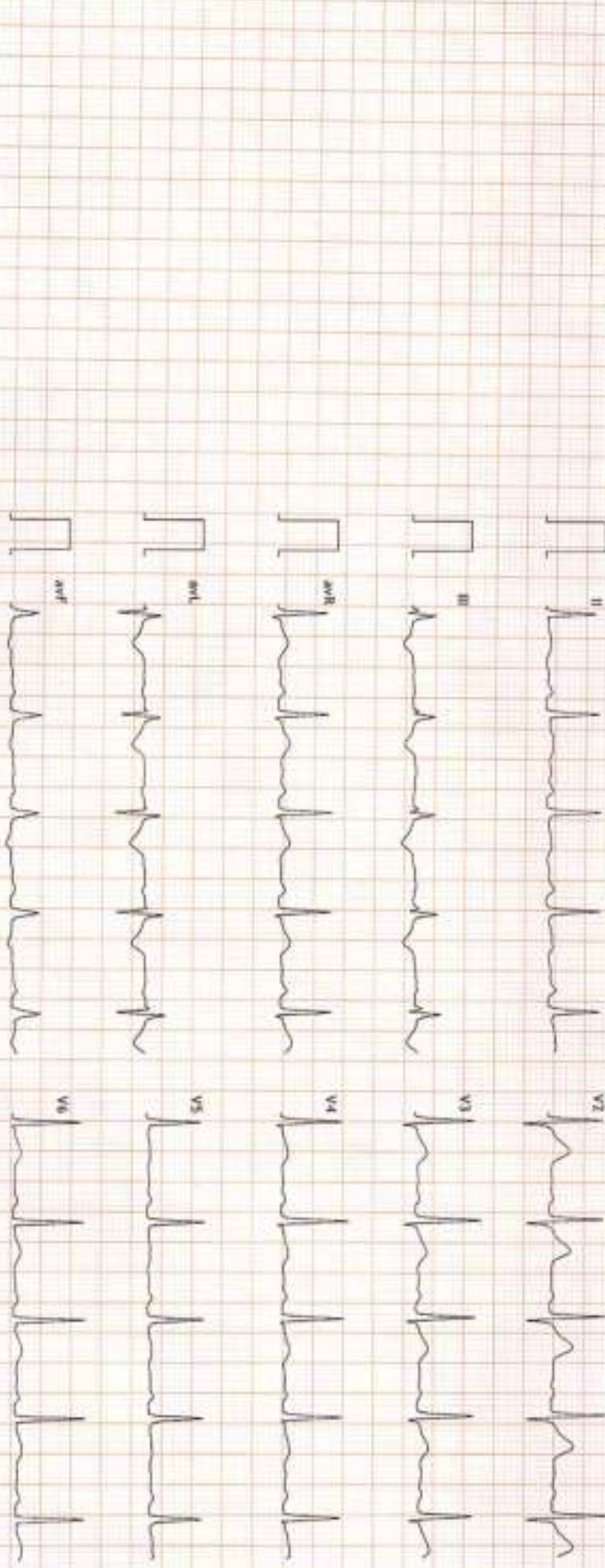
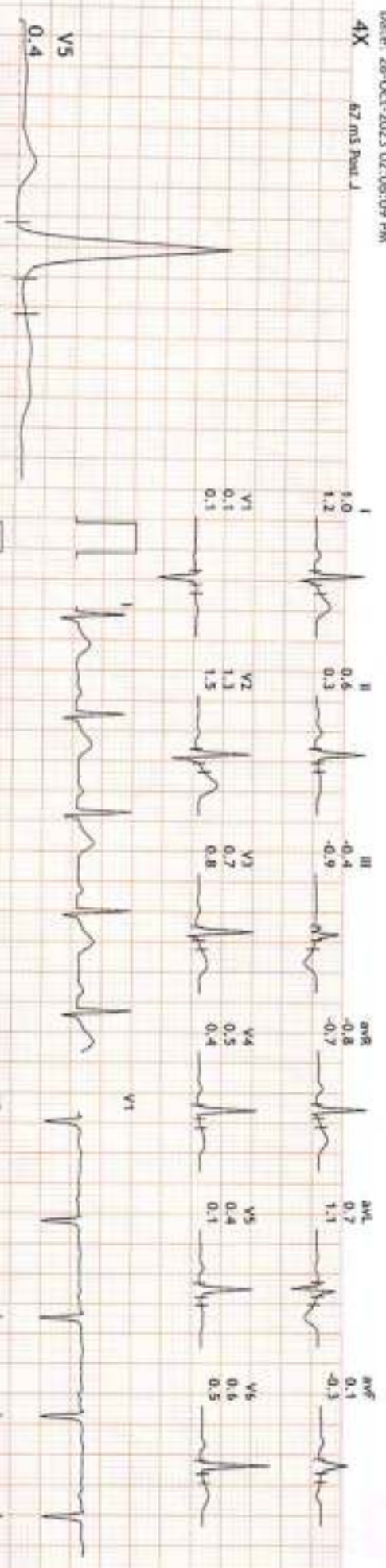
HR: 90 bpm
METs: 1.0
BP: 120/80

APHR: 50% of 180
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
10.05-100/Hz

Ex Time 00:36
BLC :On
Notch :On

Standing
10.0 mm/mV
25 mm/Sec.



