



भारत सरकार

Government of India



जोधर



दिनेश कंवत

Dinesh Kanwat

जन्म तिथि/DOB: 14/08/1985

पुरुष/ MALE

9908 5176 5641

VID : 9195 6544 8843 9420

मेरा आधार, मेरी पहचान

11



EDWARDS, JAMES H. 1910-1970  
MUSEUM OF THE UNIVERSITY OF CALIFORNIA  
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भारतीय सरकार  
विद्युतचलित निदेशावली



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

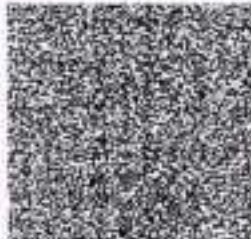


भारतीय सरकार  
विद्युतचलित निदेशावली



पता:  
पिंकी मीना, प्लॉट नं. E-323, वैशाली नगर, जैपुर, राजस्थान - 302021

Address:  
Pinki Meena, Plot No. E-323, Vaishali Nagar,  
Vaishali Nagar, Vaishali Nagar, Jaipur, Jaipur,  
Rajasthan - 302021



9908-5376 5641

VID : 9195 6544 8843 9420



### General Physical Examination

Date of Examination: 08/12/2022

Name: DINESH KANWAT Age: 38yr DOB: 14.08.1985 Sex: Male

Referred By: BANK OF BARODA

Photo ID: ADHARCARD ID #: 5641

Ht: 183 (cm)

Wt: 99 (Kg)

Chest (Expiration): 119 (cm)

Abdomen Circumference: 106 (cm)

Blood Pressure: 125/85 mm Hg PR: 75 / min RR: 17 / min Temp: Afebrile

BMI 29

Eye Examination: Glass vision R/E ] 6/6, N/6 NCB (NCB)  
L/E ] 6/6, N/6

Other: N/A

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

Signature Of Examinee : *Dinesh Kanwat*

Name of Examinee: DINESH KANWAT

Signature Medical Examiner : *Dr. Piyush Goyal*

Name Medical Examiner Dr. Piyush Goyal

**Dr. PIYUSH GOYAL**  
MBBS, DMRD (Radiologist)  
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# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)



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Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
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NAME :- Mr. DINESH KANWAT

Age :- 38 Yrs 3 Mon 26 Days

Sex :- Male

Patient ID :-12234080

Date :- 08/12/2023 09:46:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 08/12/2023 17:01:39

## HAEMOGARAM

### HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 MALE			
HAEMOGLOBIN (Hb)	14.1	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	4.80	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	56.0	%	40.0 - 80.0
LYMPHOCYTE	40.0	%	20.0 - 40.0
EOSINOPHIL	2.0	%	1.0 - 6.0
MONOCYTE	2.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	4.48 L	$\times 10^6/\mu\text{L}$	4.50 - 5.50
HEMATOCRIT (HCT)	42.30	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	94.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	31.5	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	33.4	g/dL	31.5 - 34.5
PLATELET COUNT	138 L	$\times 10^3/\mu\text{L}$	150 - 410
RDW-CV	13.3	%	11.6 - 14.0
MENTZER INDEX	20.98 H		0.00 - 0.00

A complete blood picture (CBP) is a kind of blood test that is done to assess a person's overall health and diagnose a wide range of health disorders like leukemia, anemia and other infections.

A complete blood count (CBC) is a complete blood test that diagnose many components and features of a persons blood which includes: -

\*Red Blood Cells (RBC), which carry oxygen -

\*White Blood Cells (WBC), which help in fighting against infections -

\*Hemoglobin, which is the oxygen carrying protein in the red blood cells -

\*Hematocrit (HCT), the proportion of RBC to the fluid component, or plasma present in blood -

\*Platelets, which aid in blood clotting

(CBC): Methodology: TLC,TRBC,PCV,PLT Impedance method, HB Colorimetric method, and MCH,MCV,MCHC,MENTZER INDEX are calculated. InstrumentName: MINDRAY BC-3000 Plus 3 part automatic analyzer.

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## HAEMATOLOGY

### Erythrocyte Sedimentation Rate (ESR)

Method - Westergren

13

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

(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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<b>NAME :- Mr. DINESH KANWAT</b>	Patient ID :-42234080	Date :- 08/12/2023	09:46:55
Age :- 38 Yrs 3 Mon 26 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- Mr.MED/WHEEL		

Final Authentication : 08/12/2023 17:01:39

**HAEMATOLOGY**

Test Name	Value	Unit	Biological Ref Interval
<b>GLYCOSYLATED HEMOGLOBIN (HbA1C)</b> Method:- CAPILLARY w/o EDTA	5.8	%	Non-diabetic: < 5.7 Pre-diabetics: 5.7-6.4 Diabetics: = 6.5 or higher ADA Target: 7.0 Action suggested: > 6.5
<b>MEAN PLASMA GLUCOSE</b> Method:- Calculated Parameter	114	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 glycaemia. The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx. - 8-9 weeks) and therefore provides much more reliable information for glycaemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-8 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.)

- Erythropoiesis**
  - Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis
  - Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease
- Altered Haemoglobin-Genetic or chemical alterations in haemoglobin, haemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.**
- Glycation**
  - Increased HbA1c: alcoholism, chronic renal failure, decreased intracellular pH.
  - Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH
- Erythrocyte destruction**
  - Increased HbA1c: increased erythrocyte life span: Splenectomy
  - Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapson
- Others**
  - Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, 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

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**HAEMATOLOGY**

**BLOOD GROUP ABO**  
Method:- Haemagglutination reaction

**"O" POSITIVE**



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**BIOCHEMISTRY**

Test Name	Value	Unit	Biological Ref Interval
<b>LIPID PROFILE</b>			
TOTAL CHOLESTEROL Method:- CHOD-PAP methodology	154.00	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	126.00	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	45.20	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	87.80	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-199 Very High > 190
VLDL CHOLESTEROL Method:- Calculated	25.20	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method:- Calculated	3.41		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Method:- Calculated	1.94		0.00 - 3.50
TOTAL LIPID Method:- CALCULATED	493.02	mg/dl	400.00 - 1000.00

1. 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  
2. 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

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**BIOCHEMISTRY**

recommended

3 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



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## BIOCHEMISTRY

### LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method- DMSO/Diazot	0.62	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method- DMSO/Diazot	0.21	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method- Calculated	0.41	mg/dl	0.30-0.70
SGOT Method- IFCC	16.2	U/L	0.0 - 40.0
SGPT Method- IFCC	18.2	U/L	0.0 - 40.0
SERUM ALKALINE PHOSPHATASE Method- DGKC - SCE	96.50	U/L	53.00 - 141.00
SERUM GAMMA GT Method- Szasz methodology Immunoat Nemo Biodes Rx India Interpretation: Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 1 to 30 times normal levels in intra- or post- hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 3 times normal) are observed with infectious hepatitis.	32.20	U/L	10.00 - 45.00
SERUM TOTAL PROTEIN Method- Direct Buret Reagent	6.85	g/dl	6.00 - 8.40
SERUM ALBUMIN Method- Bromocresol Green	4.45	g/dl	3.50 - 5.50
SERUM GLOBULIN Method- CALCULATION	2.40	gm/dl	2.20 - 3.50
A/G RATIO	1.85		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 may be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminases), 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 ,parasitosis) 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 Method- Urease/GLDH	36.90	mg/dl	10.00 - 50.00
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InstrumentName: HORIBA CA 60 Interpretation : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE Method- Jaffe's Method	1.20	mg/dl	Males : 0.6-1.50 mg/dl 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	5.63	mg/dl	2.40 - 7.00
-----------------	------	-------	-------------

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

SODIUM Method- ISF	145.0	mmol/L	135.0 - 150.0
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POTASSIUM Method- ISE	4.12	mmol/L	3.50 - 5.50
--------------------------	------	--------	-------------

CHLORIDE Method- ISE	106.6	mmol/L	94.0 - 110.0
-------------------------	-------	--------	--------------

SERUM CALCIUM Method- Arsenazo III Method	9.65	mg/dl	8.80 - 10.20
----------------------------------------------	------	-------	--------------

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 Method- Direct Biuret Reagent	6.85	g/dl	6.00 - 8.40
------------------------------------------------------	------	------	-------------

SERUM ALBUMIN Method- Bismarscol Green	4.45	g/dl	3.50 - 5.50
-------------------------------------------	------	------	-------------

SERUM GLOBULIN Method- CALCULATION	2.40	gm/dl	2.20 - 3.50
---------------------------------------	------	-------	-------------

A/G RATIO	1.85		1.30 - 2.50
-----------	------	--	-------------

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of dis... liver, kidney and

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**BIOCHEMISTRY**

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.

Apart from renal failure Blood Urea can increase in dehydration and GI bleed



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**TOTAL THYROID PROFILE**

**IMMUNOASSAY**

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

**THYROID-TRIIODOTHYRONINE T3**

1.14

ng/mL

0.70 - 2.04

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 50% 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 7 Primary hypothyroidism is accompanied by serum T3 and T4 values & serum TSH levels 8 Normal T4 levels accompanied by T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9 Normal or T3 & T4 10 Normal T3 & T4 along with TSH indicate mild / Subclinical Hypertthyroidism 11 Normal T3 & T4 along with TSH is seen in Hypothyroidism 12 Normal T3 & T4 levels with TSH indicate Mild / Subclinical Hypoth

**DURING PREGNANCY - REFERENCE RANGE** for TSH in uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL, 2nd Trimester : 0.20-3.00 uIU/mL, 3rd Trimester : 0.30-3.00 uIU/mL. The production, circulation, and degradation 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 radioactive 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-THYRONINE (T4)** due to a real change with age or an increasing proportion of unrecognized 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 50% 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.

