
बैंक ऑफ बड़ौदा
Bank of Baroda
Cheena Kumari Jain
92883


GPS Map Camera
Jaipur, Rajasthan, India
G49, Vidhyadhar Enclave II, near Cinestar, Sector 2, Central Spine,
Vidyadhar Nagar, Jaipur, Rajasthan 302023, India
Lat 26.964541°
Long 75.782566°
09/12/23 02:50 PM GMT +05:30
Google

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

P3 HEALTH SOLUTIONS LLP
(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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

General Physical Examination

Date of Examination: 09/12/2023

Name: Cheena Kumawat Jain Age: 33 DOB: 29/11/1990 Sex: female

Referred By: Bank of Baroda

Photo ID: Bank Id ID #: 92883

Ht: 162 (cm) Wt: 70 (Kg)

Chest (Expiration): 95 (cm) Abdomen Circumference: 100 (cm)

Blood Pressure: 120/80 mm Hg PR: 72 / min RR: 18 / min Temp: Afebrile

BMI 26.7

With Nata

Eye Examination: R|E, 6/6, N/6, NCB
L|E 6/6 N/6 NCB

Other: No

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

Signature Of Examine : ..... Name of Examinee: Cheena Kumawat Jain

Signature Medical Examiner : ..... Name Medical Examiner Dr. Piyush Goyal

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NAME :- Mrs. CHEENA KUMARI JAIN		Patient ID :-12234099	Date :- 09/12/2023 10:18:22
Age :-	33 Yrs 10 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Female	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 10/12/2023 10:28:18

HAEMOGARAM

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 FEMAL			
HAEMOGLOBIN (Hb)	12.3	g/dL	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	9.60	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	67.0	%	40.0 - 80.0
LYMPHOCYTE	29.0	%	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)	4.33	x10^6/ul.	3.80 - 4.80
HEMATOCRIT (HCT)	39.10	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	90.0	fl.	83.0 - 101.0
MEAN CORP HB (MCH)	28.3	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	**31.4** L	g/dL	31.5 - 34.5
PLATELET COUNT	282	x10^3/ul.	150 - 410
RDW-CV	13.8	%	11.6 - 14.0

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)	10	mm in 1st hr	00 - 20

Method:- Westergreen

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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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	**119.0** H	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	**170.0** 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-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin therapy or various liver diseases .

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
GLYCOSYLATED HEMOGLOBIN (HbA1C)			
Method:- CAPILLARY with EDTA	7.0	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	**154** H	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: alcoholism, chronic renal failure, decreased intraerythrocytic 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 antiretrovirals, ribavirin & dapsone.
5. 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
LIPID PROFILE			
TOTAL CHOLESTEROL Method:- CHOD-PAP methodology	152.00	mg/dl	Desirable <200 Borderline 200-239 High> 240
InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.			
TRIGLYCERIDES Method:- GPO-PAP	**169.00** H	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
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.			
DIRECT HDL CHOLESTEROL Method:- Direct clearance Method	46.50	mg/dl	MALE- 30-70 FEMALE - 30-85
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.			
LDL CHOLESTEROL Method:- Calculated Method	77.33	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Method:- Calculated	33.80	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method:- Calculated	3.27		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Method:- Calculated	1.66		0.00 - 3.50
TOTAL LIPID Method:- CALCULATED	531.48	mg/dl	400.00 - 1000.00

1. Measurements in the same patient can show physiological& analytical variations. Three serialsamples 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 fromperipheral tissues.

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BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method - DMSO/Diazo	0.56	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method - DMSO/Diazo	0.12	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method - Calculated	0.44	mg/dl	0.30-0.70
SGOT Method:- IFCC	14.6	U/L	0.0 - 40.0
SGPT Method:- IFCC	18.5	U/L	0.0 - 35.0
SERUM ALKALINE PHOSPHATASE Method:- IFCC	96.50	IU/L	53.00 - 141.00
SERUM GAMMA GT Method:- Szasz methodology Interpretation: Elevations in GGT levels appears earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 10 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal)are observed with infectious hepatitis	29.20	U/L	5.00 - 32.00
SERUM TOTAL PROTEIN Method - Direct Biuret Reagent	6.36	g/dl	6.00 - 8.40
SERUM ALBUMIN Method - Bromocresol Green	4.12	g/dl	3.50 - 5.50
SERUM GLOBULIN Method - CALCULATION	2.24	gm/dl	2.20 - 3.50
A/G RATIO	1.84		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 antiretrovirals, 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	26.20	mg/dl	10.00 - 50.00

