


भारत सरकार  
Government of India

अधर

रेखा देवी  
Rakha Devi  
जन्म तिथि/DOB: 01/01/1972  
महिला/ FEMALE

PSWP Date: 11-04-2012



2665 9280 7534  
VID : 9177 1891 0797 0130

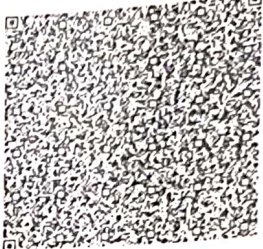
मेरा अधर, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण  
भारतीय पहचान प्राधिकरण Authority of India

अधर

पता:  
W/O अरुण कुमार, काशी बाजार, पी एस- भगवान बाजार,  
छपरा, सारण,  
बिहार - 841301

Address:  
W/O Arun Kumar, Kashi Bazar, P.S- Bhagwan  
Bazar, Chapra, Saran,  
Bihar - 841301



Download Date: 23-09-2012

2665 9280 7534  
VID : 9177 1891 0797 0130

1947 | help@uidai.gov.in | www.uidai.gov.in

ID: 291  
REKHA DEVI  
Female 51 Years

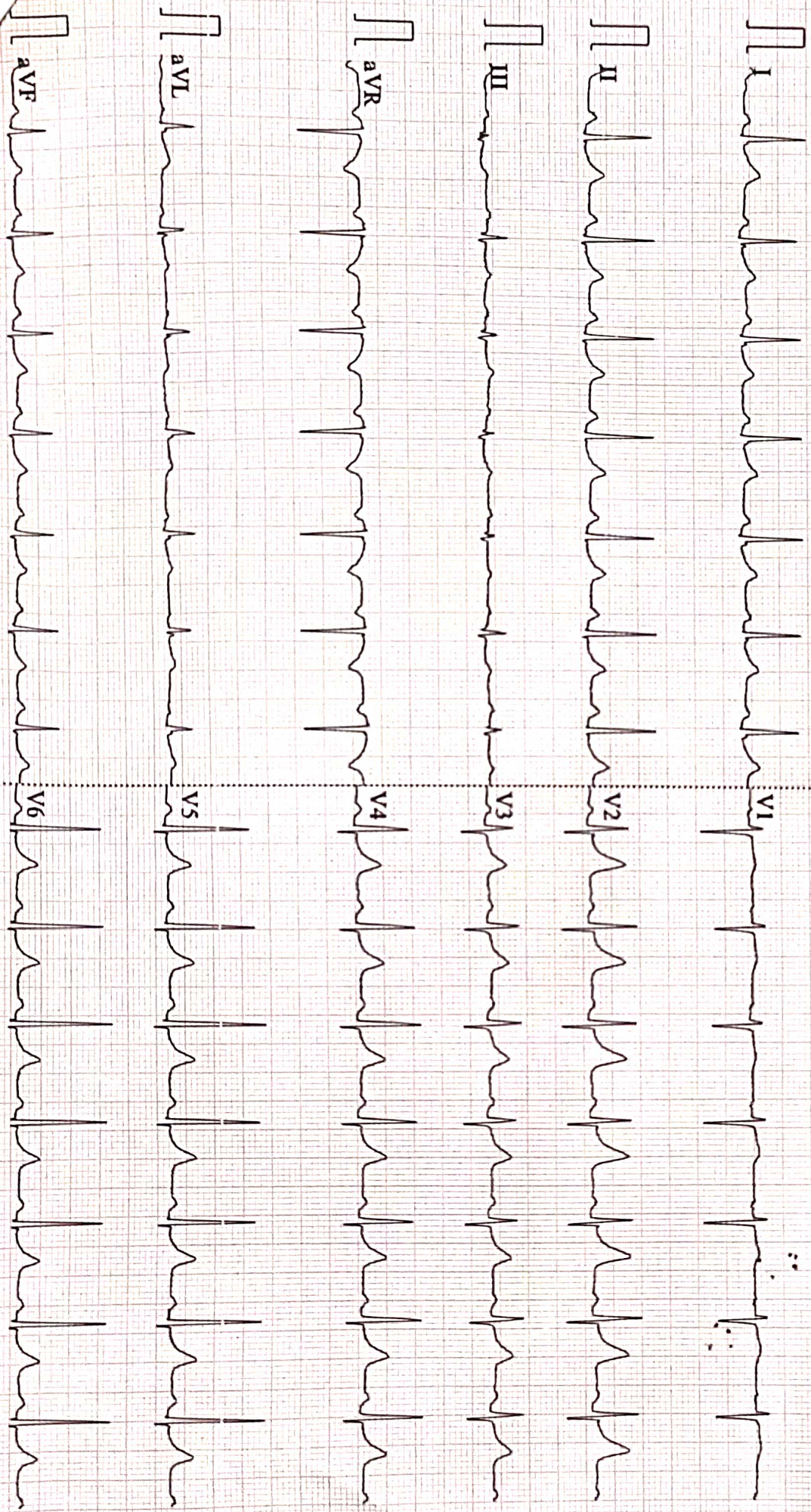
17-05-2023 09:38:39 AM

HR : 87 bpm  
P : 96 ms  
PR : 150 ms  
QRS : 76 ms  
QT/QTc : 353/426 ms  
P/QRS/T : 49/29/44 °  
RV5/SV1 : 1.559/0.748 mV