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**TSH**

0.648

uIU/mL

0.350 - 5.500

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 50% 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 use

*Tanu*

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

Technologist  
VIKAL KANWAT

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📍 B-14, Vidhyadhar Enclave-II, Near Axis Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
☎ +91 141 4824885 📧 maxcarediagnostics1@gmail.com

<b>NAME :- Mr. DINESH KANWAT</b>	Patient ID :-12234080	Date :- 08/12/2023	09:46:55
Age :- 38 Yrs 3 Mon 26 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 08/12/2023 17:01:39

### IMMUNOASSAY

evaluating differential diagnosis

#### INTERPRETATION-Ultra Sensitive 4th generation assay

- 1.Primary hyperthyroidism is accompanied by :normal T3 & T4 values along with ↓ TSH level.
- 2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease.
- 3.Low TSH,high FT4 and TSH receptor antibody(TNAb)-ve seen in patients with Toxic adenoma/Toxic Multinodular goiter.
- 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis.
- 5.HighTSH,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.
- 7.Primary hypothyroidism is accompanied by : serum T3 and T4 values & ↑serum TSH levels.
- 8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis.
- 9.Normal or ↓ T3 & ↓T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3).
- 10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism.
- 11.Normal T3 & T4 along with ↑ TSH is seen in Hypothyroidism.
- 12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism.
- 13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propranolol.
- 14.Although ↑ TSH levels are nearly always indicative of Primary Hypothyroidism , rarely they can result from TSH secreting pituitary tumours.

#### DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

- 1st Trimester : 0.10-2.50 uIU/mL
- 2nd Trimester : 0.25-3.00 uIU/mL
- 3rd Trimester : 0.30-3.00 uIU/mL

The production, stimulation, 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 radionuclide 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 unrecognized thyroid disease in the elderly.

\*\*\* End of Report \*\*\*

Technologist  
VIRAJ KANWAT  
Page No. 16 of 16

*Tanu*

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





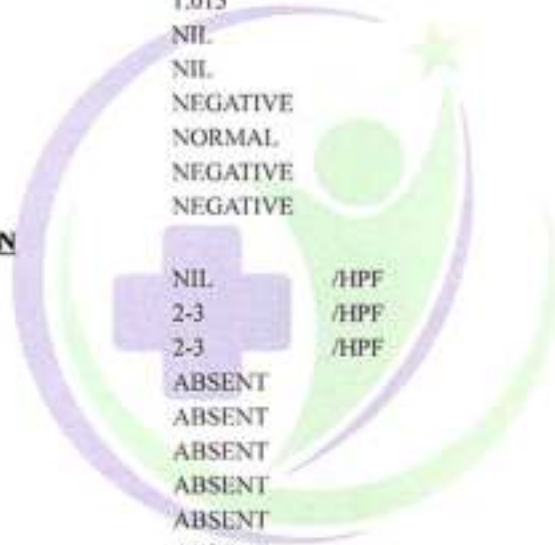
📍 B-14, Vidhyadhar Enclave-II, Near Axix Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
☎ +91 141 4824885 📧 maxcarediagnostics1@gmail.com

<b>NAME :- Mr. DINESH KANWAT</b>	Patient ID :-12234080	Date :- 08/12/2023	09:46:55
Age :- 38 Yrs 3 Mon 26 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 08/12/2023 17:01:39

**CLINICAL PATHOLOGY**

Test Name	Value	Unit	Biological Ref Interval
<b>Urine Routine</b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
REACTION(PH)	5.5		5.0 - 7.5
SPECIFIC GRAVITY	1.015		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<b><u>MICROSCOPY EXAMINATION</u></b>			
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



*Tanu Rungta*

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

**Technologist**  
VIKARANTSI  
Page No. 12 of 18



# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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



NAME:	MR. DINESH KANWAT	AGE	38 YRS/M
REF.BY	BANK OF BARODA	DATE	08/12/2023

## 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**

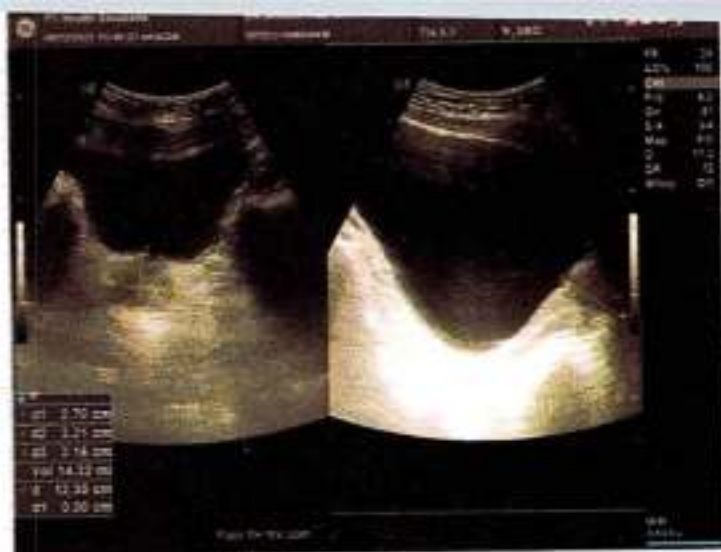
**M.B.B.S; M.D. (Radiodiagnosis)**

**RMC No. 43418/17437**











# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

- 📍 B-14, Vidhyadhar Enclave-II, Near Axix Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
- ☎ +91 141 4824885 📧 maxcarediagnostics1@gmail.com



MR. DINESH KANWAT	38Y/M
Registration Date: 08/12/2023	Ref. by: BANK OF BARODA

## ULTRASOUND OF WHOLE ABDOMEN

Liver is enlarged in size (180 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 and shows an anterior wall echogenic polyp measuring 3.4mm x 3.7mm. Wall is not thickened. No calculus 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. **Few category- I cortical cysts are seen in the left kidney larger measuring 12mm.**

Right kidney is measuring approx. 118 mm.

Left kidney is measuring approx. 125 mm.

Urinary bladder is well distended and does not show any calculus or mass lesion.

Prostate is normal in size with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.

No significant free fluid is seen in pelvis.

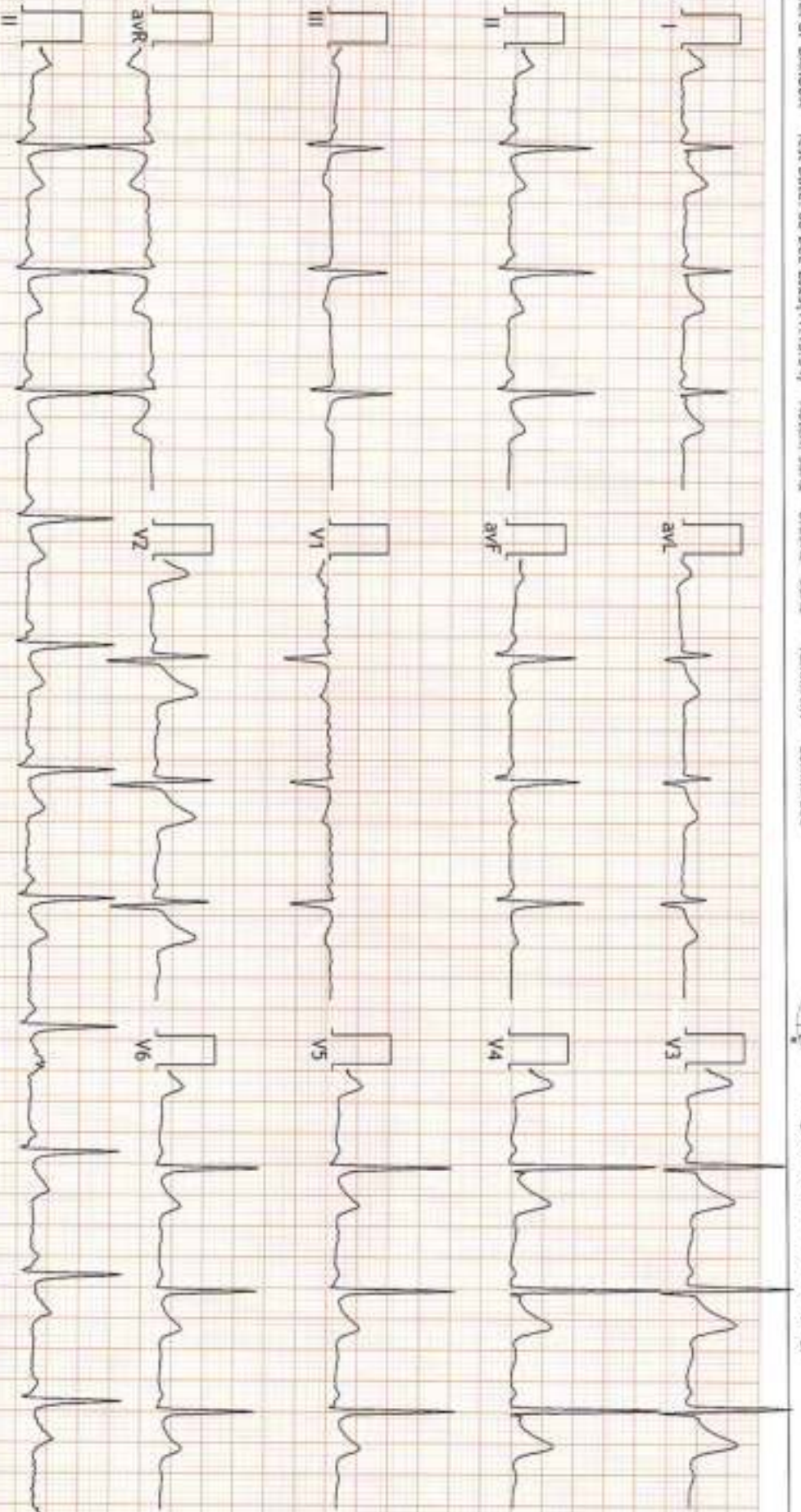
### IMPRESSION:-

- Mild hepatomegaly with grade II hepatic steatosis
- GB polyp.
- Left renal category-I cortical cysts .
- 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 LLP