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	0.94	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	5.21	mg/dl	2.40 - 7.00

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

SODIUM Method:- ISE	137.5	mmol/L	135.0 - 150.0
POTASSIUM Method:- ISE	3.90	mmol/L	3.50 - 5.50
CHLORIDE Method:- ISE	98.1	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	6.36	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	4.12	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	2.24	gm/dl	2.20 - 3.50
A/G RATIO	1.84		1.30 - 2.50

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

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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-hourcollections 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 bloodincreases. 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 Method:- ECLIA	0.78	ng/mL	0.70 - 2.04

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 8-10 PM. The variation is the order of 50% hence time of the day has influence on the measures 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,simoultaneous 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) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.High TSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos 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 levels8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis9.Normal or↑ 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 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 disintegration 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. ***

THYROID - THYROXINE (T4) Method:- ECLIA	7.10	µg/dL	5.10 - 14.10

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 8-10 PM. The variation is the order of 50% hence time of the day has influence on the measures 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,simoultaneous 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) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.High TSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos 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 levels8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis9.Normal or↑ 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 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 disintegration 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.

TSH Method:- ECLIA	1.248	µIU/mL	0.350 - 5.500

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 8-10 PM. The variation is the order of 50% hence time of the day has influence on the measures 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,simoultaneous measurement of TSH with free T4 is use

Technologist
VIKARAN,TSI

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

P3 HEALTH SOLUTIONS LLP
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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

NAME :-	**Mrs. CHEENA KUMARI JAIN**	Patient ID :-12234099	Date :- 09/12/2023 10:18:22
Age :-	33 Yrs 10 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Female	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 10/12/2023 10:28:18

IMMUNOASSAY

evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay
1.Primary hypothyroidism is accompanied by ↑serum 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(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter
4.High TSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos 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 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 propanolol.
14.Although ↑ TSH levels are nearly always indicative of Primary Hypothroidism ,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 : 0.20-3.00 uIU/mL
3rd Trimester : 0.30-3.00 uIU/mL
The production, circulation, and disintegration 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
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+91 141 4824885 maxcarediagnostics1@gmail.com

NAME :-	**Mrs. CHEENA KUMARI JAIN**	Patient ID :-12234099	Date :- 09/12/2023 10:18:22
Age :-	33 Yrs 10 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Female	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 10/12/2023 10:28:18

CLINICAL PATHOLOGY

URINE SUGAR (FASTING) Collected Sample Received	Nil	Nil

Technologist
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NAME :- Mrs. CHEENA KUMARI JAIN		Patient ID :-12234099	Date :- 09/12/2023 10:18:22
Age :-	33 Yrs 10 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Female	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 10/12/2023 10:28:18

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)	5.0		5.0 - 7.5
SPECIFIC GRAVITY	1.025		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		

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Tems (P) Ltd
#P3 HEALTH SOLUTIONS LLP B-14, Vidhyadhar nahar , Jaipur
1234569244/Mrs Cheena Kumari Jain 33Yrs/Female Kgs/31 Cms BP: ___/___ mmHg
Ref.: BANK OF BARODA Test Date: 09-Dec-2023(3:05:58 P) Notch: 50Hz 0.05Hz - 35Hz 10mm/mV 25mm/Sec

HR: 85 bpm

PR Interval: 132 ms
QRS Duration: 82 ms
QT/QTc: 362/433ms
P-QRS-T Axis: 41 - 70 - -28 (Deg)

RMS

TUNL

FINDINGS: Normal Sinus Rhythm
Vent Rate : 85 bpm; PR Interval :132 ms; QRS Duration: 82 ms; QT/QTc Int : 362/433 ms
P-QRS-T axis: 41• 70• -28• (Deg)
Comments :