Diagnosis Information:

Sinus Rhythm  
\*\*\*Normal ECG\*\*\*

Ref-Phys   
Report Confirmed by:





ISO 9001 : 2015

# AAROGYAM DIAGNOSTICS

(A UNIT OF CULPAM HEALTH CARE PVT. LTD.)

F- 41, P.C. Colony, Opp. Madhuban Complex,  
Near Malahi Pakari Chowk, Kankarbagh, Patna – 20

9264278360, 9065875700, 8789391403

info@aarogyamdiagnostics.com

www.aarogyamdiagnostics.com

<b>Date</b>	<b>17/05/2023</b>	<b>Srl No.</b>	<b>5</b>	<b>Patient Id</b>	<b>2305170005</b>
<b>Name</b>	<b>Mrs. REKHA DEVI</b>	<b>Age</b>	<b>51 Yrs.</b>	<b>Sex</b>	<b>F</b>
<b>Ref. By</b>	<b>Dr.BOB</b>				

Test Name	Value	Unit	Normal Value
BOB			
HB A1C	5.2	%	

### EXPECTED VALUES :-

Metabolically healthy patients	=	4.8 - 5.5 % HbA1C
Good Control	=	5.5 - 6.8 % HbA1C
Fair Control	=	6.8-8.2 % HbA1C
Poor Control	=	>8.2 % HbA1C

### REMARKS:-

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.

\*\*\*\* End Of Report \*\*\*\*

**Dr.R.B.RAMAN**  
**MBBS, MD**  
**CONSULTANT PATHOLOGIST**



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<b>Date</b>	<b>17/05/2023</b>	<b>Srl No. 5</b>	<b>Patient Id 2305170005</b>
<b>Name</b>	<b>Mrs. REKHA DEVI</b>	<b>Age 51 Yrs.</b>	<b>Sex F</b>
<b>Ref. By Dr.BOB</b>			

Test Name	Value	Unit	Normal Value
COMPLETE BLOOD COUNT (CBC)			
HAEMOGLOBIN (Hb)	<b>9.0</b>	gm/dl	11.5 - 16.5
TOTAL LEUCOCYTE COUNT (TLC)	6,800	/cumm	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHIL	60	%	40 - 75
LYMPHOCYTE	33	%	20 - 45
EOSINOPHIL	02	%	01 - 06
MONOCYTE	05	%	02 - 10
BASOPHIL	00	%	0 - 0
ESR (WESTEGREN's METHOD)	16	mm/1st hr.	0 - 20
R B C COUNT	<b>3.02</b>	Millions/cmm	3.8 - 4.8
P.C.V / HAEMATOCRIT	<b>28.0</b>	%	35 - 45
M C V	92.72	fl.	80 - 100
M C H	29.8	Picogram	27.0 - 31.0
M C H C	<b>32.1</b>	gm/dl	33 - 37
PLATELET COUNT	2.11	Lakh/cmm	1.50 - 4.00
BLOOD GROUP ABO	"O"		
RH TYPING	POSITIVE		
BLOOD SUGAR FASTING	86.2	mg/dl	70 - 110
SERUM CREATININE	1.02	mg%	0.5 - 1.3
BLOOD UREA	22.7	mg /dl	15.0 - 45.0
SERUM URIC ACID	5.9	mg%	2.5 - 6.0
<b><u>LIVER FUNCTION TEST (LFT)</u></b>			



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<b>Ref. By Dr.BOB</b>			

Test Name	Value	Unit	Normal Value
BILIRUBIN TOTAL	0.60	mg/dl	0 - 1.0
CONJUGATED (D. Bilirubin)	0.22	mg/dl	0.00 - 0.40
UNCONJUGATED (I.D.Bilirubin)	0.38	mg/dl	0.00 - 0.70
TOTAL PROTEIN	<b>6.3</b>	gm/dl	6.6 - 8.3
ALBUMIN	<b>3.3</b>	gm/dl	3.4 - 5.2
GLOBULIN	3	gm/dl	2.3 - 3.5
A/G RATIO	<b>1.1</b>		
SGOT	33.5	IU/L	5 - 35
SGPT	38.0	IU/L	5.0 - 45.0
ALKALINE PHOSPHATASE IFCC Method	<b>122.2</b>	U/L	35.0 - 104.0
GAMMA GT	23.8	IU/L	6.0 - 42.0