FINDINGS: Normal Sinus Rhythm  
Vent Rate : 70 bpm; PR Interval : 156 ms; QRS Duration: 82 ms; QT/QTc Int : 351/380 ms  
P-QRS-T axis: 111 - 75 - 69 (Deg)  
Comments :

*Sinus rhythm with small q in lead III and aVF*

Dr. Naresh Kumar Mohanka  
RMC No. 35703  
MBBS, DIP. CARDIO (ESCORTS)  
D.E.M. (RCCP) MEDICINA  
Dr. NARESH MOHANKA



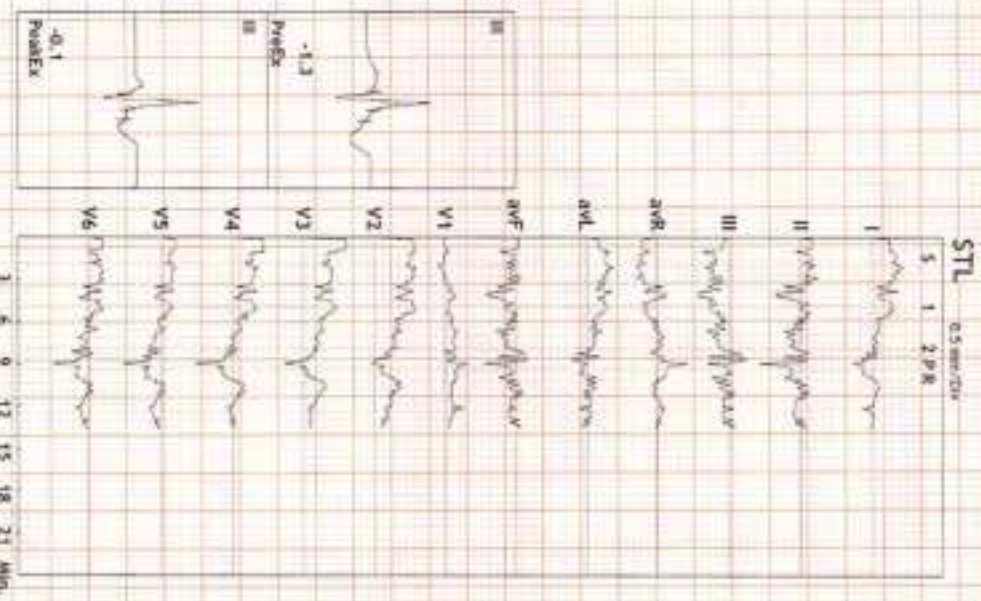
B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur  
 12234000/RR DIRECT KARNAT 38 Yrs/Male 0 Kg/70 Cms  
 Date: 08-Dec-2023 11:18:49 AM  
 Ref. By : BANK OF BARODA  
 Medication : Nil  
 Objective :

Protocol : BRUCE  
 History : Nil

Stage	StageTime (min:Sec)	PhaseTime (min:Sec)	Speed (mph)	Grade (%)	METS	H.R. (bpm)	B.P. (mmHg)	R.P.R. (bpm)	PVC	Comments
Supine					1.0	71	125/85	88	-	
Standing					1.0	71	125/85	88	-	
HV					1.0	78	125/85	97	-	
ExStart					1.0	80	125/85	100	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	108	135/85	145	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	137	145/85	198	-	
PeakEx	1:35	7:36	3.4	14.0	8.7	159	155/90	246	-	
Recovery	1:00		0.0	0.0	1.2	120	155/90	185	-	
Recovery	2:00		0.0	0.0	1.0	100	165/90	165	-	
Recovery	3:00		0.0	0.0	1.0	97	155/90	150	-	
Recovery	4:00		0.0	0.0	1.0	102	145/85	147	-	

**Findings :**  
 Exercise Time : :07:35  
 Max HR Attained : :159 bpm 87% of Max Predictable HR 182  
 Max BP : 165/90(mmHg)  
 Max Workload attained : 8.7(Fair Effort Tolerance)

Base line ecg show vnl These is mild  
 St t changes seen during exercise  
 in infero lat leads with rS over rL. So  
 base line with i min of recovery. again  
 reappear during late recovery. TmT  
 mildly positive for RMI. Correlate



Dr. Nareesh Kumar Mohanka  
 RMC No. 35705  
 MBBS, Dip. CARDIO (ESCORTS)  
 D.E.M. (PROSP. ILM)  
 DR. NAREESH MOHINKA



HR: 71 bpm  
METS: 1.0  
BP: 125/85

MPHR: 39% of 182  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRICE  
10.05-100Hz

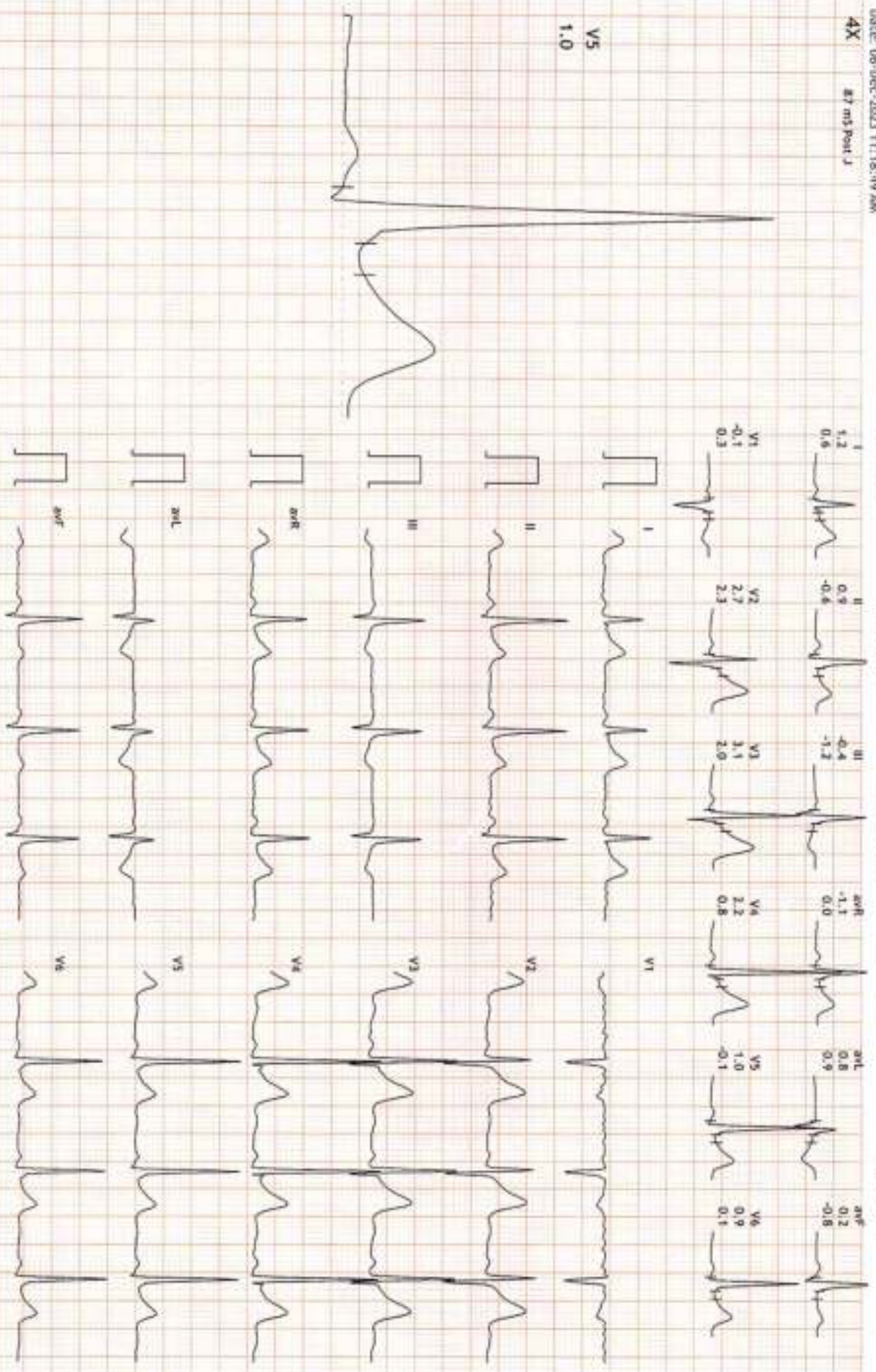
Ex Time 00:33  
BLC: On  
Watch: On

Sapine  
10.0 mm/mV  
25 mm/Sec.