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

Dr. NARESH MOHINKA

P3 HEALTH SOLUTIONS LLP

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

12234066/MRS CHEENA KUMARI JAIN 33 Yrs/Female 0 Kg/0 Cms

Date: 09-Dec-2023 03:10:45 PM

Ref.By : BANK OF BARODA

Medication : Nil

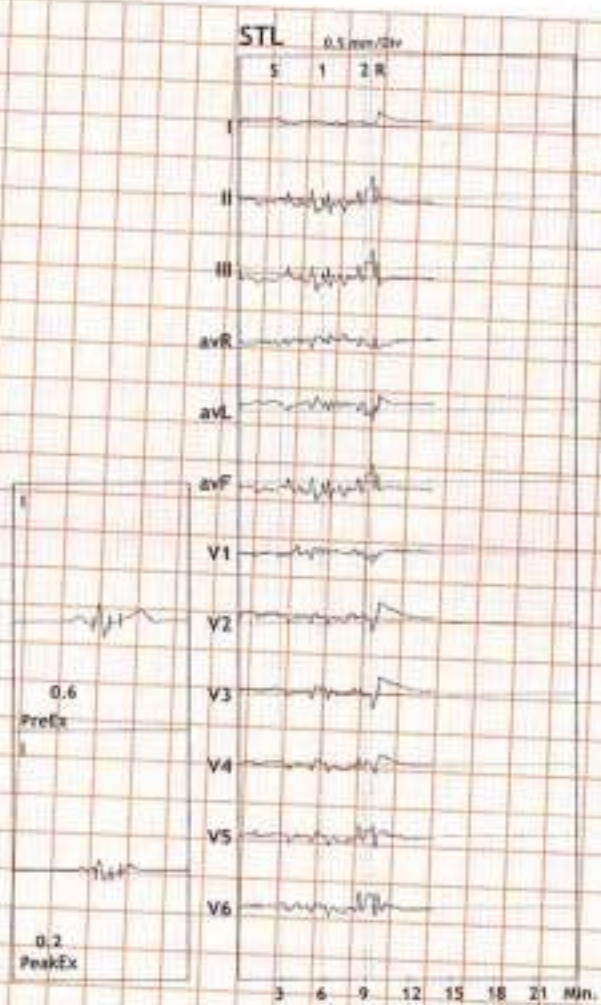
Objective :

Summary

Protocol : BRUCE

History : Nil

Stage	StageTime (Min:Sec)	PhaseTime (Min:Sec)	Speed (mph)	Grade (%)	METs	H.R. (bpm)	B.P. (mmHg)	R.P.P. x100	PVC	Comments
Supine					1.0	81	120/80	97	-	
Standing					1.0	96	120/80	115	-	
HV					1.0	94	120/80	112	-	
ExStart					1.0	112	120/80	134	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	127	130/80	165	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	160	140/80	224	-	
PeakEx	0:32	6:33	3.4	14.0	7.7	176	140/80	246	-	
Recovery	1:00		0.0	0.0	1.2	127	140/80	177	-	
Recovery	2:00		0.0	0.0	1.0	113	150/85	169	-	
Recovery	3:00		0.0	0.0	1.0	102	140/80	142	-	
Recovery	4:00		0.0	0.0	1.0	110	130/80	143	-	



Findings :

Exercise Time :06:32

Max HR Attained :176 bpm 94% of Max Predictable HR 187

Max BP : 150/85(mmHg)

Max WorkLoad attained :7.7(Fair Effort Tolerance)

Dr. Naresh Kumar Mohanka
RMC No. 13570
MBBS, DIP. CARDIAC (ESCORTS)
D.E.M. (ROGP-UK)

Advice/Comments:

Base line ecg showed NNI There is mild st t changes seen during exercise in inferior lat leads which reverted to base line with 1 min of recovery
TMT is negative for RIHD. Cost effective Clinically

DR. NARESH MOHINKA

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 78 bpm
METS: 1.0
BP: 120/80

MPHR:41% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 00:39
BLC :On
Notch :On

Supine
10.0 mm/mV
25 mm/Sec.