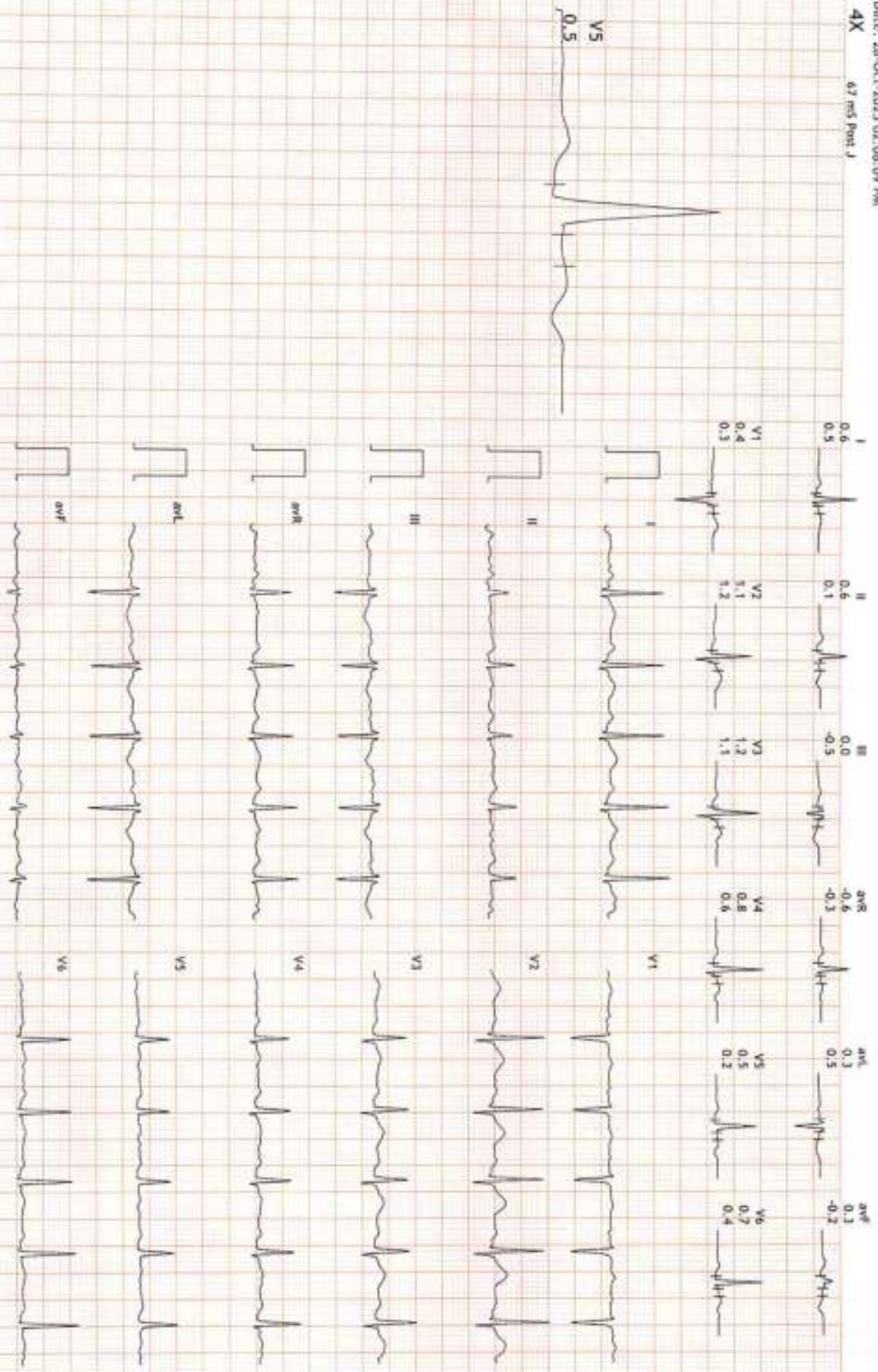
HR: 108 bpm
METs: 1.0
Sp: 120/80

AP-PR: 50% of 180
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
10.05-100/Hz

Ex Time 01:43
BLC :On
Notch :On

HV
10.0 mm/mV
25 mm/Sec.



