

NAME:	Mr Raman Kumar	UHID:	
AGE:	39	DATE OF HEALTHCHECK:	27-11-2020
GENDER:	M		

HEIGHT:	179	MARITAL STATUS:	M
WEIGHT:	82.6	NO OF CHILDREN:	3
BMI:	25.8		

C/O: Numbness, stiffness
 in both hands & feet
 - at work - average
 P/M/H: - Lumbar Spinalgia

K/C/O: DM, Dyslipidemia
 PRESENT MEDICATION: - Tab - Amlodipine
 10mg

ALLERGY: - no

H/O RTA - Back Injury - 2012

PHYSICAL ACTIVITY: Active / Moderate / Sedentary

H/A: SMOKING: -

FAMILY HISTORY FATHER: - (H/O)
 MOTHER: - (H/O)

ALCOHOL: - occ,

TOBACCO/PAN: - yes

O/E:

LYMPHADENOPATHY: - (H/O)

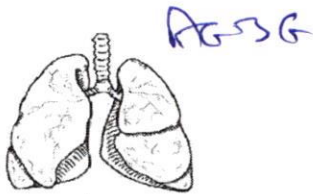
BP: 130/80 PULSE: - 96/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING: - (H/O)

TEMPERATURE: - SCARS: -

OEDEMA: -

S/E:
RS:



P/A: - (H/O)

CVS: - (H/O)

Extremities & Spine: - Back pain

CNS: - (H/O)

ENT: - (H/O)

Skin: - (H/O)

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

Name: Mr Sumen Kumar	Age: 39	Date of Health check-up: 21/11/2021
----------------------	---------	-------------------------------------

Findings and Recommendation:

Findings:-

Plat ↓
Sega ↑↑
Dyslipidaemia
GTT ↑

Recommendation:-

- T. Totala 700
|-----|
BBK Bn

- T. Rosunae E 2.10
|-----|

Signature:

Consultant -



- Repeat CBC / LFT 2-15 der

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

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 27/11/23

Name: Mr. Surmen Khar Age: 39 Gender: Male / Female

Without Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

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

Near : Right Eye No Left Eye 2/6

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near	<u>Tto</u>					<u>Tto</u>				

Colour Vision : NAD

Anterior Segment Examination : NAD (B0)

Pupils : _____

Fundus : _____

Intraocular Pressure : 12 mm Hg (B0)

Diagnosis : cataract glasses.

Advice : _____

Re-Check on 6 mths (This Prescription needs verification every year)

✓ D 11

Dr. R

(Consultant Ophthalmologist)
DR. RUCHIRA SHARMA
 M. S. (OPHTH)
 CONSULTING OPHTHALMOLOGIST
 & MICRO SURGEON
 REG. No.: 3262 / 09 / 02

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: Mr. Suman Kumar	MR NO:
Age/Gender : 34 yrs / M	Date: 27/11/23

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				

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: _____



• ANDHERI • COLABA • NASHIK • VASHI

Name : Mr. Suman Kumar Gender : Male Age : 39 Years
 UHID : FVAH 9536. Bill No : Lab No : V-2814-23
 Ref. by : SELF Sample Col.Dt : 27/11/2023 09:50
 Barcode No : 6177 Reported On : 27/11/2023 17:47

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

CBC (Complete Blood Count)-WB (EDTA)

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
Haemoglobin(Colorimetric method)	14.2 g/dl	13 - 18
RBC Count (Impedance)	4.56 Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	44.7 %	35 - 55
MCV:(Calculated parameter)	98.1 fl	78 - 98
MCH:(Calculated parameter)	31.2 pg	26 - 34
MCHC:(Calculated parameter)	31.8 gm/dl	30 - 36
RDW-CV:	14.8 %	11.5 - 16.5
Total Leucocyte count(Impedance)	5550 /cumm.	4000 - 10500
Neutrophils:	60 %	40 - 75
Lymphocytes:	31 %	20 - 40
Eosinophils:	02 %	0 - 6
Monocytes:	07 %	2 - 10
Basophils:	00 %	0 - 2
Platelets Count(Impedance method)	1.09 Lakhs/c.mm	1.5 - 4.5
MPV	11.1 fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)		
RBCs:	Normochromic, Normocytic	
WBCs:	Normal	
Platelets	Large platelets, Reduced, Manual platelet count = 1.10 Lakhs/c.mm	
Note:	Test Run on 5 part cell counter.	