RMS

4X 73 ms Post J

V5
0.2

I	II	III	avR	avL	avF
0.5 0.5	0.0 0.0	-0.5 -0.5	-0.3 -0.3	0.5 0.5	-0.3 -0.2

V1	V2	V3	V4	V5	V6
-0.1 -0.2	0.9 0.8	0.3 0.3	0.3 0.2	0.2 0.1	0.3 0.1

I
II
III
avR
avL
avF

V1
V2
V3
V4
V5
V6

DR. NARESH MOHINKA

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 95 bpm
METS: 1.0
BP: 120/80

MPHR:50% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 01:25
BLC :On
Notch :On

Standing
10.0 mm/mV
25 mm/Sec.

4X 73 mS Post J

V5
0.1

I	II	III	avR	avL	avF
0.5	-0.5	-1.0	0.0	0.7	-0.8
0.5	-0.8	-1.3	0.1	0.9	-1.1

V1	V2	V3	V4	V5	V6
0.0	0.4	0.3	0.2	0.1	0.3
0.3	0.7	0.6	0.4	0.2	0.3

I
II
III
avR
avL
avF
V1
V2
V3
V4
V5
V6

DR. NARESH MOHINKA

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 100 bpm
METS: 1.0
BP: 120/80

MPHR:53% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 02:20
BLC :On
Notch :On

HV
10.0 mm/mV
25 mm/Sec.

RMS

4X 73 mS Post J

V5
0.1

I	II	III	avR	avL	avF
0.6	-0.2	-0.8	-0.2	0.7	-0.5
0.6	0.1	-0.5	-0.3	0.5	-0.7

V1	V2	V3	V4	V5	V6
0.0	0.8	0.4	0.3	0.1	0.2
-0.1	0.7	0.4	0.3	0.1	0.1

I V1
II V2
III V3
avR V4
avL V5
avF V6

DR. NARESH MOHINKA

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

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cm
Date: 09-Dec-2023 03:10:45 PM

HR: 114 bpm
METS: 1.0
BP: 120/80

MPHR:60% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 02:53
BLC :On
Notch :On

ExStart
10.0 mm/mV
25 mm/Sec.

12 Lead + Median

RMS

4X 73 ms Post J

V5
0.2

I	II	III	aVR	aVL	aVF
0.6	-0.1	-0.7	-0.3	0.6	-0.4
0.6	0.0	-0.6	-0.3	0.6	-0.3

V1	V2	V3	V4	V5	V6
-0.3	0.5	0.3	0.3	0.2	0.3
-0.1	0.5	0.4	0.2	0.1	0.1

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

DR. NARESH MOHINKA

P3 HEALTH SOLUTIONS LLP

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 126 bpm
METS: 4.7
BP: 130/80

MPHR:67% of 187
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/Sec.

RMS

4X 73 mS Post J

V5
0.0

I	II	III	avR	avL	avF
0.2 0.3	-0.9 -0.5	-1.1 -0.8	0.3 0.1	0.7 0.6	-1.0 -0.6

V1	V2	V3	V4	V5	V6
0.3 0.5	0.5 1.0	0.2 0.6	0.2 0.5	0.0 0.4	0.2 0.5

I
II
III
avR
avL
avF
V1
V2
V3
V4
V5
V6

DR. NARESH MOHINKA

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 160 bpm
METS: 7.1
BP: 140/80

MPHR:85% of 187
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.

RMS

4X 73 mS Post J

V5
-0.3

I 0.4 0.7
II -0.5 0.8
III -0.9 0.1
avR 0.0 -0.7
avL 0.6 0.3
avF -0.7 0.5

V1 -0.1 -0.1
V2 0.7 1.4
V3 -0.2 0.8
V4 -0.1 1.0
V5 -0.3 0.7
V6 -0.1 0.8

I
II
III
avR
avL
avF

V1
V2
V3
V4
V5
V6

DR. NARESH MOHINKA

P3 HEALTH SOLUTIONS LLP

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

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 176 bpm
METS: 7.7
BP: 140/80

MPHR:94% of 187
Speed: 3.4 mph
Grade: 14.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 06:30
BLC :On
Notch :On

BRUCE:PeakEx(0:30)
10.0 mm/mV
25 mm/Sec.