P3 NEALIN SOLU RIMS LLP
B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur

12233831/MR. MUKESH KUMAR SAINI

40 Yrs/Male

0 Kg/0 Cms

Date: 28-Oct-2023 02:08:09 PM

4X 67 ms Post J

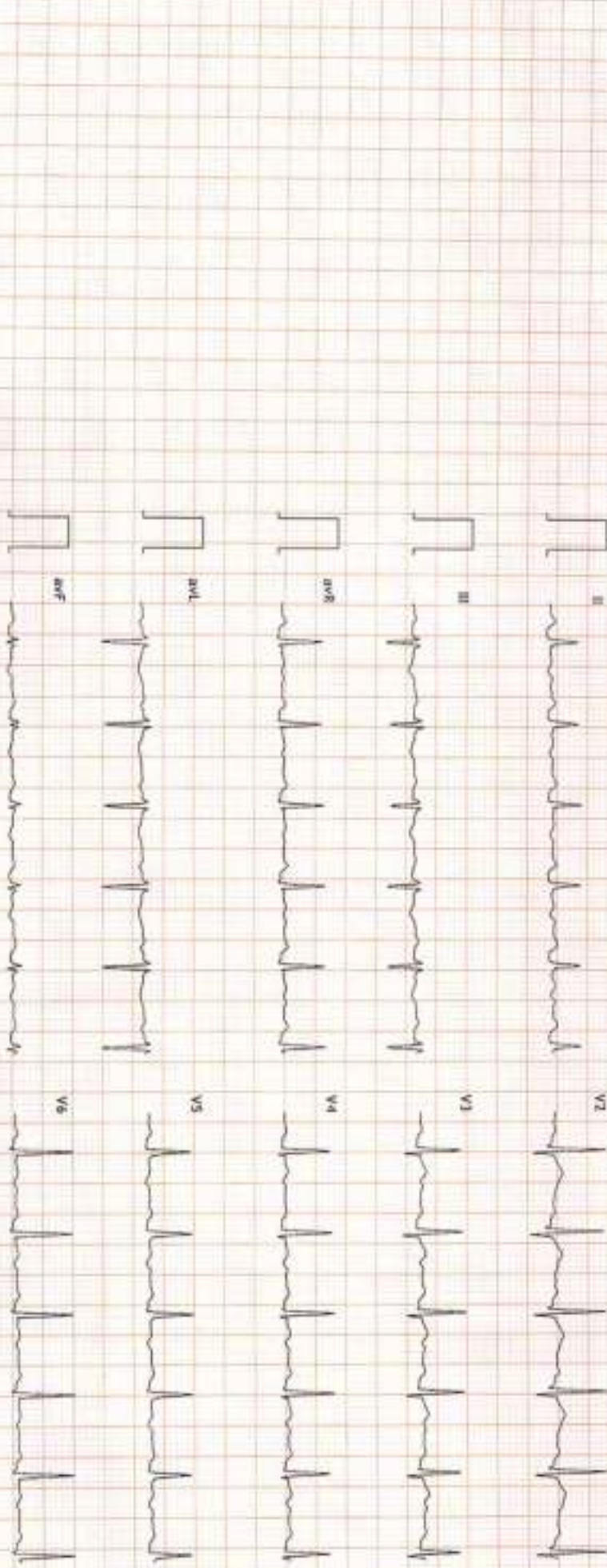
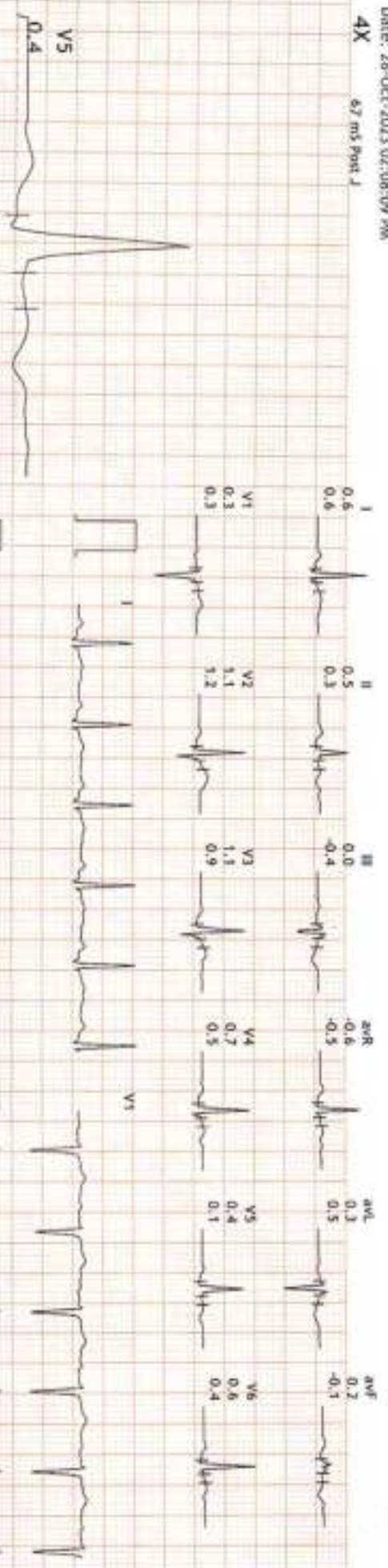
HR: 110 bpm
MEFS: 1.0
BP: 120/80

APR: 61% of 180
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
10.05-100Hz

Ex Time 01:51
BLC :On
Notch :On

ExStart
10.0 mm/mV
25 mm/Sec.



HR: 128 bpm
METs: 4.7
BP: 130/80

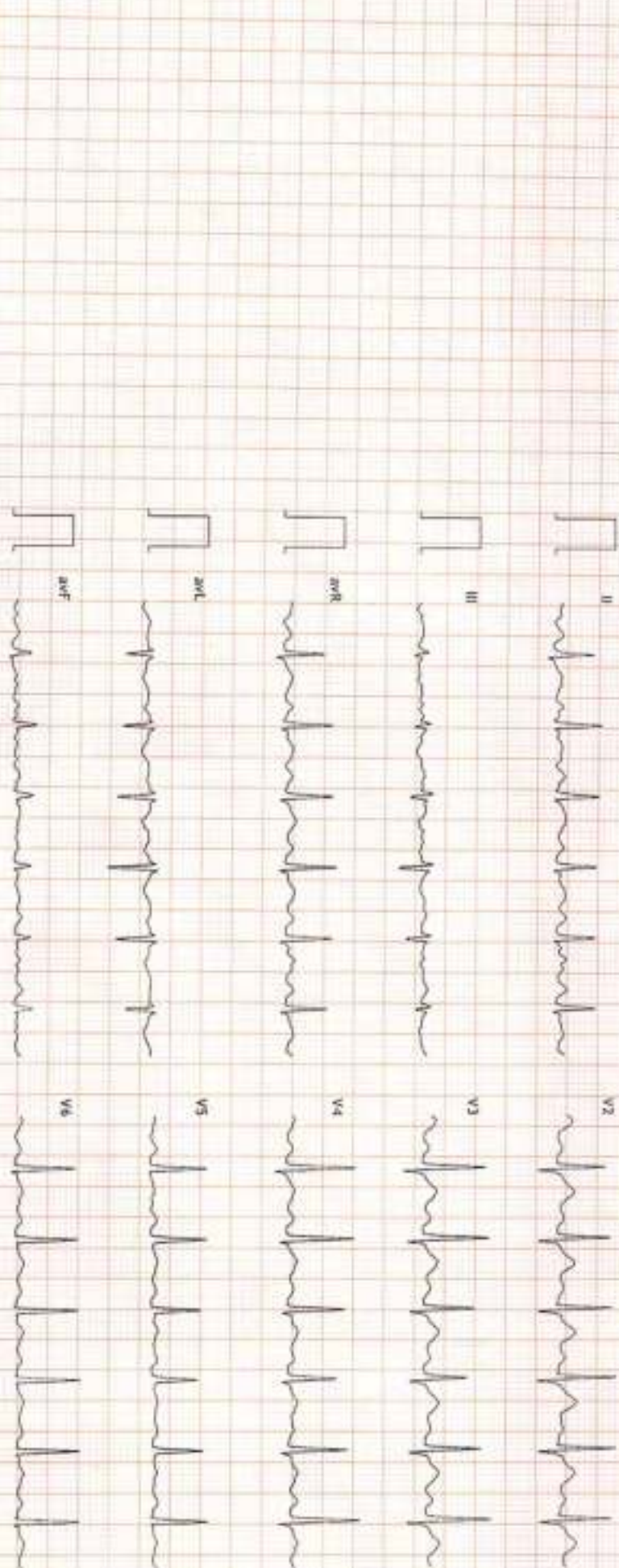
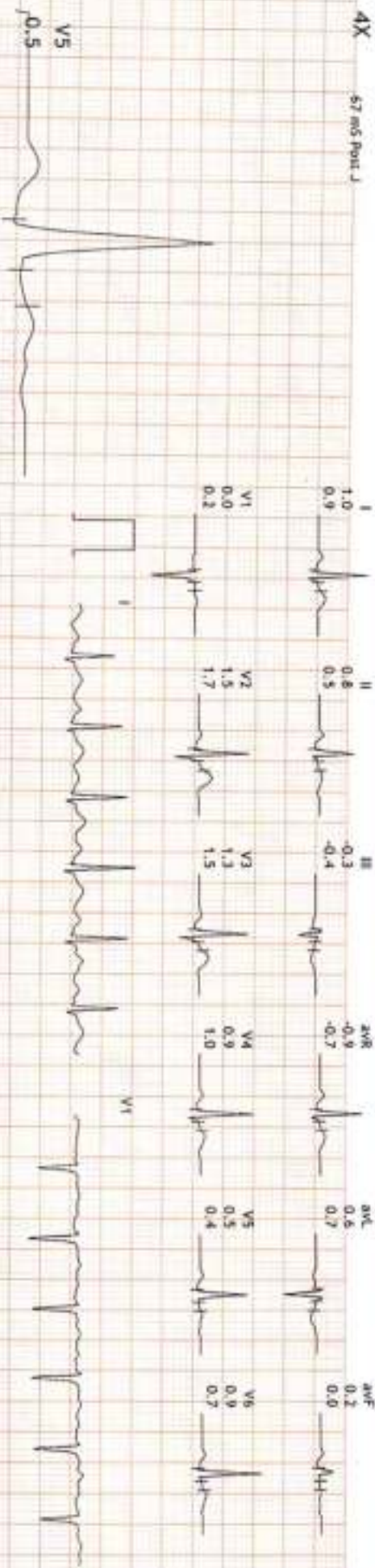
MPHR: 71% of 180
Speed: 1.7 mph
Grade: 10.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 02:59
ELC :On
Notch :On