#### LFT INTERPRET

#### LIPID PROFILE

TRIGLYCERIDES	119.1	mg/dL	25.0 - 165.0
TOTAL CHOLESTEROL	111.9	mg/dL	29.0 - 199.0
H D L CHOLESTEROL DIRECT	57.2	mg/dL	35.1 - 88.0
V L D L	<b>23.82</b>	mg/dL	4.7 - 22.1
L D L CHOLESTEROL DIRECT	<b>30.88</b>	mg/dL	63.0 - 129.0
TOTAL CHOLESTEROL/HDL RATIO	1.956		0.0 - 4.97
LDL / HDL CHOLESTEROL RATIO	0.54		0.00 - 3.55
THYROID PROFILE			
QUANTITY	20	ml.	



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<b>Ref. By Dr.BOB</b>			

Test Name	Value	Unit	Normal Value
COLOUR	PALE YELLOW		
TRANSPARENCY	CLEAR		
SPECIFIC GRAVITY	1.030		
PH	5.5		
ALBUMIN	NIL		
SUGAR	NIL		
<b>MICROSCOPIC EXAMINATION</b>			
PUS CELLS	1-2	/HPF	
RBC'S	NIL	/HPF	
CASTS	NIL		
CRYSTALS	NIL		
EPITHELIAL CELLS	1-3	/HPF	
BACTERIA	NIL		
OTHERS	NIL		

Assay performed on enhanced chemi lumenescence system ( Centaur-Siemens)

Serum T3,T4 & TSH measurements form the three components of Thyroid screening panel, useful in diagnosing various disorders of Thyroid gland function.

1. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH level.
2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 levels along with depressed TSH values.
3. Normal T4 levels are accompanied by increased T3 in patients with T3 thyrotoxicosis.



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<b>Ref. By Dr.BOB</b>			

Test Name	Value	Unit	Normal Value
4. Slightly elevated T3 levels may be found in pregnancy and estrogen therapy, while depressed levels may be encountered in severe illness, renal failure and during therapy with drugs like propranolol and propyl thiouracil.			
5. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, and may be seen in secondary thyrotoxicosis.			

\*\*\*\* End Of Report \*\*\*\*

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**CONSULTANT PATHOLOGIST**



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<b>Date</b> 17/05/2023	<b>Srl No.</b> 5	<b>Patient Id</b> 2305170005
<b>Name</b> Mrs. REKHA DEVI	<b>Age</b> 51 Yrs.	<b>Sex</b> F
<b>Ref. By</b> Dr.BOB		

Test Name	Value	Unit	Normal Value
<b><u>BIOCHEMISTRY</u></b>			
BLOOD SUGAR PP	109.6	mg/dl	80 - 160

\*\*\*\* End Of Report \*\*\*\*

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Name :- Rekha Devi

Age/Sex:-51yrs/F

Ref by :- Self.

Date :17/05/23

Thanks for referral.

### REPORT OF USG OF WHOLE ABDOMEN

- Liver** :- Mild enlarged in size (14.5cm)with raised echotexture. No focal or diffuse lesion is seen.  
IHBR are not dilated. PV is normal in course and calibre with echofree lumen.
- G. Bladder** :- It is normal in shape, size & position. It is echofree & shows no evidence of calculus, mass or sludge.
- CBD** :- It is normal in calibre & is echofree.
- Pancreas** :- Normal in shape, size & echotexture. No evidence of parenchymal / ductal calcification is seen. No definite peripancreatic collection is seen.
- Spleen** :- Mild enlarged in size (12.3cm)with normal echotexture. No focal lesion is seen. No evidence of varices is noticed.
- Kidneys** :- Both kidneys are normal in shape, size & position. Sinus as well as cortical echoes are normal. No evidence of calculus, space occupying lesion or hydronephrosis is seen.  
Right Kidney measures 9.8cm and Left Kidney measures 9.9cm.
- Ureters** :- Ureters are not dilated.
- U. Bladder**:- It is echofree. No evidence of calculus, mass or diverticulum is seen.
- Uterus** :- Normal in size (6.7cm x 2.7cm) and anteverted in position with normal myometrial echotexture and endometrial thickness.
- Ovaries** :- Both adenexa normal.  
No pelvic (POD) collection is seen.
- Others** :- No ascites or abdominal adenopathy is seen.  
No free subphrenic / basal pleural space collection is seen.

### IMPRESSION:-

*Mild Hepatosplenomegaly with Mild Fatty Liver,  
Otherwise Normal scan.*

*Dr. V. Kumar  
MBBS, MD (Radio-Diagnosis)  
Consultant Radiologist*