12 Lead + Median

4X 73 mS Post J

V5
0.3

I	II	III	avR	avL	avF
0.2 0.5	0.6 0.6	0.3 0.1	-0.4 -0.6	0.0 0.2	0.5 0.3

V1	V2	V3	V4	V5	V6
-0.2 0.3	0.3 1.2	-0.2 0.6	0.0 0.6	0.3 0.7	0.8 1.2

I
II
III
avR
avL
avF
V1
V2
V3
V4
V5
V6

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

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

12 Lead + Median

HR: 128 bpm
METS: 1.3
BP: 140/80

MPHR:68% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 06:32
BLC :On
Notch :On

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

RMS

4X 73 mS Post J

V5
0.3

I	II	III	avR	avL	avF
0.8 1.4	-0.1 1.2	-0.9 -0.3	-0.3 -1.3	0.8 0.8	-0.5 0.5

V1	V2	V3	V4	V5	V6
0.1 0.0	1.3 2.2	1.0 2.2	0.7 1.8	0.3 1.3	0.3 1.3

I
II
III
avR
avL
avF
V1
V2
V3
V4
V5
V6

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 116 bpm
METS: 1.0
BP: 150/85

MPHR:62% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 06:32
BLC :On
Notch :On

Recovery(2:00)
10.0 mm/mV
25 mm/Sec

RMS

4X 73 mS Post J

V5
0.0

I 0.4 1.1
II -0.3 0.8
III -0.7 -0.3
avR 0.0 -0.9
avL 0.5 0.7
avF -0.5 0.2

V1 0.2 0.0
V2 0.7 1.5
V3 0.6 1.5
V4 0.2 1.0
V5 0.0 0.8
V6 0.0 0.7

I
II
III
avR
avL
avF

V1
V2
V3
V4
V5
V6

DR. NARESH MOHINKA

P3 HEALTH SOLUTIONS LLP

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 103 bpm
METS: 1.0
BP: 140/80

MPHR:55% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 06:32
BLC :On
Notch :On

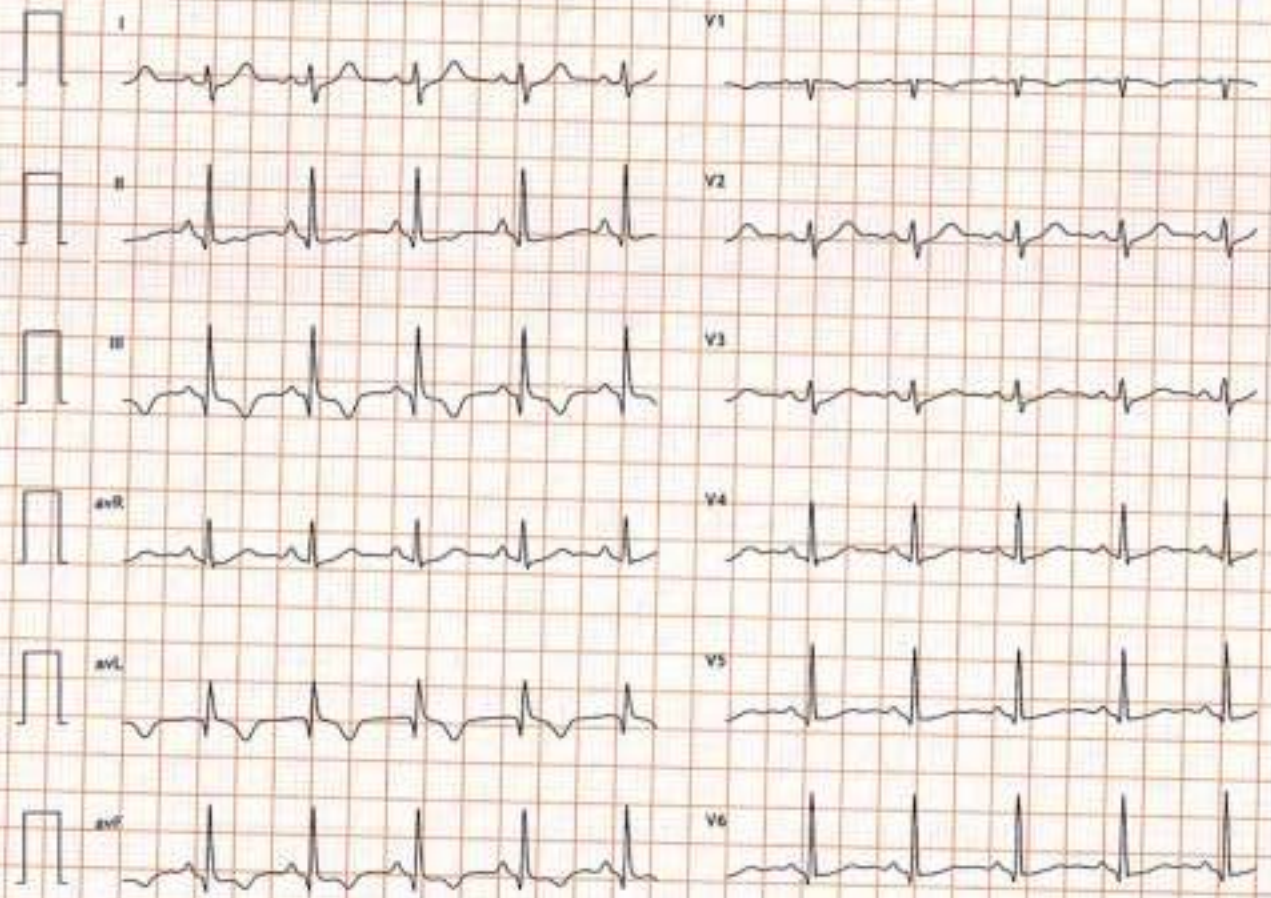
Recovery(3:00)
10.0 mm/mV
25 mm/Sec.