BRUCE: Stage 1(3:00)
10.0 mm/mV
25 mm/Sec.

4X 67 ms Post J



HR: 149 bpm

MCFS: 7.1

BP: 140/85

MPH: 82% of 180

Speed: 2.5 mph

Grade: 12.0%

Raw ECG

BRUCE

(0.05-100)Hz

Ex Time 05:59

BLC :On

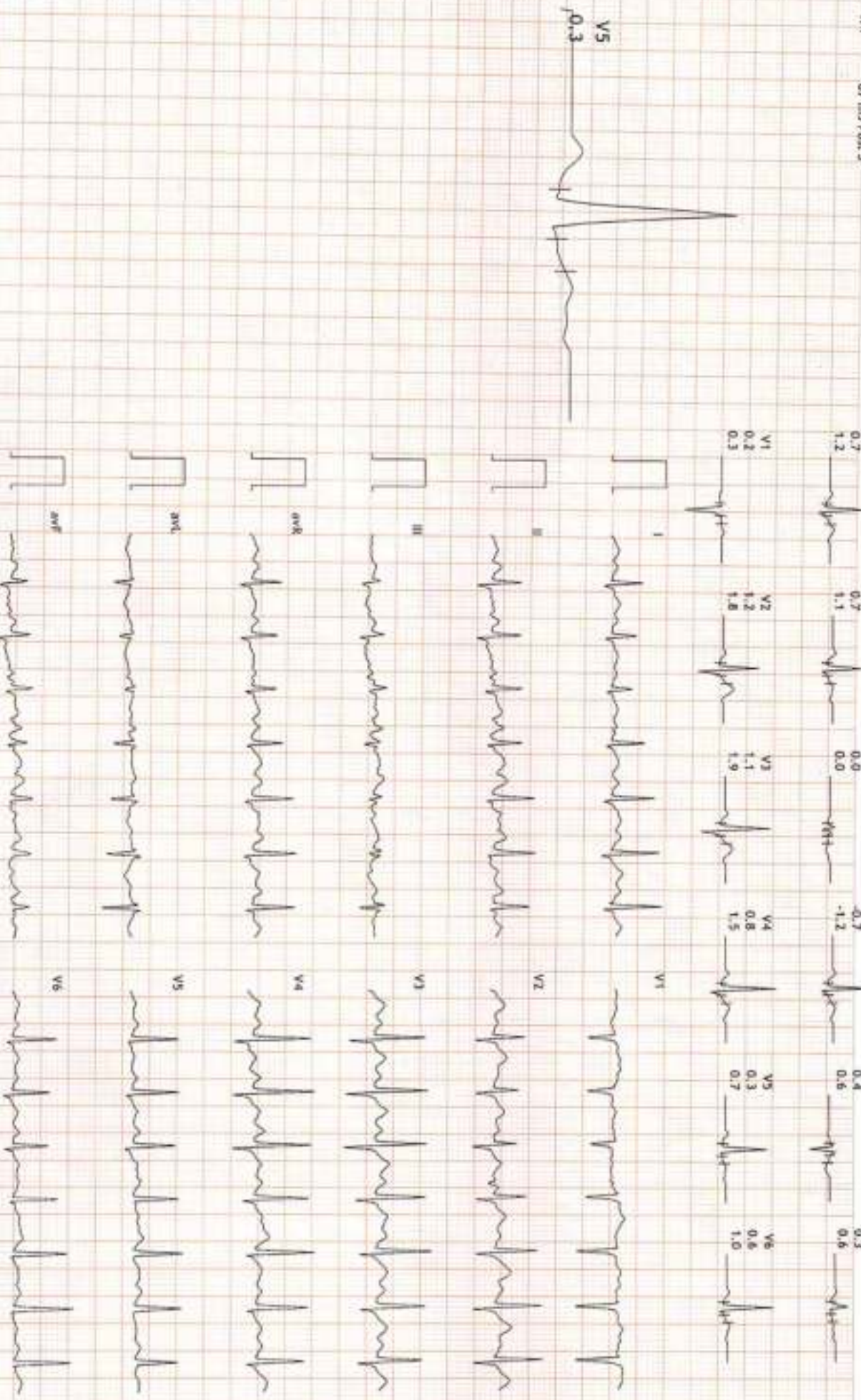
Notch :On

BRUCE:Stage 2(3:00)

10.0 mm/mV

25 mm/Sec.