4X 87 mS Post J

V5  
1.0





HR: 70 bpm  
MET5: 1.0  
BP: 125/85

MPHR: 38% of 182  
Speed: 0.0 mph  
Grade: 0.0%

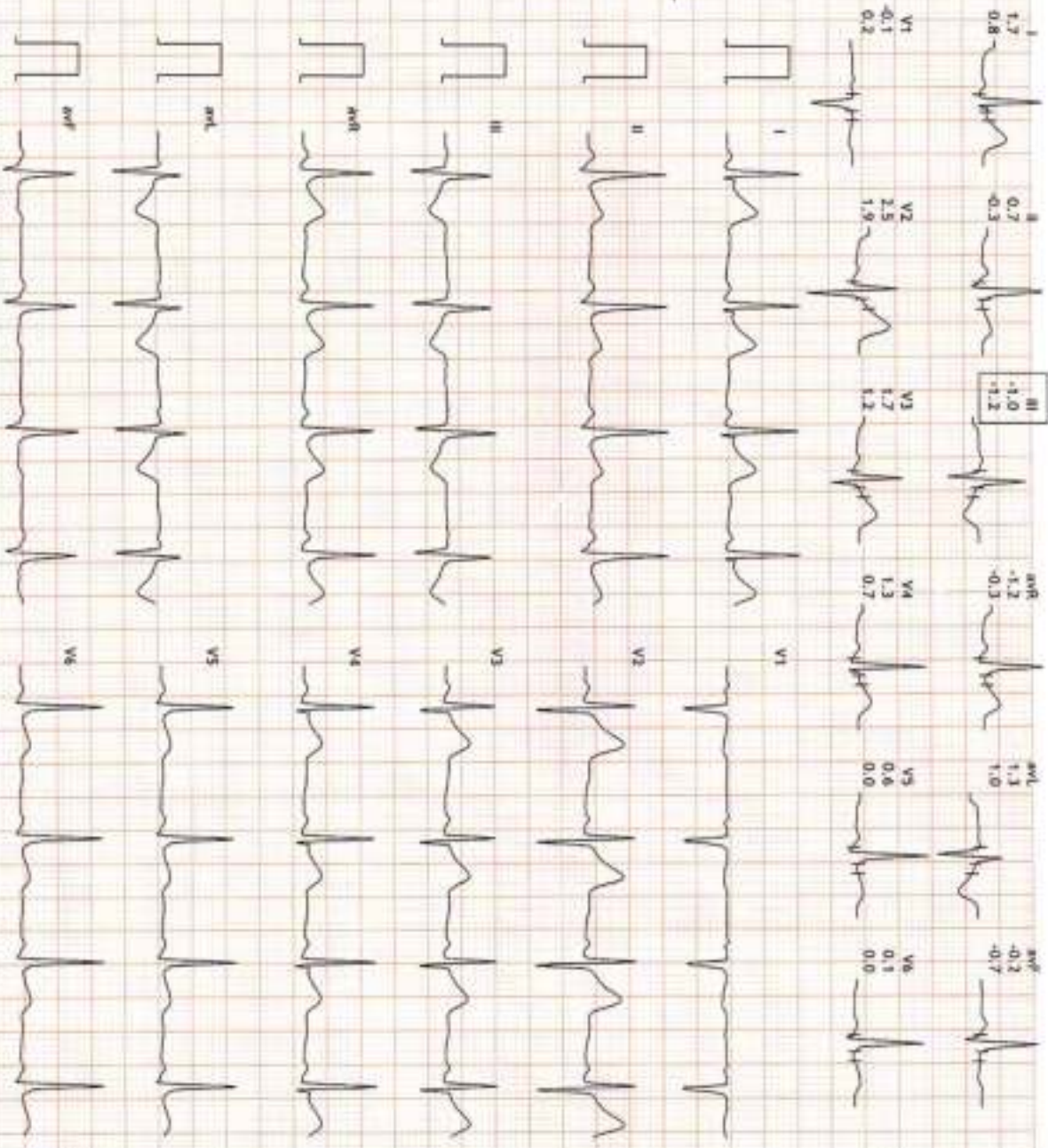
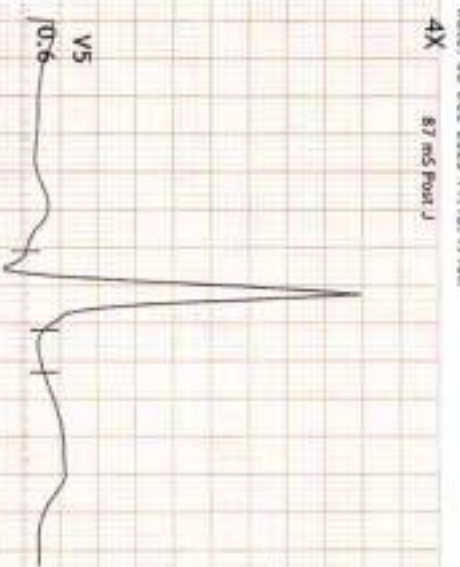
Raw ECG  
BRUCE  
10.05-1001Hz

Ex Time 01:10  
BLC :On  
Heitch :On

Standing  
10.0 mm/mV  
25 mm/Sec.



4X 87 mS Four J





HR: 77 bpm  
METs: 1.0  
BP: 125/85

MPHR: 42% of 182  
Speed: 0.0 mph  
Grade: 0.0%

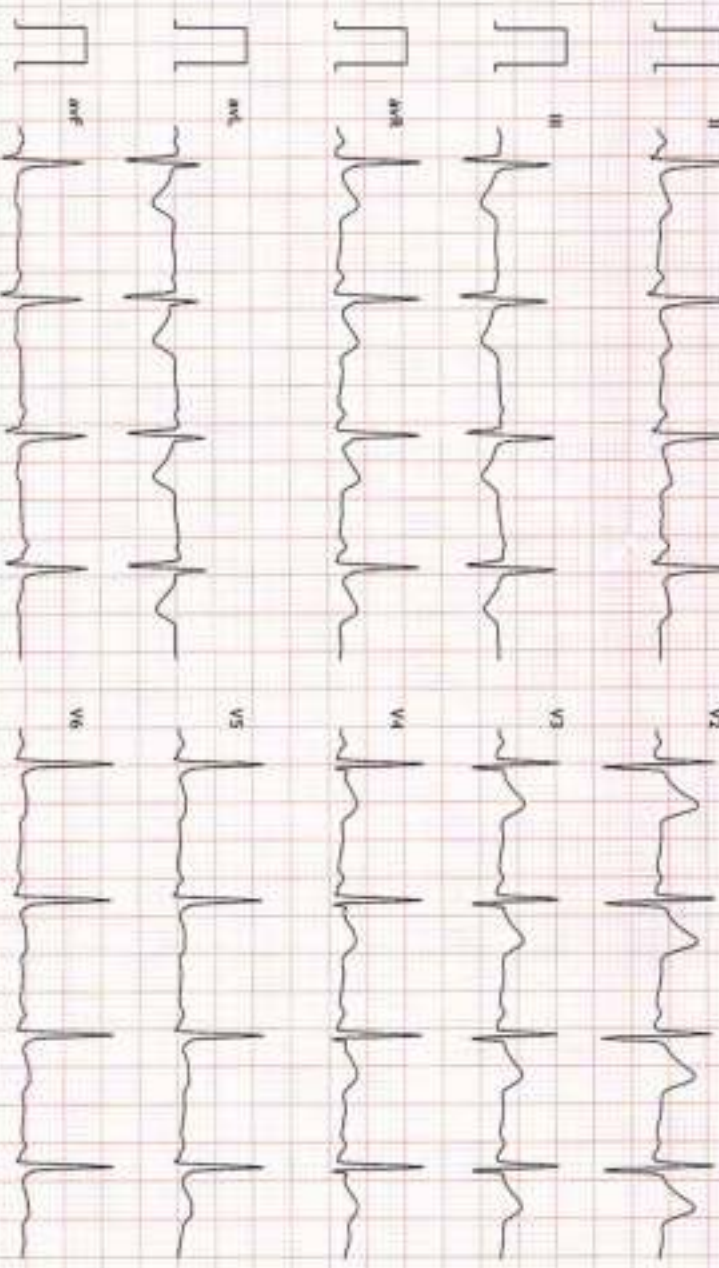
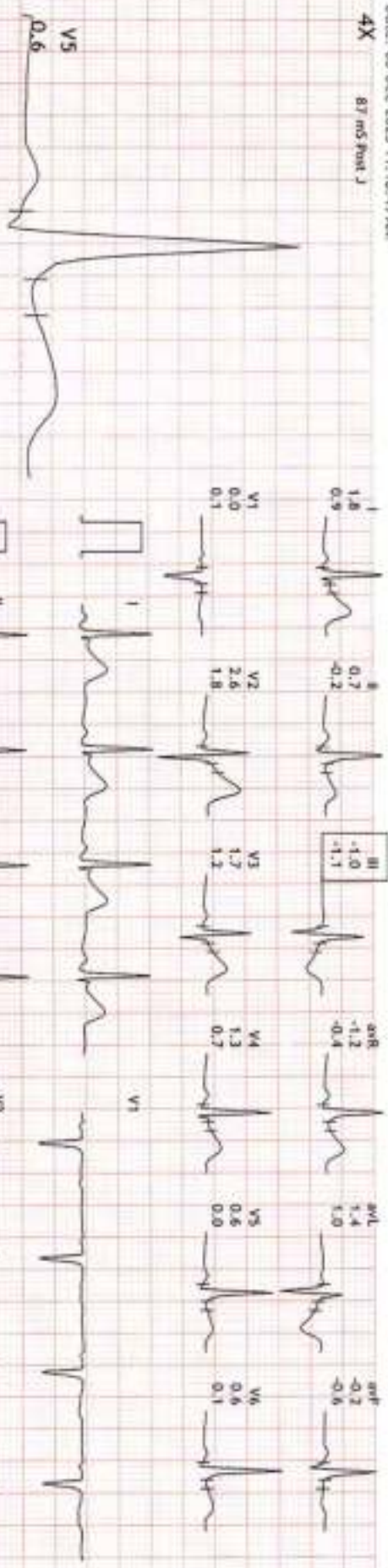
Raw ECG  
BRUCE  
10.05-100/Hz

