

Patient Name :-	PEEYUSH KALRA	Date :-	30/03/2023
Age & Sex :-	32Y   M		
Referred By :-	HEALTH CHECK UP		

**RADIOGRAPH CHEST PA**

**Report:**

Inspiratory film.

Trachea is central.

Bilateral hila appear unremarkable.

Bilateral lung field appears normal.

Costo-phrenic angle appear normal.

Mediastinal, thymic and diaphragmatic outlines appear normal.

Cardiac silhouette appear normal.

Visualized bony thoracic cage and soft tissues are normal.

**IMPRESSION: X ray chest PA reveals no significant abnormality.**

Please correlate with clinical findings and relevant investigations.



**Dr. Shashank S. Durshetwar**

**MD Radiology**

**Consultant Radiologist**

Patient Name : MR. PEEYUSH KALRA  
Age / Gender : 32 years / Male  
Patient ID : 21497  
Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup  
Collection Time : 30/03/2023, 08:54 AM  
Reporting Time : 30/03/2023, 02:59 PM  
Sample ID :



Test Description	Value(s)	Unit(s)	Reference Range
<b>CBC</b>			
<b>Complete Blood Count (CBC)</b>			
Hemoglobin (Hb)* Method : Cymeth Photometric Measurement	12.4	gm/dL	13.5 - 18.0
Erythrocyte (RBC) Count* Method : Electrical Impedance	6.17	mil/cu.mm	4.7 - 6.0
Packed Cell Volume(Hematocrit) Method : Calculated	39.5	%	42 - 52
<b>Red cell Indices</b>			
Method - Calculated/Electrical Impedance			
MCV	64.02	fL	78 - 100
MCH	20.10	pg	27 - 31
MCHC	31.39	gm/dL	32 - 36
RDW - CV	14.2	%	11.5 - 14.0
<b>Total and Differential count</b>			
Method - Electrical Impedance and VCSN Technology			
Total Leucocytes (WBC) Count*	6800	cell/cu.mm	4000-10000
Neutrophils	48	%	40 - 80
Lymphocytes	42	%	20 - 40
Monocytes	06	%	2 - 10
Eosinophils*	04	%	1 - 6
Basophils	00	%	0 - 2
<b>Platelet Count</b> Method : Electrical Impedance Sample Type : EDTA Whole Blood.	150	10 <sup>3</sup> /ul	150 - 450

**E.S.R**

**Erythrocyte Sedimentation Rate** 08 mm/hr <15  
Method : EDTA Whole blood, modified westergren

**Interpretation:**

It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

\*\*END OF REPORT\*\*

Dr. Bhavika Dholya  
M. D. Pathology  
Registration No: G-32571

can to Validate



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Test Description	Value(s)	Unit(s)	Reference Range
<b>BLOOD GROUP &amp; RH (D) FACTOR, EDTA WHOLE BLOOD</b>			
Blood Group	"B"		
<small>Method : Forward and Reverse By Tube Method</small>			
RH Factor	Negative		
<b>Methodology</b>			
This is done by forward and reverse grouping by tube Agglutination method.			
<b>Interpretation</b>			
Newborn baby does not produce ABO antibodies until 3 to 6 months of age. So the blood group of the Newborn baby is done by ABO antigen grouping (forward grouping) only, antibody grouping (reverse grouping) is not required. Confirmation of the New-born's blood group is indicated when the A and B antigen expression and the isoagglutinins are fully developed (2-4 years).			
<b>THYROID FUNCTION TEST 1</b>			
T3-Total	1.16	ng/mL	0.69 - 2.15 ng/mL
<small>Method : Serum, CLIA</small>			
T4-Total	5.29	ug/dL	5.2 - 12.7 ug/dL
<small>Method : Serum, CLIA</small>			
TSH	7.61	uIU/mL	0.3 - 4.5 uIU/mL
<small>Method : Serum, CLIA</small>			
<b>Interpretation</b>			

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Test Description	Value(s)	Unit(s)	Reference Range
<b>BLOOD GLUCOSE FASTING (FBS)</b>			
Glucose fasting Method : GOD-POD	114.9	mg/dL	Normal: 70 - 99 Impaired Tolerance: 100-125 Diabetes mellitus: $\geq$ 126 (on more than one occasion) (American diabetes association guidelines 2018)
Urine Fasting	Absent		
<b>BLOOD GLUCOSE POST PRANDIAL (PP2BS)</b>			
Blood Glucose-Post Prandial Method : GOD-POD	112.8	mg/dL	70 - 140
Urine Post Prandial	Absent		
<b>GLYCOSYLATED HB (HBA1C)</b>			
Glyco Hb (HbA1C)	5.1	%	Non-Diabetic: $\leq$ 5.6 Pre Diabetic: 5.7-6.4 Diabetic: $\geq$ 6.5
Estimated Average Glucose :	99.67		mg/dL
<b>Interpretations</b>			
<ol style="list-style-type: none"> <li>HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%</li> <li>Low glyated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.</li> <li>In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control. <ul style="list-style-type: none"> <li>Excellent control-6-7 %</li> <li>Fair to Good control – 7-8 %</li> <li>Unsatisfactory control – 8 to 10 %</li> <li>Poor Control – More than 10 %</li> </ul> </li> </ol>			

**\*\*END OF REPORT\*\***

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Reporting Time : 30/03/2023, 03:06 PM

Sample ID :