4X 67 ms Post J



B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur

1223831/MR WIKESH KUMAR SAINI

40 Yrs/Male

0 Kg/0 Cms

Date: 28-Oct-2023 02:08:09 PM

HR: 161 bpm

MEFS: 8.6

SP: 150/85

MPHR:89% of 180

Speed: 3.4 mph

Grade: 14.0%

Raw ECG

BRUCE

(0.05-100)Hz

Ex Time 07:24

BLC :On

Notch :On

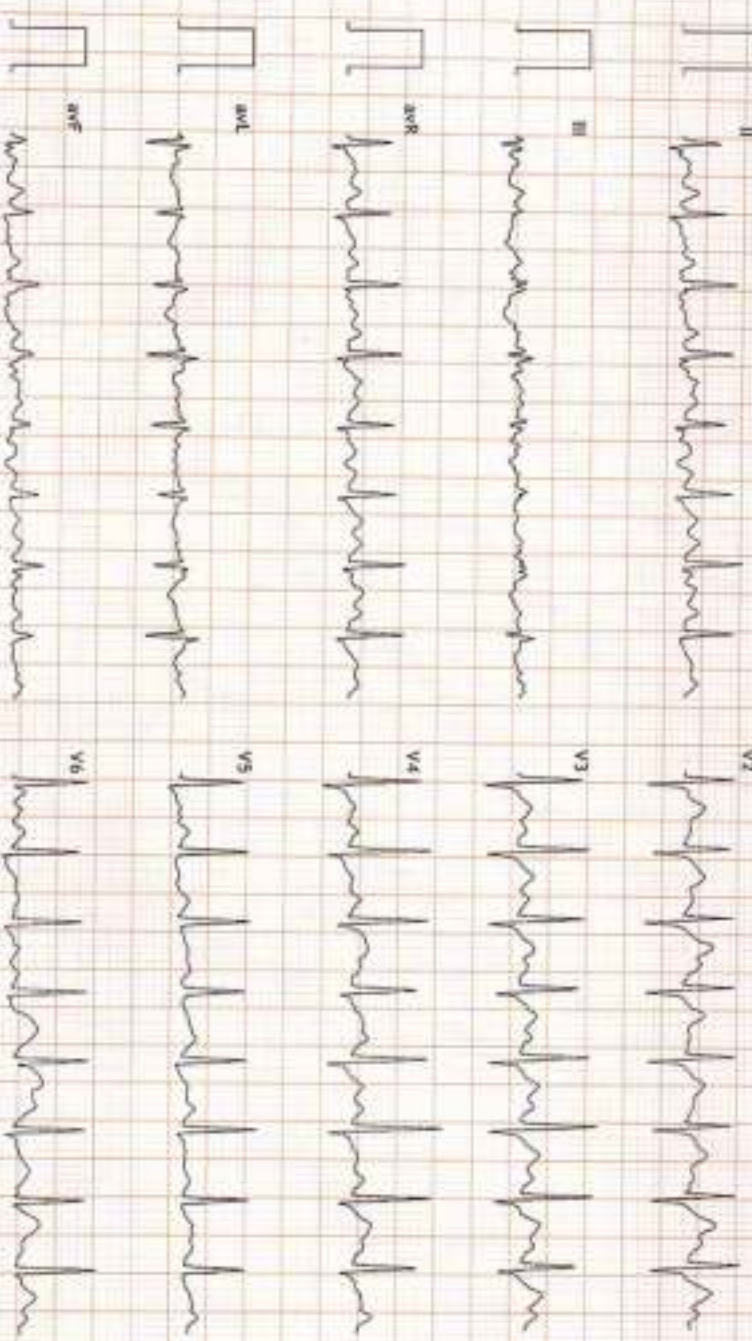
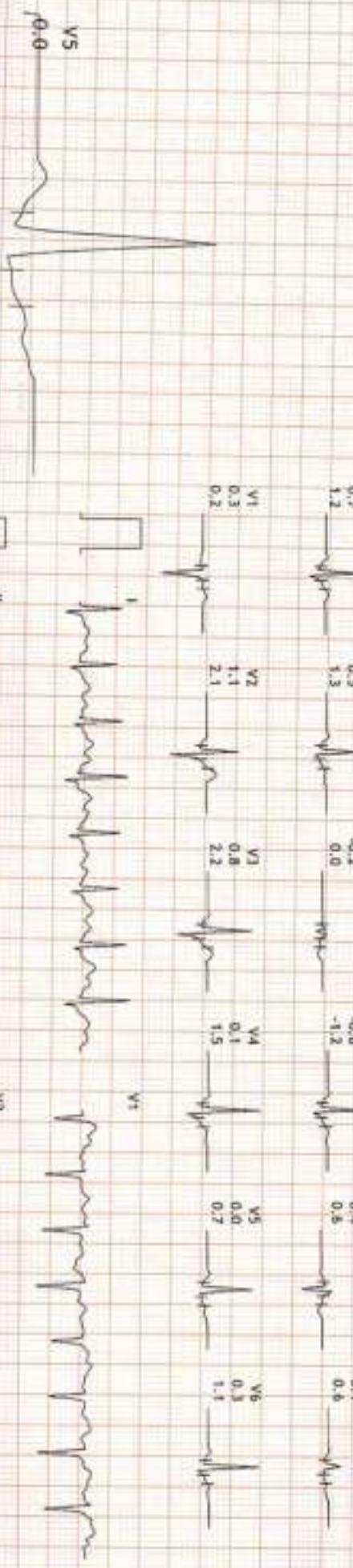
BRUCE:PeakEx(1:24)

10.0 mm/mV

25 mm/Sec.