Ex Time 01:19  
BLC :On  
Notch :On

HV  
10.0 mm/mV  
25 mm/Sec



4X 87 ms Print J





HR: 80 bpm  
METs: 1.0  
BP: 125/85

MPHR: 43% of 182  
Speed: 0.0 mph  
Grade: 0.0%

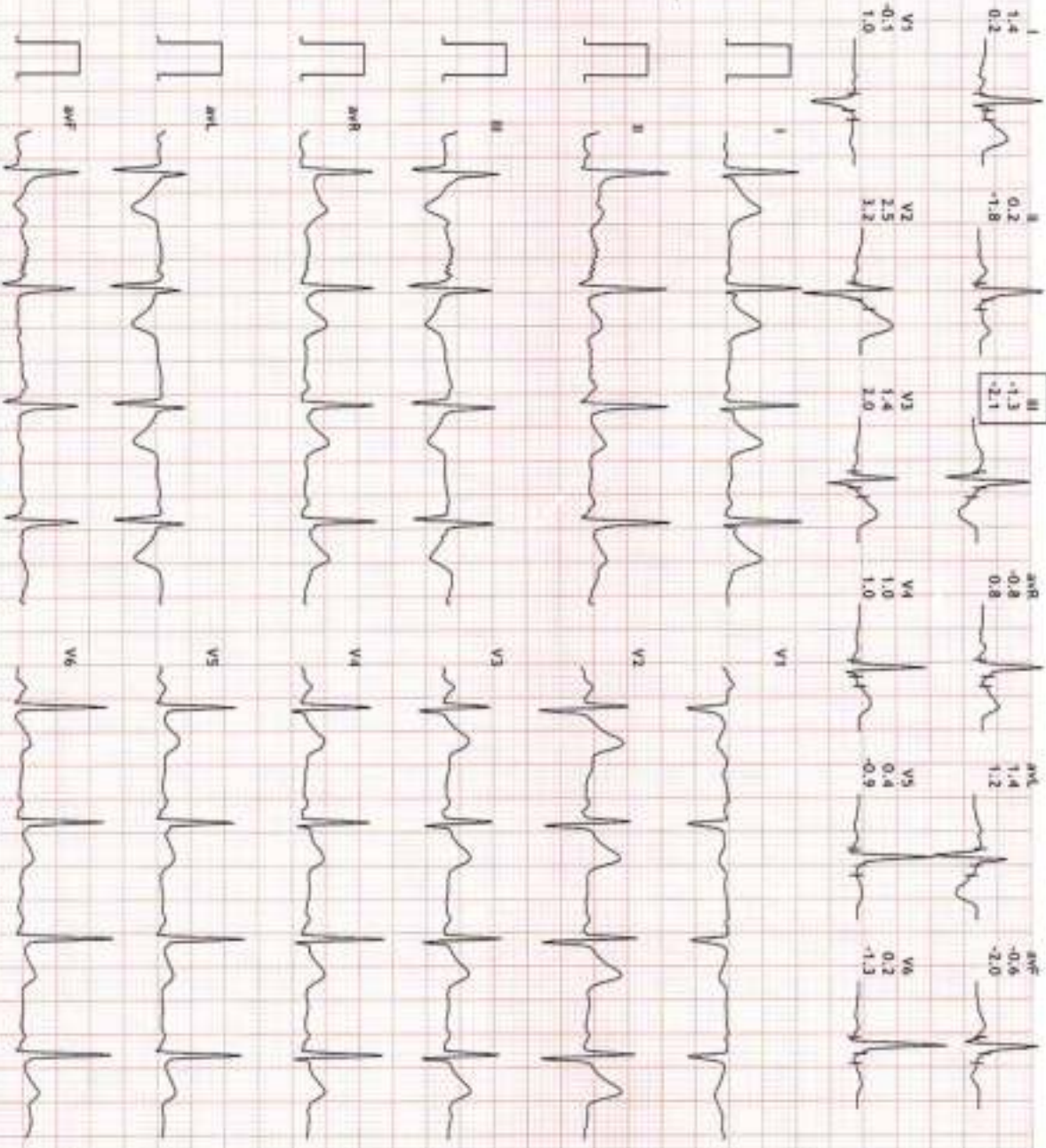
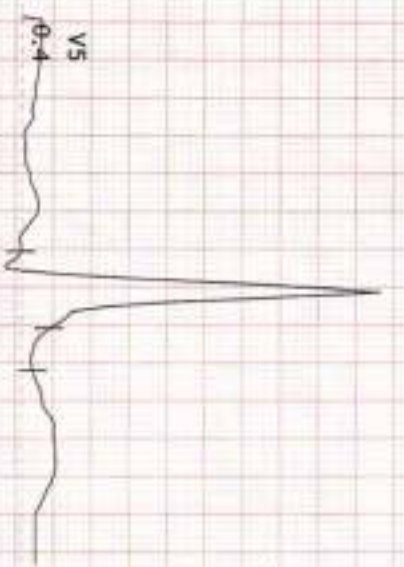
Raw ECG  
BRUCE  
10.05-100Hz

Ex Time 01:51  
BLC :On  
Mech: On

ExStart  
10.0 min/mV  
25 mm/5sec



4X 87 ms Post J





HR: 109 bpm  
MET5: 4.7  
BP: 135/85

MPH: 55% of 182  
Speed: 1.7 mph  
Grade: 10.0%

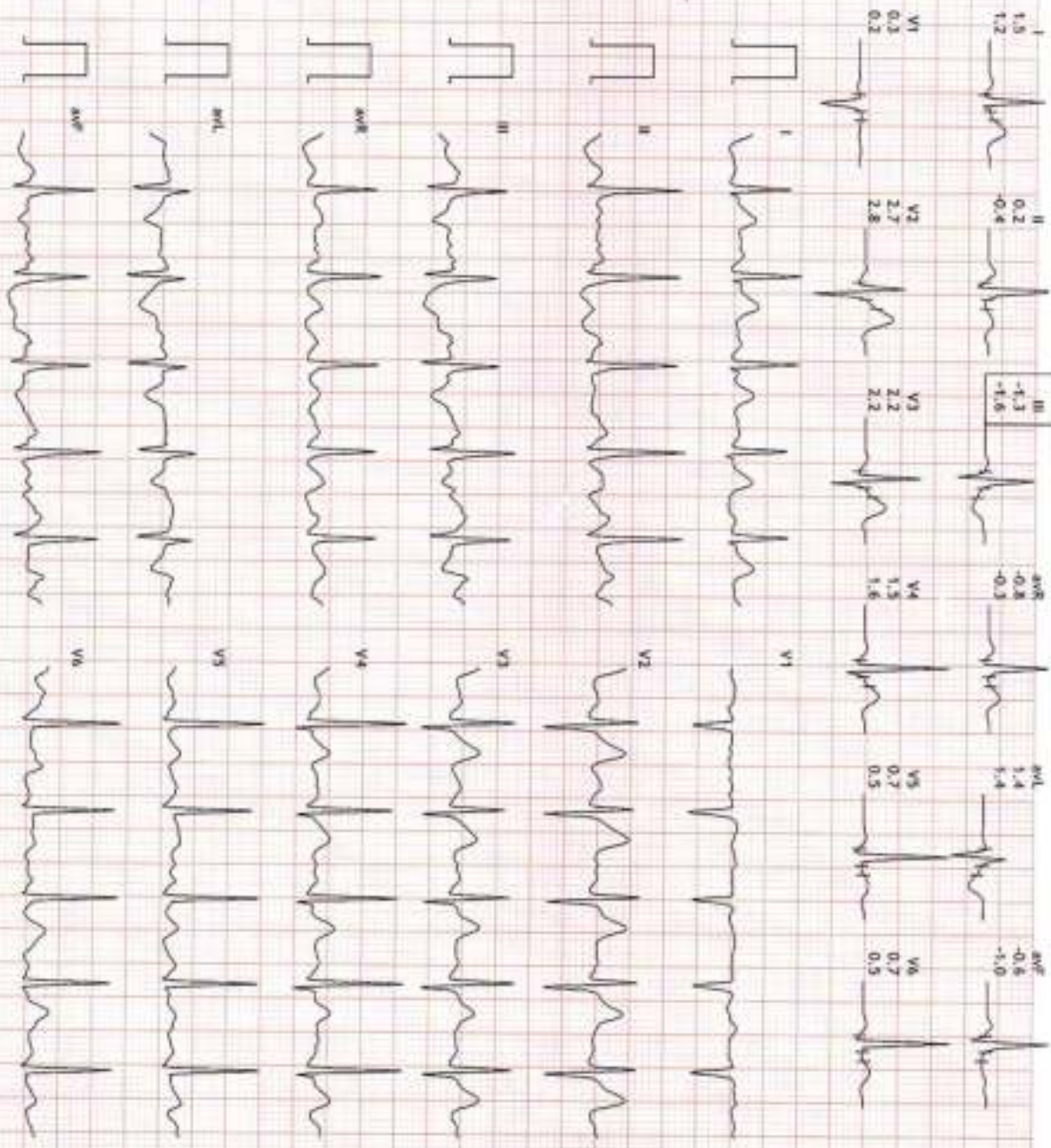
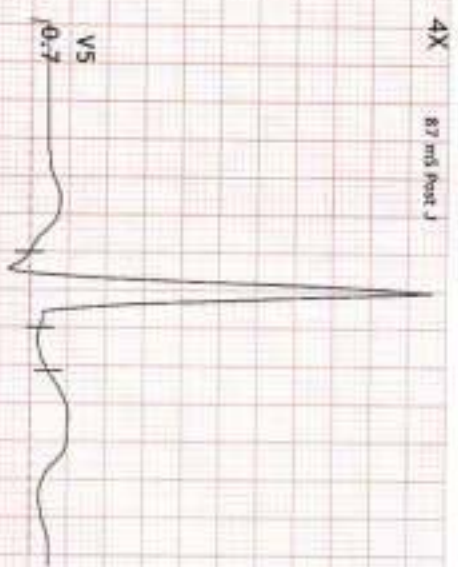
Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 02:59  
BLC :On  
Notch :On

