Apollo TOUCHING LIVES

MEDICAL SUMMARY

Apollo Clinic VASHI

NAME:	Mr. Kalyan Chakravarty	UHID:	
AGE:	36	DATE OF HEALTHCHECK:	21/8/2025
GENDER:	M		

HEIGHT:	165	MARITAL STATUS:	M
WEIGHT:	93.4	NO OF CHILDREN:	2
BMI:	34.3		

C/O: - Vertigo - 2 day Back
Cervical pain, heart
Consultation: 6 months
2 episodes

K/C/O:

PRESENT MEDICATION: - Not taking medicine

P/M/H: - No

P/S/H: - No

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

ALCOHOL: } No

TOBACCO/PAN:

FAMILY HISTORY FATHER: - HTN, CVA

MOTHER: - DM

O/E:

BP: 110/80 PULSE: 86/min

TEMPERATURE: N SCARS:

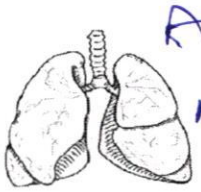
LYMPHADENOPATHY:

PALLOR/ICTERUS/CYNOSIS/CLUBBING: } NAD

OEDEMA:

S/E:

RS: AE=E



No adv sounds

P/A: - NAD

CVS: S1 S2, No murmurs

Extremities & Spine: - Varicose, Gait pain

ENT: - } NAD

Skin: -

CNS: Conscious, oriented, cooperative

Vision:

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

Vashi : **M/S. Indira Health & Lifestyle Pvt. Ltd.** 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

Name: Mr. kalyan chakravarthy	Age: 36	Date of Health check-up: 21/8/23

Findings and Recommendation:

Findings:-

- FL (T)
- HbA1C T.

Recommendation:-

- Neurologist opinion

Dr. A/Euu.

Signature:

Consultant –

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

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MC-2364

Apollo Clinic VASHI

Name	: Mr. Kalyan Chakravarthy	Gender	: Male	Age	: 36 Years
UHID	: FVAH 7922.	Bill No	:	Lab No	: V-1912-23
Ref. by	: SELF	Sample Col.Dt	: 21/08/2023 10:55		
Barcode No	: 6278	Reported On	: 21/08/2023 17:20		

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
CBC (Complete Blood Count)-WB (EDTA)			
Haemoglobin(Colorimetric method)	14.8	g/dl	13 - 18
RBC Count (Impedance)	5.32	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	45.9	%	35 - 55
MCV:(Calculated parameter)	86.4	fl	78 - 98
MCH:(Calculated parameter)	27.8	pg	26 - 34
MCHC:(Calculated parameter)	32.2	gm/dl	30 - 36
RDW-CV:	13.5	%	11.5 - 16.5
Total Leucocyte count(Impedance)	8520	/cumm.	4000 - 10500
Neutrophils:	57	%	40 - 75
Lymphocytes:	34	%	20 - 40
Eosinophils:	04	%	0 - 6
Monocytes:	05	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.86	Lakhs/c.mm	1.5 - 4.5
MPV	8.1	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic,Normocytic		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter.		

Tejal Dighe
Entered By

Ms Kaveri Gaonkar
Verified By

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

End of Report
Results are to be correlated clinically

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL	
ESR(Westergren Method)			
Erythrocyte Sedimentation Rate:-	13	mm/1st hr	0 - 20

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TEST	RESULTS

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

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

Anushka Chavan
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL

PLASMA GLUCOSE

Fasting Plasma Glucose :	86	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : >= 126 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)
Post Prandial Plasma Glucose :	91	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : >= 200 mg/dL (on more than one occasion) (American diabetes association guidlines 2016)

Method : Hexokinase

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin :	6.0	%	Normal <5.7 % Pre Diabetic 5.7 - 6.5 % Diabetic >6.5 % Target for Diabetes on therapy < 7.0 % Re-evalution of therapy > 8.0 %
Mean Blood Glucose :	125.5	mg/dL	

Corelation 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 corelate 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% final HbA1c levels

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Lipid Profile- Serum			
S. Cholesterol(Oxidase)	194	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	153	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	30.6	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	**34.2**	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	129.2	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	**5.7**		3.5 - 5
Ratio of LDL/HDL	**3.8**		2.5 - 3.5

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.23	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.63	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.6	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.78		0.9 - 2
S.Total Bilirubin (DPD):	0.38	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.16	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.22	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	25	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	16	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	74	U/L	40 - 129
S.GGT(IFCC Kinetic):	26	U/L	11 - 50

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TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY		
S.Urea(Urease Method)	18.0	mg/dl	10.0 - 45.0
BUN (Calculated)	8.4	mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.79	mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	10.63		9:1 - 23:1

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
BIOCHEMISTRY REPORT			
S.Uric Acid(Uricase-POD):	6.7	mg/dL	3.4 - 7.0

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.66	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	94.03	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	4.49	□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 hypothyrodism.
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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URINE REPORT

TEST	RESULTS		BIOLOGICAL REFERENCE INTERVAL
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	1.015		1.005 - 1.030
URINE ALBUMIN	Absent		Absent
URINE SUGAR(Qualitative)	Absent		Absent
KETONES	Absent		Absent
BILE SALTS	Absent		Absent
BILE PIGMENTS	Absent		Absent
UROBILINOGEN	Normal(<1 mg/dl)		Normal
OCCULT BLOOD	Absent		Absent
Nitrites	Absent		Absent
MICROSCOPIC EXAMINATION			
PUS CELLS	Occasional		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	Occasional		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

Vasanti Gondal
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STOOL EXAMINATION

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
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

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Kalyan, Chakravarthy
7922

Male
36 Years

21.08.2023 12:04:39
Apollo Clinic
1st Flr,The Emerald,Sector-12,
Vashi, Mumbai-400703.