4X 5.7 mV Post J



HR: 117 bpm
MEFS: 1.3
BP: 150/85

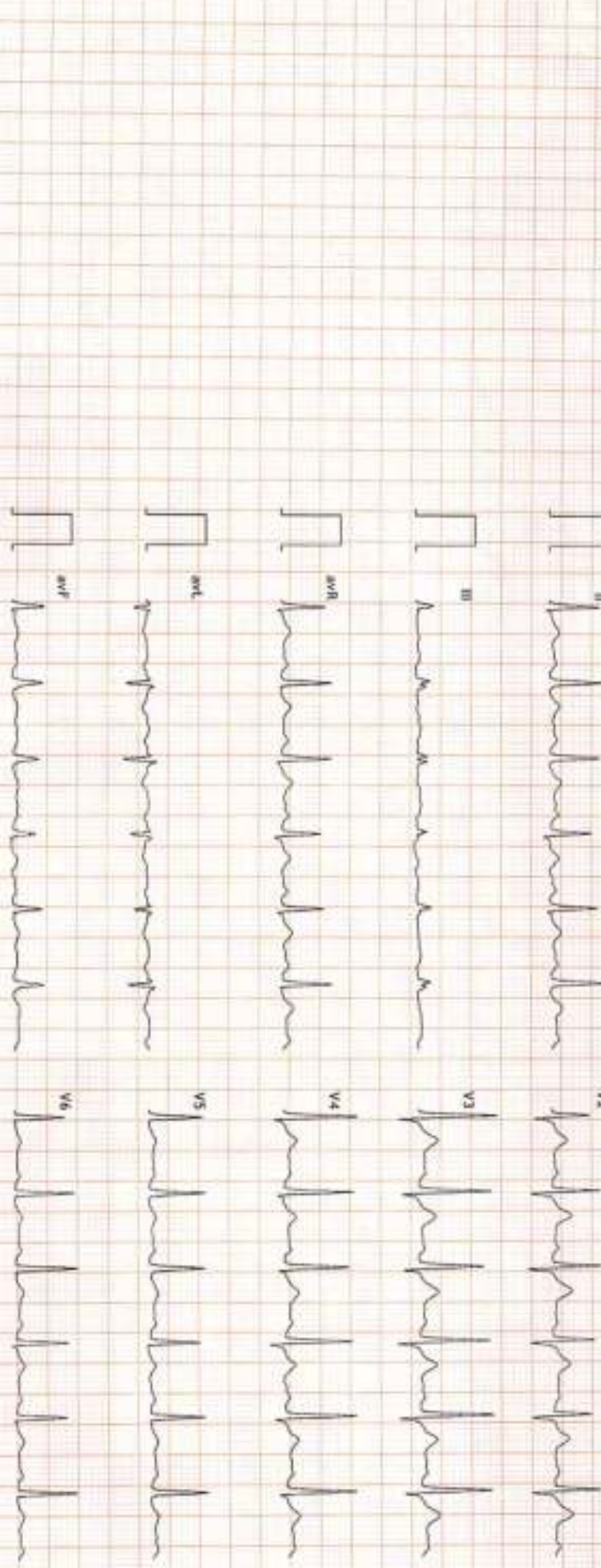
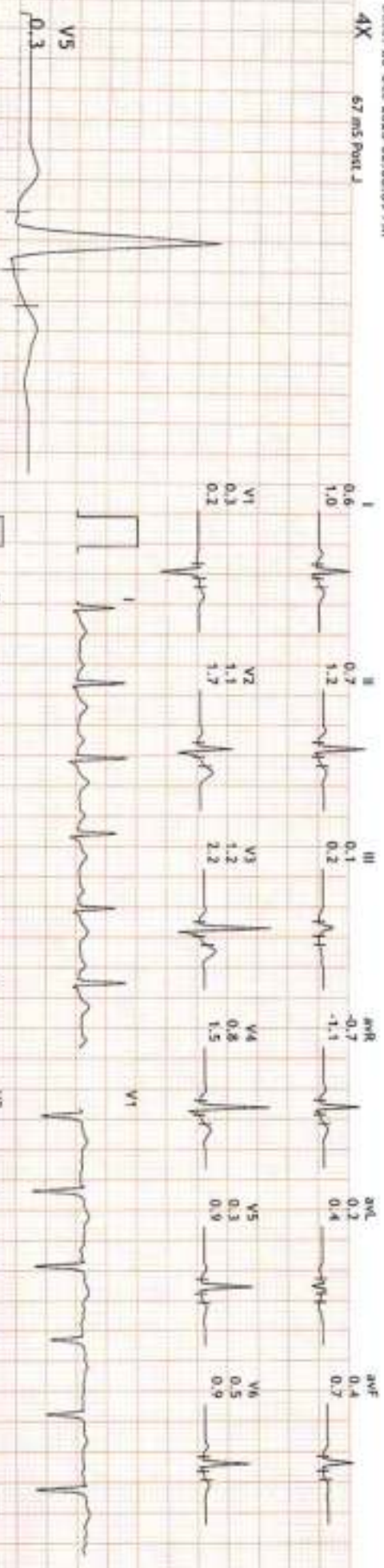
APPR: 65% of 180
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 07:26
BLC :On
Notch :On

Recovery(1:00)
10.0 mm/mV
25 mm/Sec.