BRUCE:Stage 1(3:00)  
10.0 mm/mV  
25 mm/5sec



4X 87 ms Paper J





HR: 137 bpm  
MEFS: 7.1  
BP: 145/85

MPHR: 75% of 182  
Speed: 2.5 mph  
Grade: 12.0%

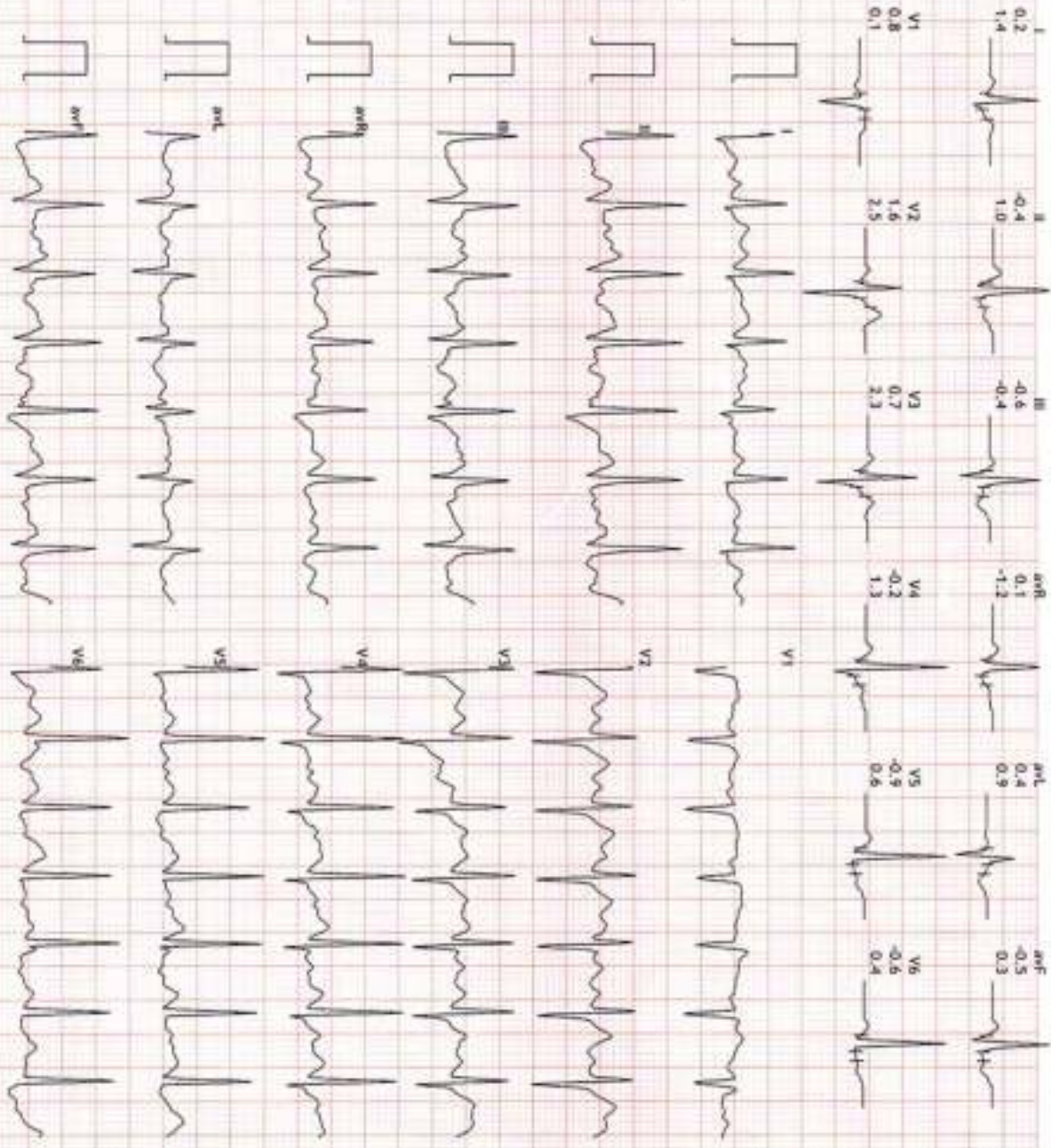
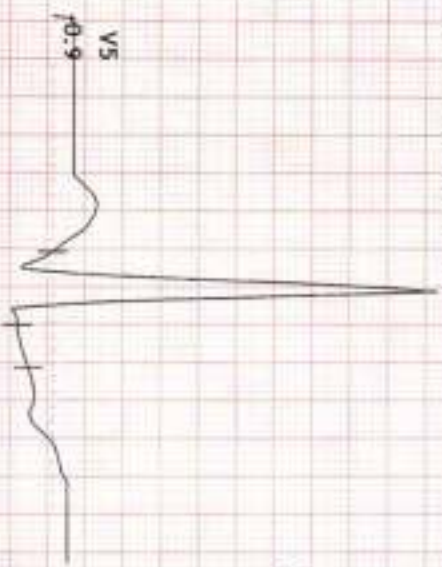
Raw ECG  
BRUCE  
10.05-100/Hz

Ex Time 05:39  
RLC -On  
Hitch -On

BRUCE: Stage 2(3:00)  
10.0 mm/1V  
25 mm/Sec



4X 87 ms Post J





HR: 158 bpm  
AETSI: 8.7  
BP: 155/90

MEPR: 86% of 182  
Speed: 1.4 mph  
Grade: 14.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

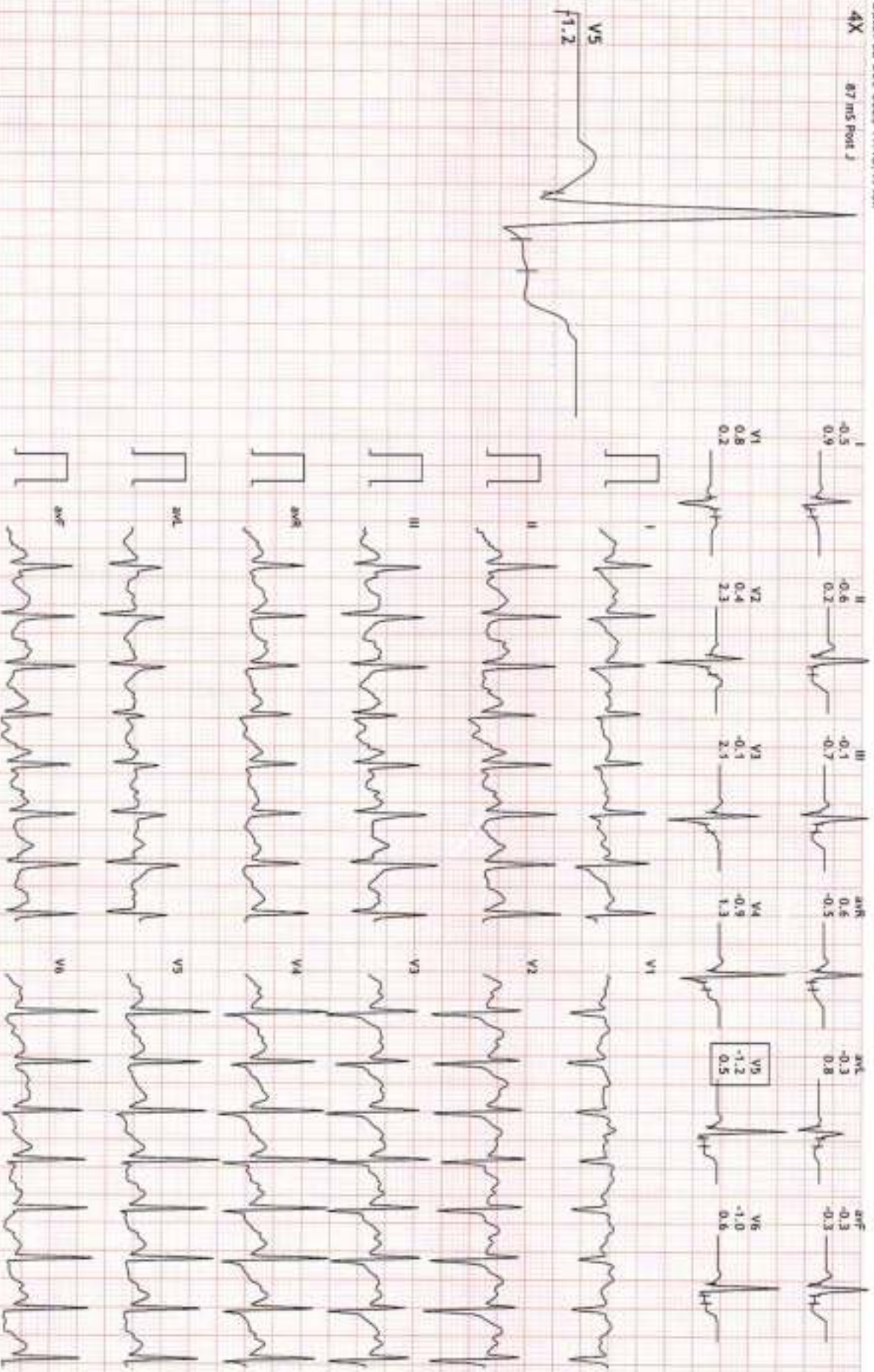
Ex Time: 07:33  
BLC: On  
Medch: On

BRUCE: PeakEx(1:33)  
10.0 mm/mV  
25 mm/Sec.