Vasanti Gondal
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Ms Kaveri Gaonkar
Verified By

Page 3 of 3
Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

Name : Mr. Suman Kumar Gender : Male Age : 39 Years
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

ESR(Westergren Method)

Erythrocyte Sedimentation Rate:- 03 mm/1st hr 0 - 20

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TEST

RESULTS

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

ABO Group: **:A:**
Rh Type: **Positive**
Method : Matrix gel card method (forward and reverse)

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : **8.7** %
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 : 202.99 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 then 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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Chief Pathologist

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Gender : Male Age : 39 Years

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
TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	<u>293</u>	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	<u>380</u>	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method :

Hexokinase

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End of Report
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LIPID PROFILE - Serum


S. Cholesterol(Oxidase)	231	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	796*	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	159.2	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	32.3	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(Direct)	94.8	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	7.2		3.5 - 5
Ratio of LDL/HDL	2.9		2.5 - 3.5

Remarks *** Rechecked & confirmed. Kindly Correlate Clinically**

Note: Lipemic sample

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum


S.Total Protein (Biuret method)	7.78	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.79	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.99	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.6		0.9 - 2
S.Total Bilirubin (DPD):	1.03	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.38	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.65	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	67	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	40	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	87	U/L	40 - 129
S.GGT(IFCC Kinetic):	208*	U/L	11 - 50

Remarks : *** Rechecked & confirmed. Kindly Correlate Clinically**

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

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
BIOCHEMISTRY		
S.Urea(Urease Method)	16.0 mg/dl	10.0 - 45.0
BUN (Calculated)	7.46 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.84 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	8.88	9:1 - 23:1
S.Uric Acid(Uricase Method)	4.9 mg/dl	3.4 - 7.0

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Dr. Milind Patwardhan
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Chief Pathologist

Name	: Mr. Suman Kumar	Gender	: Male	Age	: 39 Years
UHID	: FVAH 9536.	Bill No	:	Lab No	: V-2814-23
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
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Thyroid (T3,T4,TSH)- Serum

Total T3 (Tri-iodo Thyronine) (ECLIA)	1.91	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	83.87	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	1.89	□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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Dr. Milind Patwardhan
M.D(Path)

Page 9 of 9 **Chief Pathologist**

End of Report
Results are to be correlated clinically



Indira Health And Lifestyle Private Limited.

NABL Accredited Laboratory

The Emerald, 1st Floor, Plot No. 195, Sector-12,

Besides Neel Siddhi Tower, Vashi-Navi Mumbai-400703.

Tel.: (022) - 2788 1322 / 23 / 24 8291490000

Email: apolloclinicvashi@gmail.com



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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)	6.0	4.6 - 8.0
SPECIFIC GRAVITY	1.010	1.005 - 1.030
URINE ALBUMIN	Absent	Absent
URINE SUGAR(Qualitative)	Present (+)	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	1 - 2/hpf	0 - 3/hpf
RED BLOOD CELLS	Nil /HPF	Absent
EPITHELIAL CELLS	1 - 2 / hpf	3 - 4/hpf
CASTS	Absent	Absent
CRYSTALS	Absent	Absent
BACTERIA	Absent	Absent

Anushka Chavan
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M.D(Path)

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End of Report
Results are to be correlated clinically

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

STOOL EXAMINATION

PHYSICAL EXAMINATION

COLOUR	Brown	
CONSISTENCY	Semi Solid	
MUCUS	Absent	Absent

CHEMICAL EXAMINATION

OCCULT BLOOD (Guaiac method)	Absent	Absent
PH(Litmus paper)	Acidic	Acidic/Alkaline

MICROSCOPIC EXAMINATION

PUS CELLS	Absent	0 - 1
EPITHELIAL CELLS	Absent	Absent
RED BLOOD CELLS	Nil /HPF	Absent
FAT GLOBULES	Absent	Absent
VEGETABLE FIBRES	Present	Present
YEASTS	Absent	Absent
CYST	Absent	Absent
VEGETATIVE FORMS	Absent	Absent
OVA	Absent	Absent

Anushka Chavan
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Verified By



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Chief Pathologist

End of Report
Results are to be correlated clinically

QRS : 82 ms
QT / QTcBaz : 346 / 404 ms
PR : 170 ms
P : 96 ms
RR / PP : 726 / 731 ms
P / QRS / T : 67 / 37 / 25 degrees