4X 67 ms Post J



HR: 102 bpm

MEETS: 1.0

BP: 150/85

MPHR: 56% of 180

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

10.05-100/Hz

Ex Time 07:26

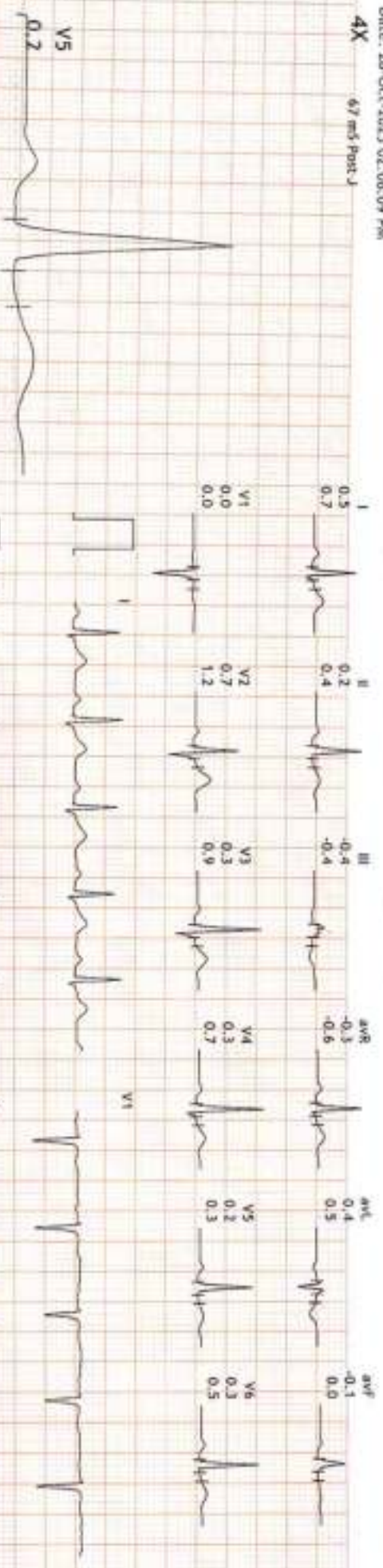
BLC : On

Notch : On

Recovery(3:00)

10.0 mm/mV

25 mm/Sec



HR: 97 bpm
AETC: 1.0
BP: 140/85

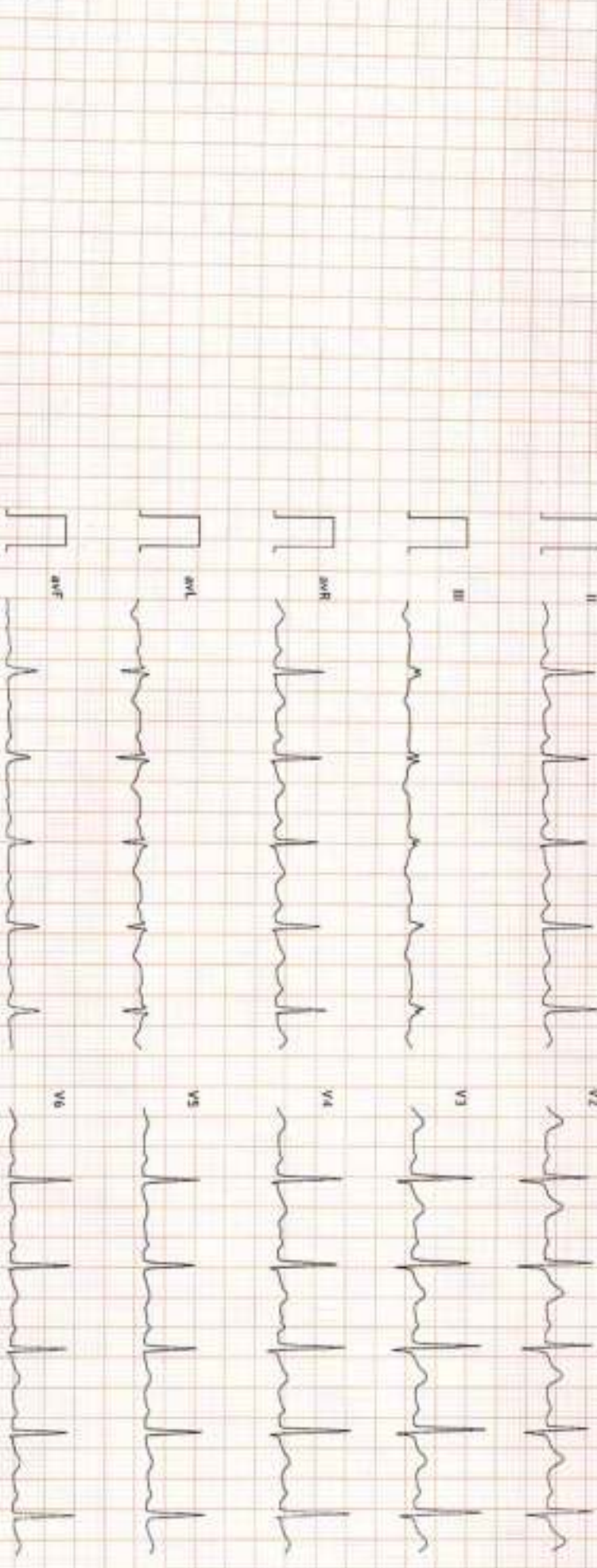
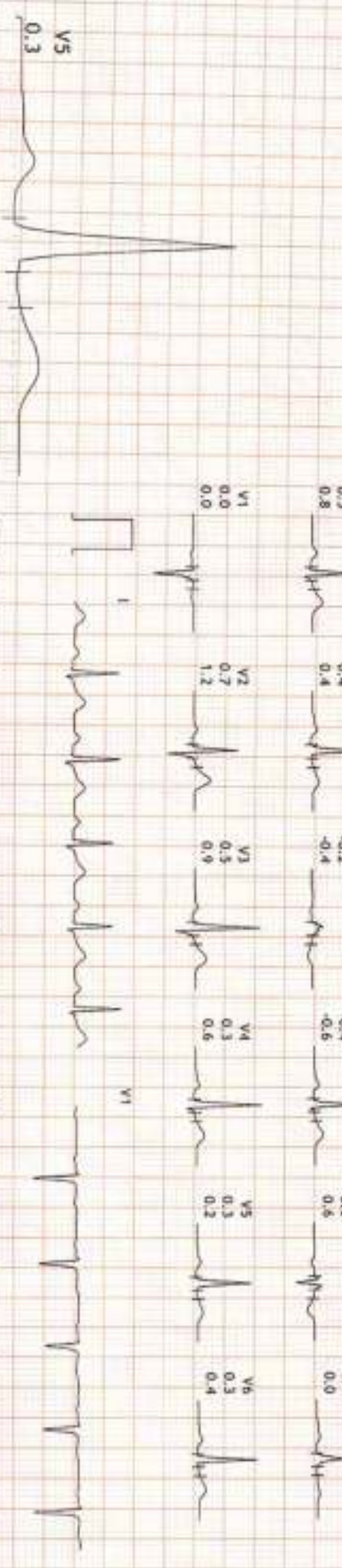
MPHR: 53% of 180
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