4X 87 ms Post J

V5  
f1.2





HR: 121 bpm  
METS: 1.3  
BP: 135/90

MPHR: 66% of 162  
Speed: 0.0 mph  
Grade: 0.0%

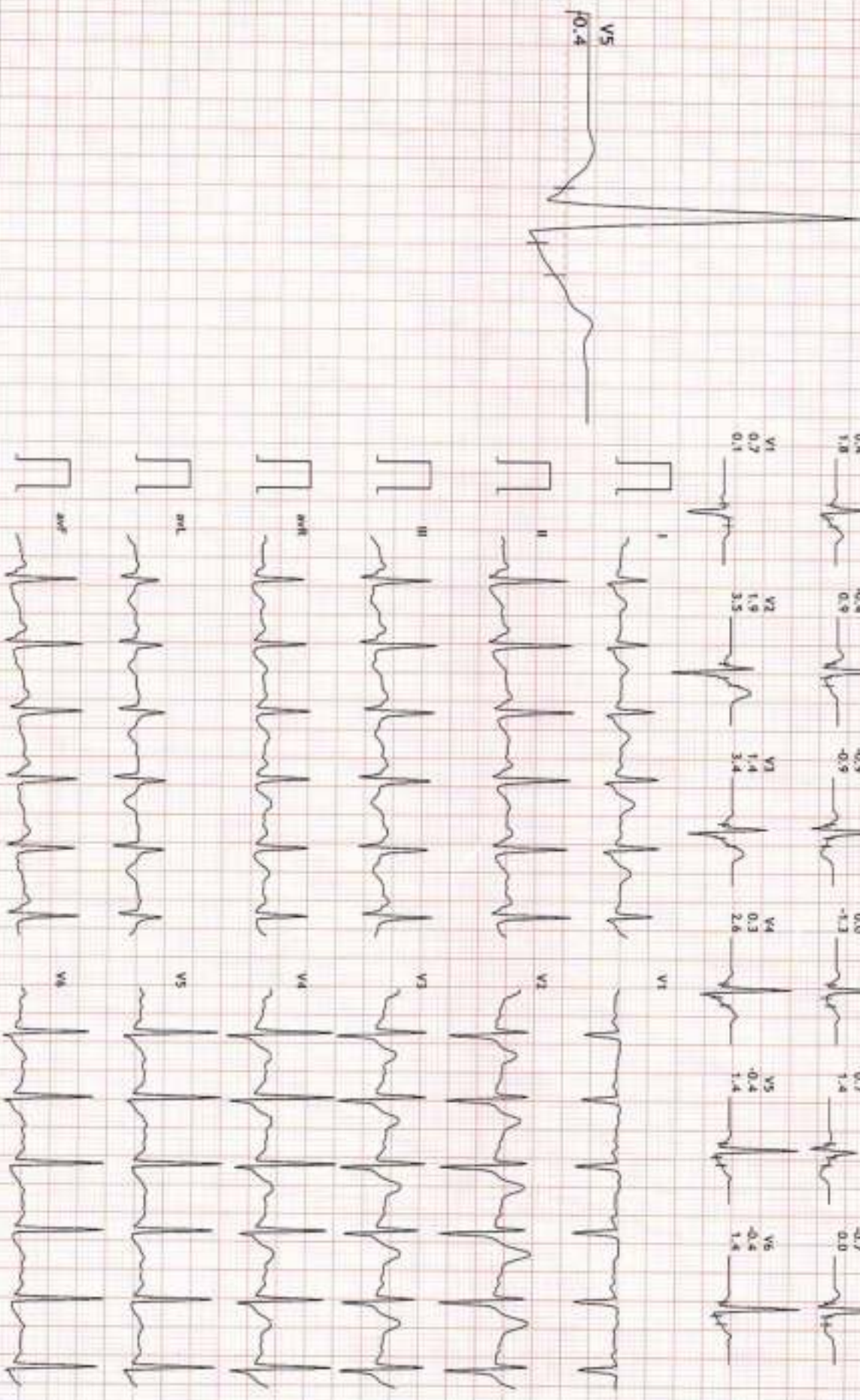
Raw ECG  
BRUCE  
10.05-100/Hz

Ex Time 07:35  
BLC :On  
Metch :On

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



4X 87 ms Print J





HR: 100 bpm  
METS: 1.0  
BP: 165/90

APPRI-S4% of 182  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
{0.05-100}Hz

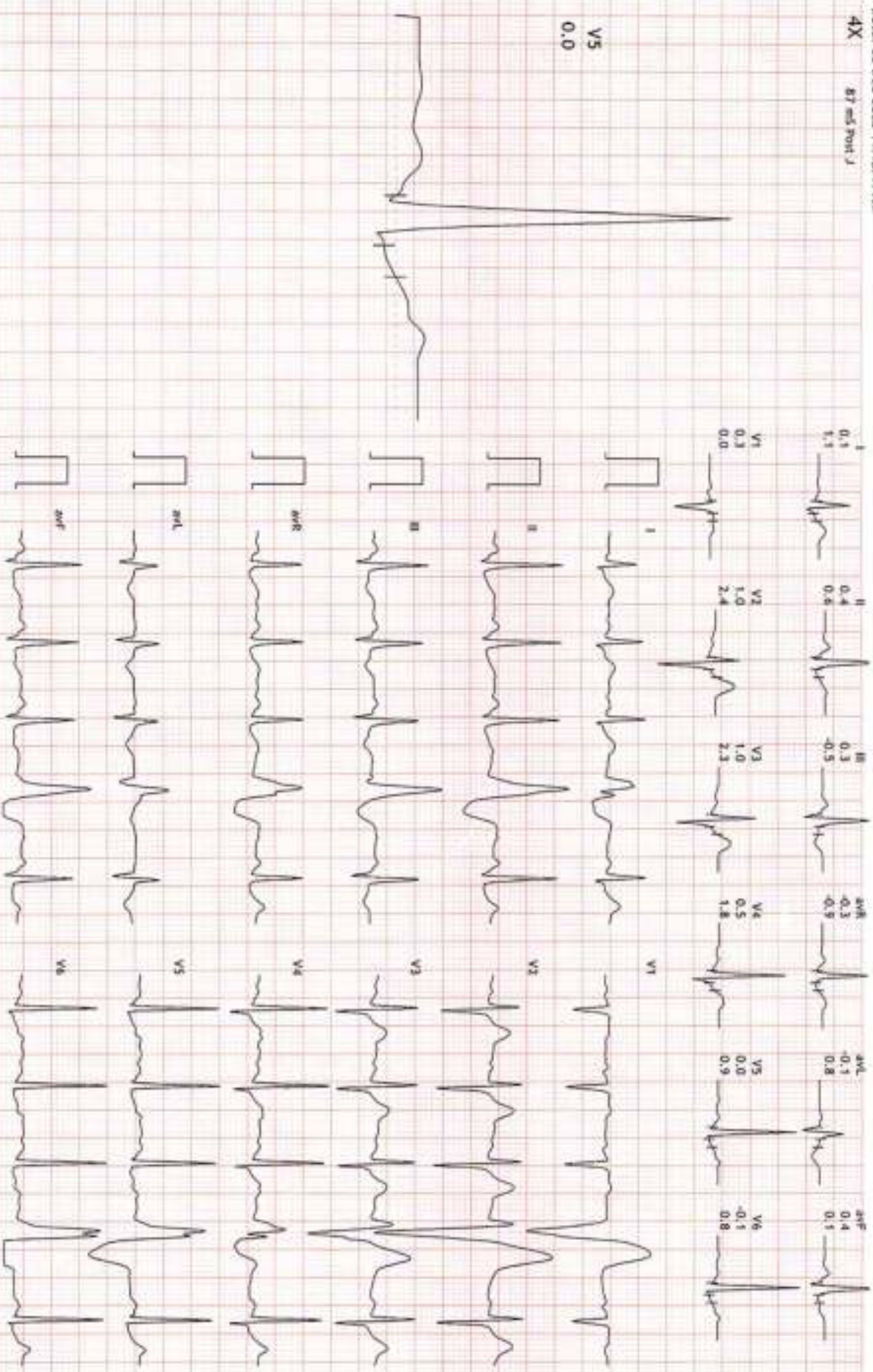
Ex Time 07:35  
BLC : On  
Meth: On

Recovery(2:00)  
10.0 mm/min  
25 mm/Sec.