71 bpm
-- / -- mmHg

NORMAL ECG

QRS :	92 ms
QT / QTcBaz :	394 / 428 ms
PR :	172 ms
P :	116 ms
RR / PP :	838 / 845 ms
P / QRS / T :	43 / 22 / 6 degrees

Normal sinus rhythm
Normal ECG

Dr. ANIRBAN DASGUPTA
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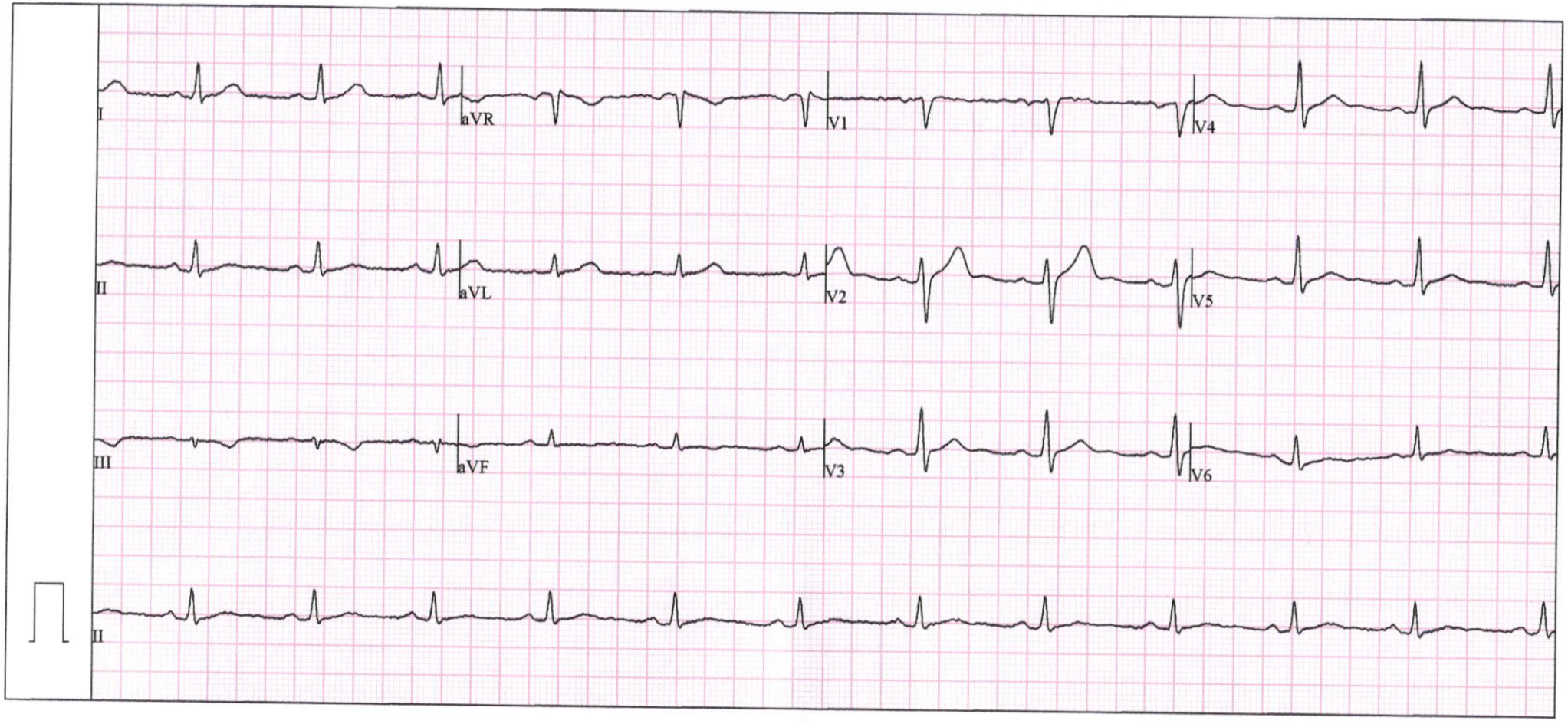
Diploma Cardiology
MMC -2005/02/0920



GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz Unconfirmed 4x2.5x3_25_R1 1/1

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TOUCHING LIVES

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VASHI

PATIENT'S NAME	KALYAN CHAKRAVARTHY	AGE :- 36Y/M
UHID	7922	DATE :- 21-08-23

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.

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Measurements

Aorta annulus	21 mm
Left Atrium	31 mm
LVID(Systole)	17 mm
LVID(Diastole)	45 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).

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PATIENT'S NAME	KALYAN CHAKRAVARTHY	AGE :- 36 Y/M
UHID	7922	DATE :-.21 Aug. 23

X-RAY CHEST PA VEIW

OBSERVATION:

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

IMPRESSION:

- **No significant abnormality seen.**

DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

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PATIENT'S NAME	KALYAN CHAKRAVARTHY	AGE :- 36y/M
UHID NO	7922	21 Aug 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 10.6 x 3.7 cm. **LEFT KIDNE** measures 11.7 x 4.5 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 REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

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Reg: No. 073826

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