4X 73 ms Post J

V5
0.2

I	II	III	aVR	aVL	aVF
0.3	-0.3	-0.6	0.0	0.4	-0.4
0.9	0.4	-0.5	-0.6	0.7	0.0

V1	V2	V3	V4	V5	V6
0.0	0.4	0.2	0.0	-0.2	-0.2
-0.2	0.9	0.8	0.5	0.4	0.3



DR. NARESH MOHINKA

P3 HEALTH SOLUTIONS LLP

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

12 Lead + Median

12234066/MRS CHEENA KUMARI JAIN
33 Yrs/Female
0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

HR: 107 bpm
METS: 1.0
BP: 130/80

MPHR:57% of 187
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(0.05-100)Hz

Ex Time 06:32
BLC :On
Notch :On

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

4X 73 ms Post J

V5
-0.1

I	II	III	avR	avL	avF
-0.3 0.7	-0.4 0.2	-0.7 -0.5	0.1 -0.4	0.5 0.6	-0.5 -0.2

V1	V2	V3	V4	V5	V6
0.1 -0.1	0.3 0.7	0.2 0.6	0.0 0.4	-0.1 0.3	-0.1 0.3

I
II
III
avR
avL
avF

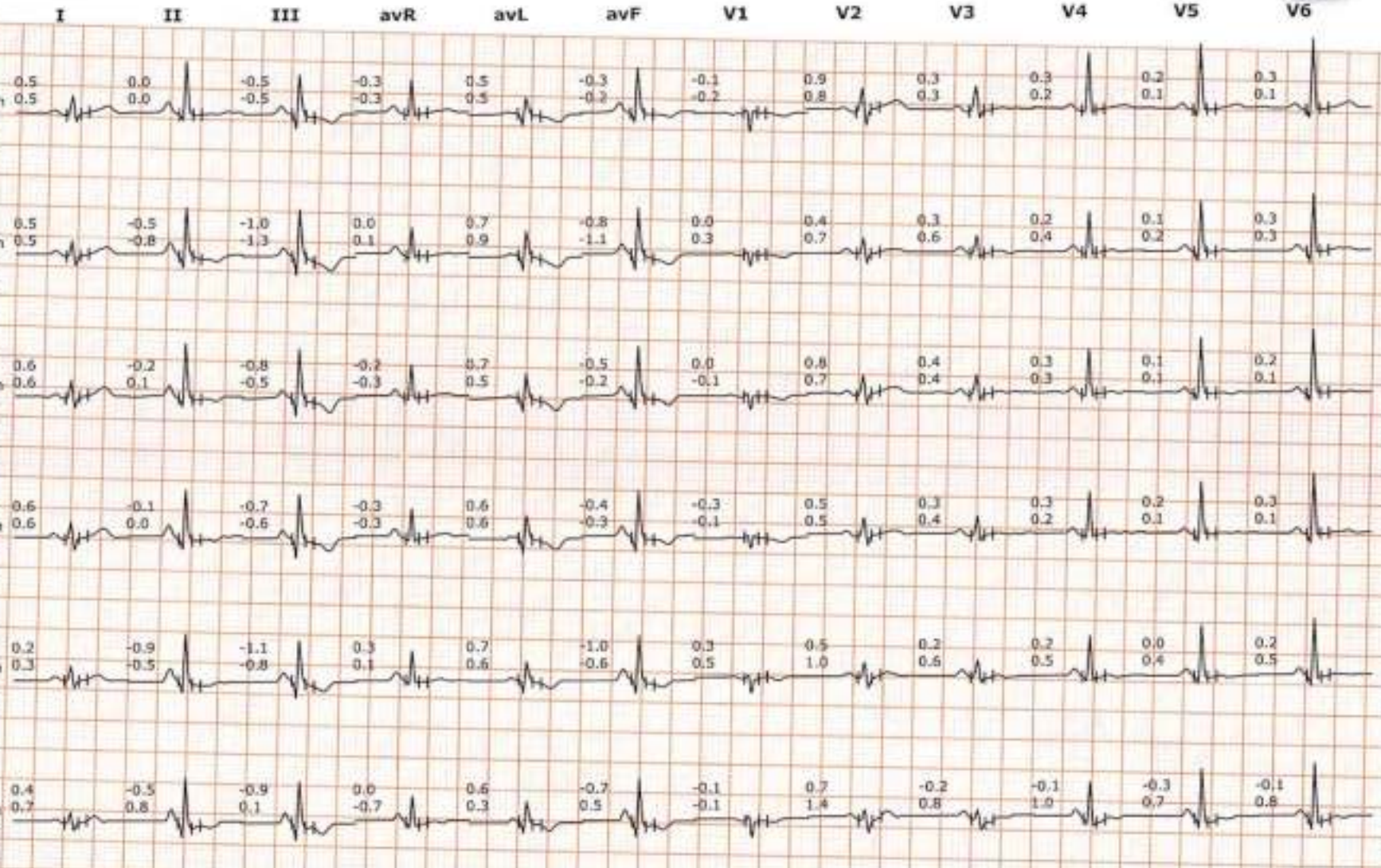
V1
V2
V3
V4
V5
V6

DR. NARESH MOHNKA

P3 HEALTH SOLUTIONS LLP
B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur
12234066/MRS CHEENA KUMARI JAIN 33 Yrs/Female 0 Kg/0 Cms
Date: 09-Dec-2023 03:10:45 PM