4X 87 ms Post J

V5  
0.0





HR: 98 bpm  
METs: 1.0  
BP: 155/90

MPHR: 53% of 182  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

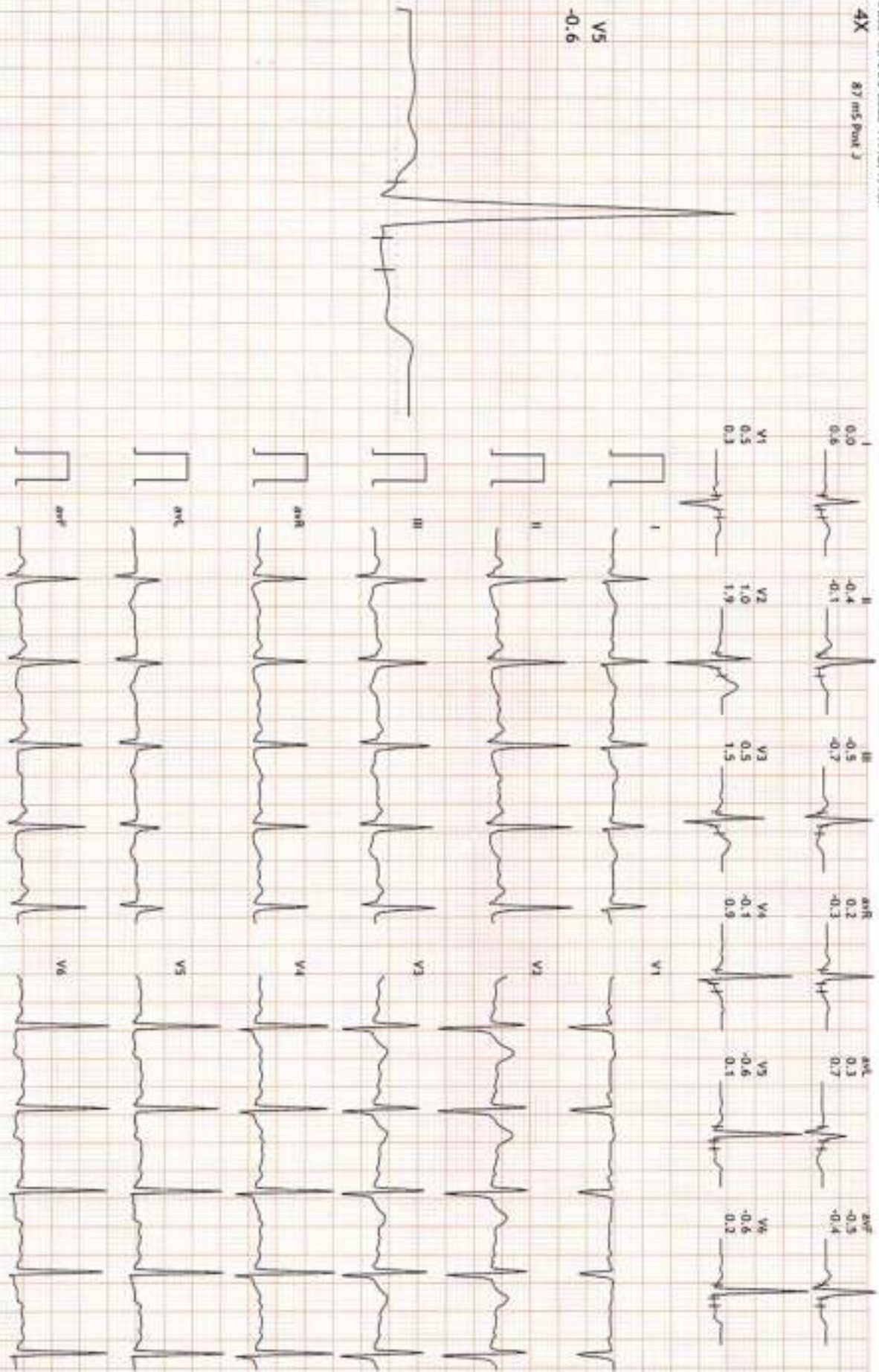
Ex Time 07:35  
BLC :On  
Watch :On

Recovery(3:00)  
10.0 min/rv  
25 min/Sec.



4X 87 ms Post J

V5  
-0.6





HR: 101 bpm  
METS: 1.0  
BP: 145/85

APHR: 55% of 182  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

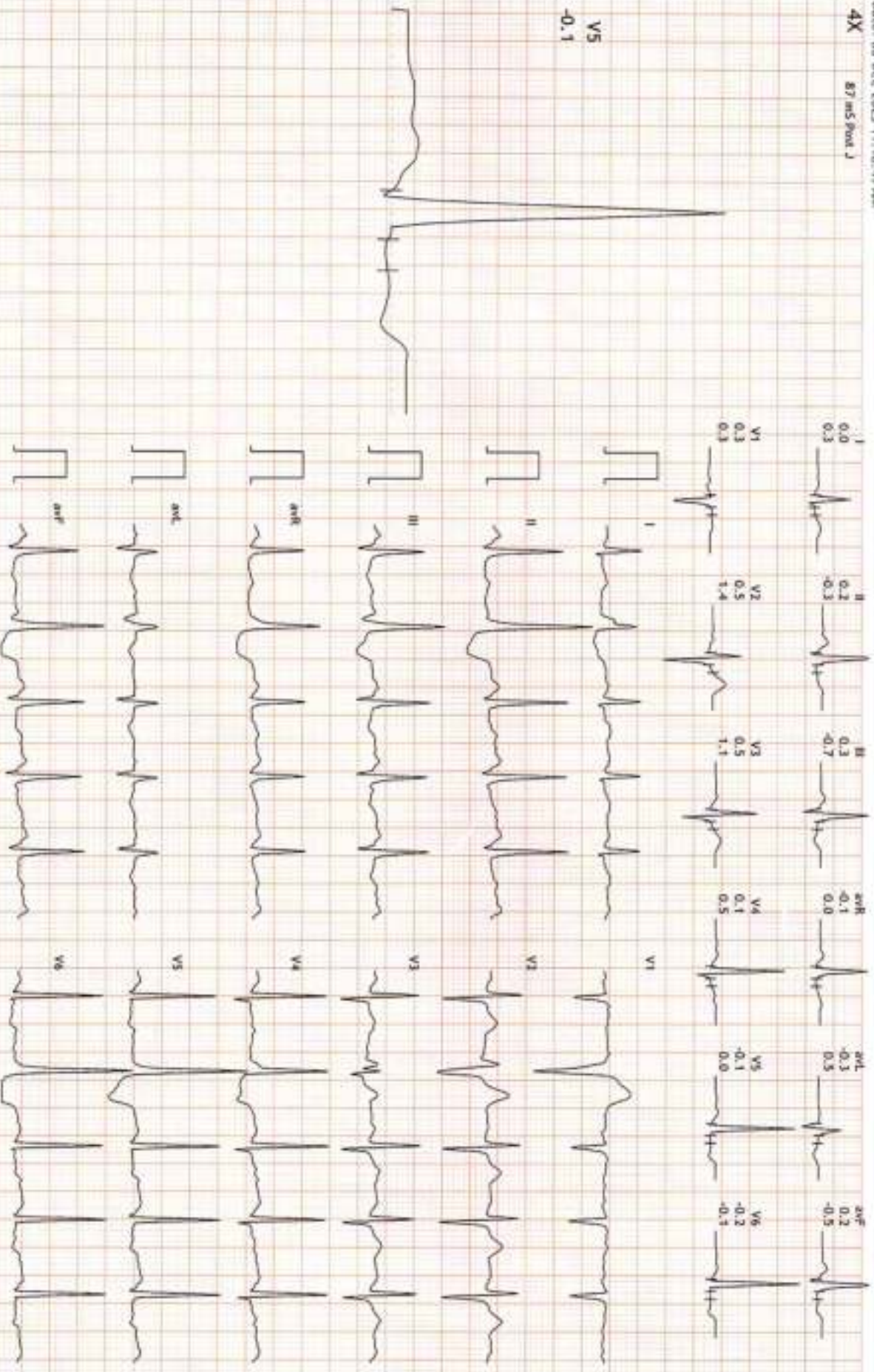
Ex Time: 07:35  
BLC :On  
Natch :On

Recovery(4:00)  
10.0 min/rwy  
25 min/Sec.

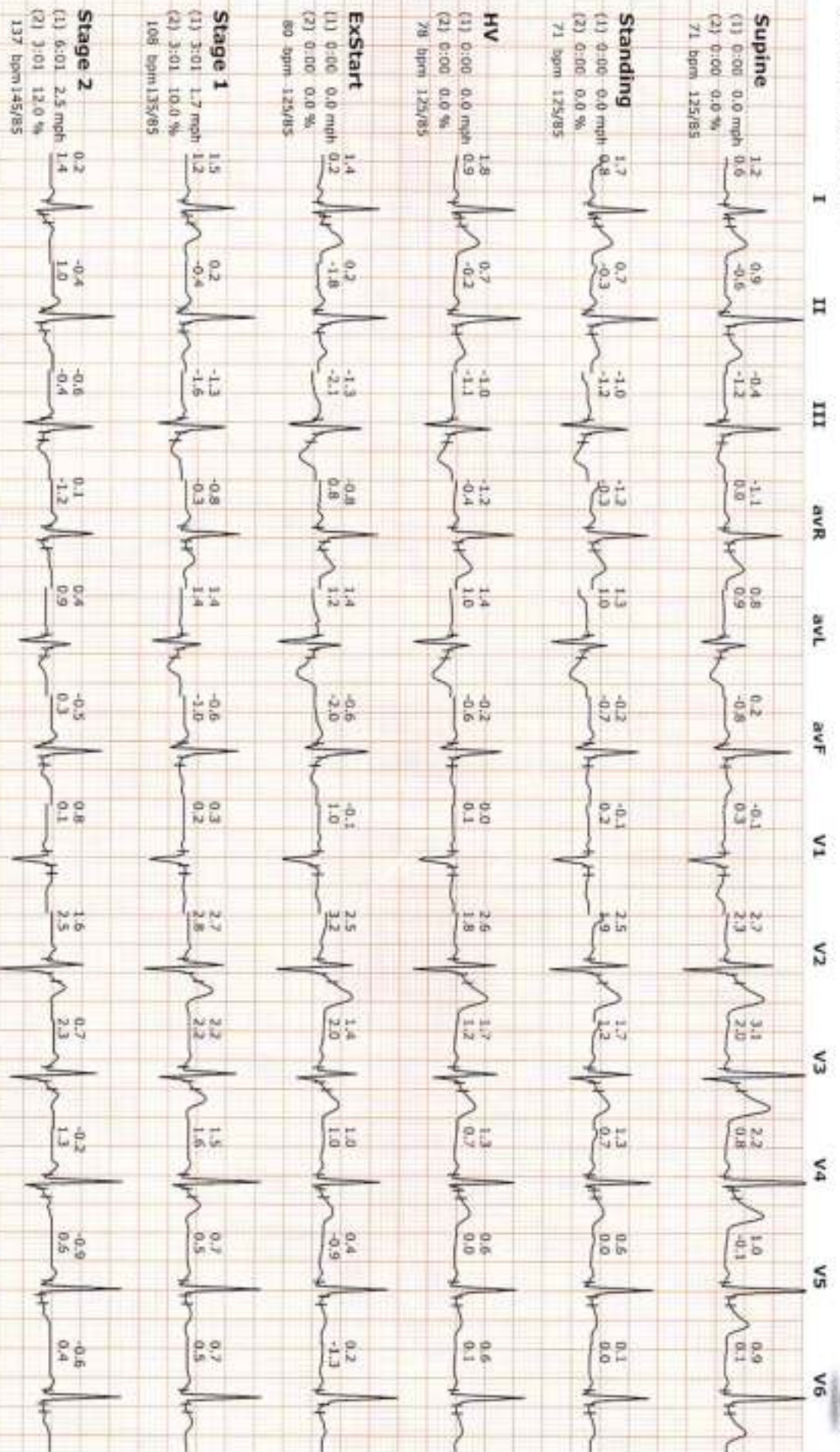


4X 87 mS Print J

V5  
-0.1









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

12234690/MR DINESH KANWAT

38 Yrs/Male

0 Kg/0 Cms

Date: 08-Dec-2023 11:18:49 AM