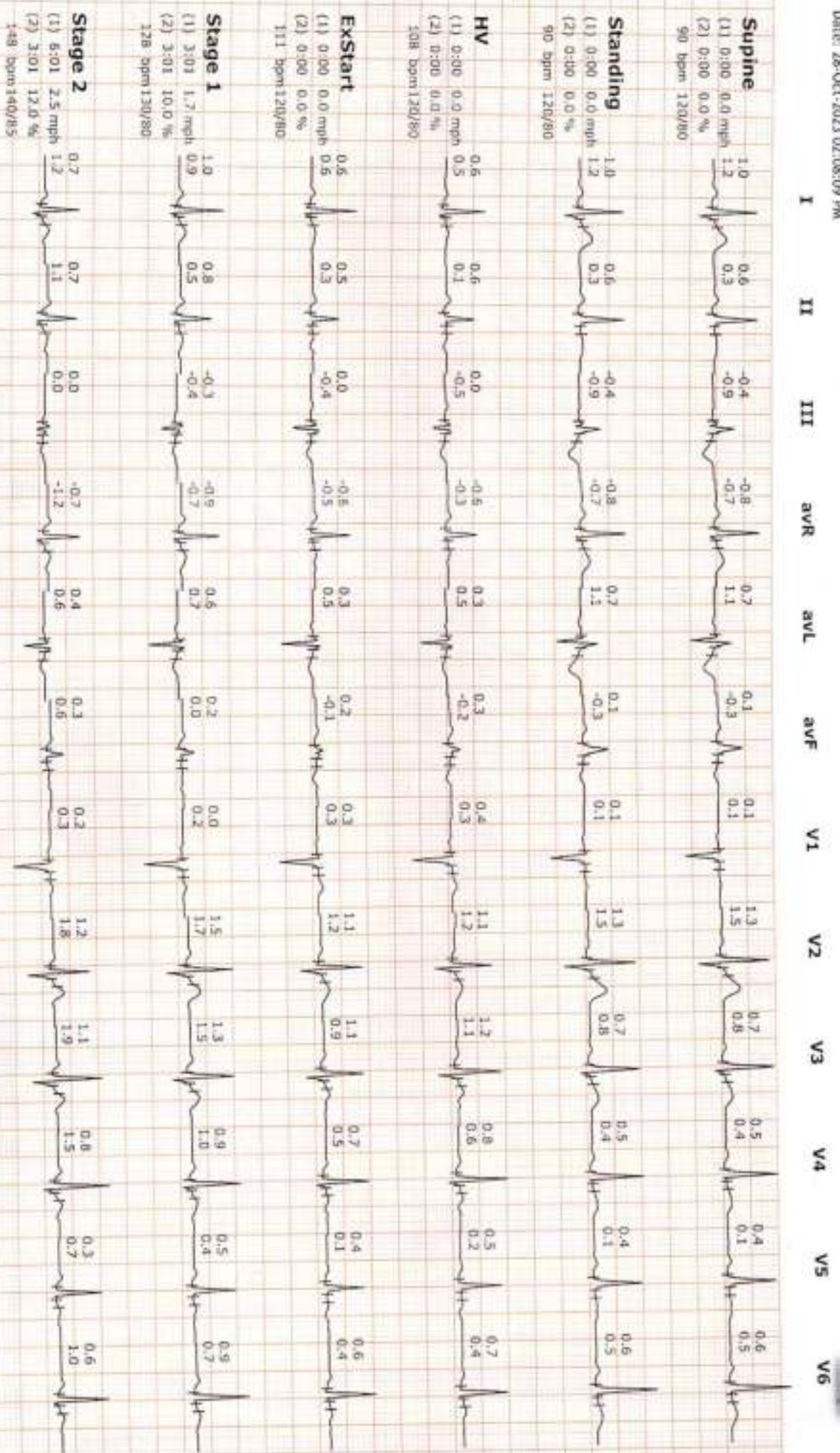
Ex Time 07:26
BLC :On
Notch :On

Recovery(4:00)
10.0 mm/mV
25 mm/Sec.

4X 67 ms Post J

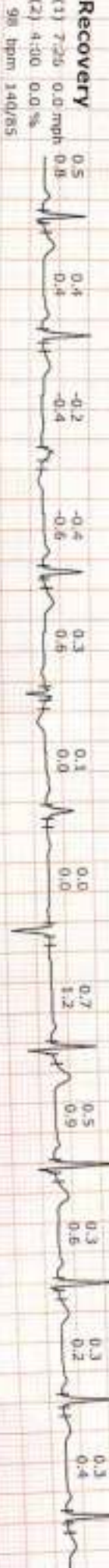
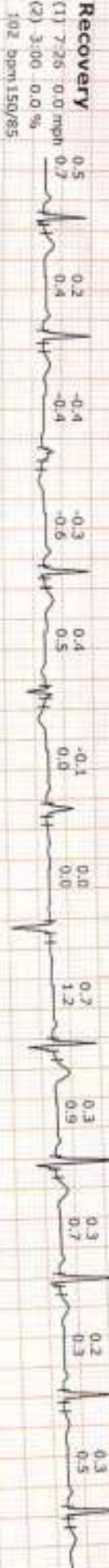


Average





I II III aVR aVL aVF V1 V2 V3 V4 V5 V6



98 bpm 140/85



11
TOSHIMA ALUMINUM CASE CO. LTD.
2007-10-14
MANUFACTURED BY PERMISSION OF FUJIFILM. SEE OTHER SIDE

X