Average

RMS



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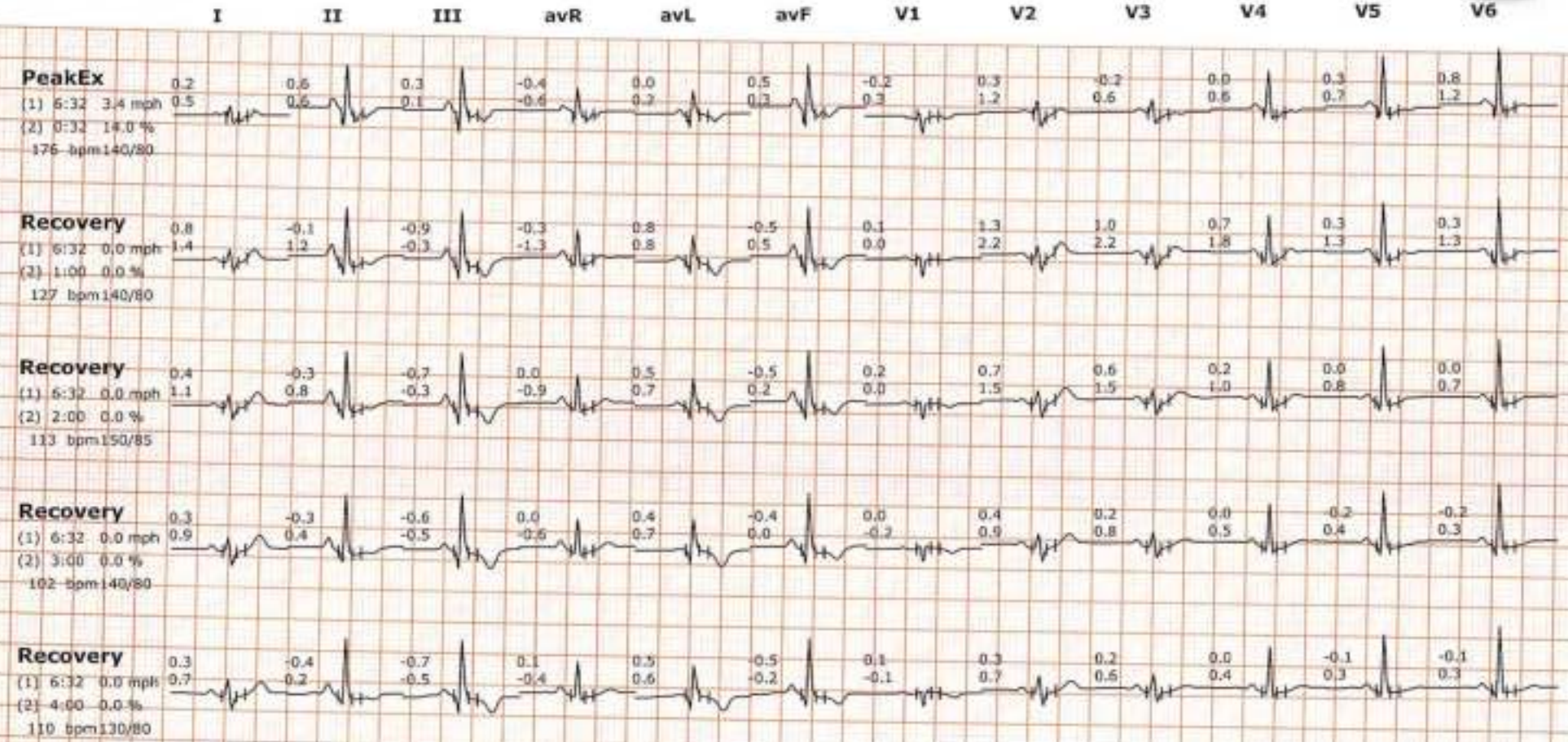

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MRS. CHEENA KUMARI JAIN	Age : 33 Y/F
Registration Date: 09/12/2023	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is mildly enlarged in size (162 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. No focal lesion is seen. Collecting system does not show any dilatation or calculus.
Right kidney is measuring approx. 106 mm.
Left kidney is measuring approx. 121 mm.

Urinary bladder does not show any calculus or mass lesion.

Uterus is anteverted and normal in size (measuring approx. 90 x 35 mm).
Myometrium shows normal echo -pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 5.1 mm.

Both ovaries are visualized. **Left ovary is mildly bulky (measuring 37 x 14 mm) with multiple peripherally arranged, non-dominant follicles and mildly echogenic stroma.** Right ovary appears normal. Largest follicle measures 16 mm in the right ovary. Right ovary measures 29 x 15 mm.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.
Very minimal free fluid is seen in pouch of Douglas.

IMPRESSION:

- **Mild hepatomegaly with grade I hepatic steatosis.**
- **Polycystic pattern, left ovary.**
- **Very minimal free fluid in POD - ? PID/post-ovulatory changes. Adv: Clinical correlation and follow up.**

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

SHARMA
Radiodiagnosis)
8/17437
LLP








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NAME:	MRS. CHEENA KUMARI JAIN	AGE	33 YRS/F
REF.BY	BANK OF BARODA	DATE	09/12/2023

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.SHALINI GOEL

M.B.B.S, D.N.B (Radiodiagnosis)

RMC No.: 21954


R
12234099 CHEEMA KUMARI JAIN 33 YRS BOB F
09 DEC 2023
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)