Normal sinus rhythm
Normal ECG

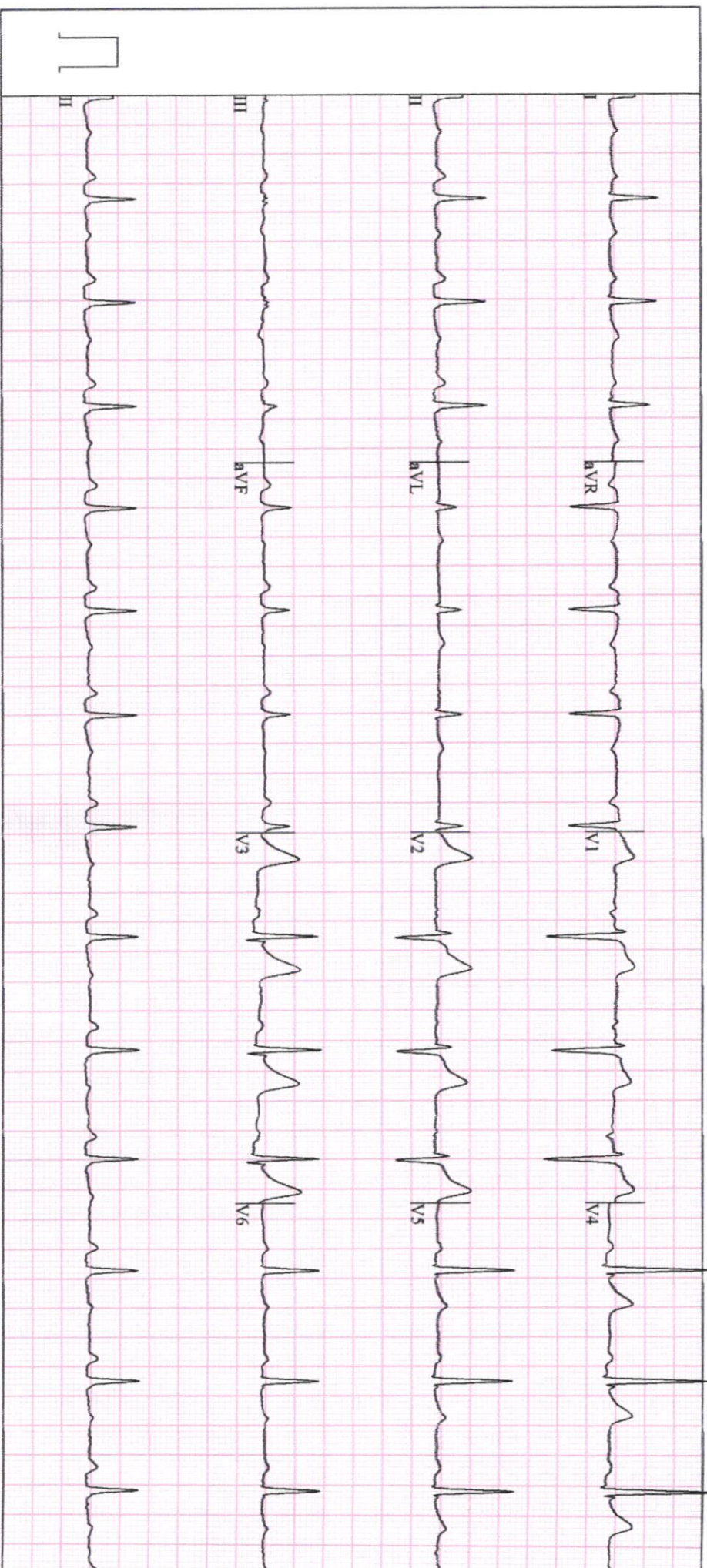
NORMAL ECG

Dr. ANIRBAN DASGUPTA

M.B., B.S., D.H.B. Medicine

Diploma, Radiology

MMC - 2005/02/0920



PATIENT'S NAME	SUMAN KUMAR	AGE :- 39Y/M
UHID	9536	DATE :- 27-11-23

2D Echo and Colour Doppler Report

All cardiac chambers are normal in dimension

No obvious resting regional wall motion abnormalities (RWMA)

Interatrial and Interventricular septum – Appears Normal

Valves – Structurally normal

Good biventricular function.

IVC is normal.

Pericardium is normal.

Great vessels - Origin and visualized proximal part are normal.

No coarctation of aorta.

Doppler study

Normal flow across all the valves.

No pulmonary hypertension.

No diastolic dysfunction.

Measurements

Aorta annulus	20 mm
Left Atrium	31 mm
LVID(Systole)	17 mm
LVID(Diastole)	43 mm
IVS(Diastole)	11 mm
PW(Diastole)	09 mm
LV ejection fraction.	55-60%

Conclusion

- Good biventricular function
- No RWMA
- Valves – Structurally normal
- No diastolic dysfunction
- No PAH

Dasgupta

Performed by: Dr. Anirban Dasgupta
D.N.B. Internal Medicine, Diploma Cardiology (PGDCC-IGNOU).

PATIENT'S NAME	SUMAN KUMAR	AGE :- 39 Y/M
UHID	9536	27 Nov 2023

DIGITAL RADIOGRAPH OF CHEST (PA VIEW)

The lung fields are clear.

Heart and aorta appears normal.

Both hila appear normal.

Both costo-phrenic angles are clear.

Visualized bony thorax appears normal.

IMPRESSION: NO SIGNIFICANT ABNORMALITY IS DETECTED.

Clinico-haematological correlation is recommended.

Thanking you for the referral,
With regards,



DR. SIDDHI PATIL
Cons. Radiologist

PATIENT'S NAME	SUMAN KUMAR	AGE :- 39y/M
UHID NO	9536	27 Nov 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 11.5 x 4.7 cm. **LEFT KIDNEY** measures 11.4 x 5.4 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.

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.CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg: No. 073826

• ANDHERI • COLABA • NASHIK • VASHI