001808923

Test Description	Value(s)	Unit(s)	Reference Range
<b>RENAL PROFILE</b>			
Urea *	22.0	mg/dL	17- 55 mg/dL
Method : Serum, Urease			
Creatinine*	0.82	mg/dL	0.6 - 1.4 mg/dl
Method : Serum, Enzymatic			
Uric Acid*	5.4	mg/dL	3.5 - 7.2
Method : Serum, Uricase/POD			
Blood Urea Nitrogen-BUN*	10.28	mg/dL	7 - 25 mg/dL
Method : Calculated			
Calcium*	9.60	mg/dL	8.8 - 10.6
Method : Arsenazo III			
Sodium*	139.5	mmol/L	136 - 146
Method : Serum, Indirect ISE			
Potassium*	4.65	mmol/L	3.5 - 5.1
Method : Serum, Indirect ISE			
Chloride*	102.6	mmol/L	97.0 - 108.0
Method : Serum, Indirect ISE			
<b>LIVER FUNCTION TEST-1</b>			
Bilirubin - Total	1.20	mg/dL	0.3 - 1.2
Method : Diazotization			
Bilirubin - Direct	0.50	mg/dL	Adults and Children: 0.0 - 0.4
Method : Serum, Diazotization			
Bilirubin - Indirect	0.70		
Method : Calculated			
SGOT	36.2	U/L	< 50
Method : Serum, UV without P5P			
SGPT	63.0	U/L	< 50
Method : Serum, UV without P5P			
Alkaline Phosphatase-ALPI	99.0	U/L	30-120
Method : Serum, PNPP, AMP Buffer, IFCC 37 degree			
Total Protein	7.62	g/dL	6.6 - 8.3
Method : Serum, Biuret, reagent blank end point			
Albumin	4.55	g/dL	Adults: 3.5 - 5.2
Method : Serum, Bromocresol green			
Globulin	3.07	g/dL	1.8 - 3.6
Method : Calculated			
A/G Ratio	1.48	ratio	1.2 - 2.2
Method : Calculated			

\*\*END OF REPORT\*\*

*Bholiya*

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**Sample ID :**



Test Description	Value(s)	Unit(s)	Reference Range
<b>LIPID PROFILE (D)</b>			
<b>Cholesterol-Total</b> Method : Serum, Cholesterol oxidase esterase, peroxidase	184.0	mg/dL	Desirable: <= 200 Borderline High: 201-239 High: > 239
<b>Triglycerides</b> Method : Serum, Enzymatic, endpoint	203.6	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500
<b>Cholesterol-HDL Direct</b> Method : Serum, Direct measure-PEG	48.6	mg/dL	Normal: > 40 Major Heart Risk: < 40
<b>LDL Cholesterol</b> Method : Calculated	94.68	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190
<b>Non - HDL Cholesterol, Serum</b> Method : calculated	135.40	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-169 mg/dL Very High: > or = 190 mg/dL
<b>VLDL Cholesterol</b> Method : calculated	40.72	mg/dL	6 - 38
<b>CHOL/HDL RATIO</b> Method : calculated	3.79	ratio	3.5 - 5.0
<b>LDL/HDL RATIO</b> Method : calculated	1.95	ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0
<b>HDL/LDL RATIO</b> Method : calculated	0.51	ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0

**Note:** 8-10 hours fasting sample is required. Test results may show interferences due to pregnancy, certain drugs such as estrogens and other drugs (such as androgenic and related steroids), and insulin therapy etc. 12 hours fast is recommended prior to the test as non fasting status may result in falsely elevated test values. Alcohol should not be consumed for atleast 24 hours before the test. Values may be increased in acute illness, colds or flu. Obesity, stress, physical inactivity, cigarette smoking may lead to increase test values. If possible all medications should be withheld for atleast 24 hours before testing (On Doctors Advice). Intraindividual variations, seasonal as well as positional variations (levels lower when sitting compared to standing etc.) have been observed. Cholesterol and HDL-C should not be measured immediately after MI, and 3 months wait is suggested.

**\*\*END OF REPORT\*\***

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Test Description	Value(s)	Unit(s)	Reference Range
<b>URINE ROUTINE</b>			
Volume*	20	ml	ml -
Colour*	Pale Yellow		Pale Yellow
Transparency (Appearance)*	Clear		Clear
Deposit*	Absent		Absent
Reaction (pH)*	5.5		4.5 - 8
Specific Gravity*	1.015		1.010 - 1.030
<b>Chemical Examination (Automated Dipstick Method) Urine</b>			
Urine Glucose (sugar)*	Absent		Absent
Urine Protein (Albumin)*	Absent		Absent
Urine Ketones (Acetone)*	Absent		Absent
Blood*	Absent		Absent
Bile pigments*	Absent		Absent
Nitrite*	Absent		Absent
<b>Microscopic Examination Urine</b>			
Pus Cells (WBCs)*	1-3	/hpf	0 - 5
Epithelial Cells*	Absent	/hpf	0 - 4
Red blood Cells*	Absent	/hpf	Absent
Crystals*	Absent		Absent
Cast*	Absent		Absent
Trichomonas Vaginalis*	Absent		Absent
Yeast Cells*	Absent		Absent
Amorphous deposits*	Absent		Absent
Bacteria*	Absent		Absent

\*\*END OF REPORT\*\*

*Bholiya*

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Routine check-up.



Name: Peet  
Date: 30/1  
Age: 3

POTEC PRK 0000  
2023/03/30 16:48:19  
NO: 03248  
NAME:

[REF]	UD: 12.0	Cyl. Form: MIX A	
<R>	SPH	CYL	AX
	-2.75	-1.50	68 A
	-3.00	-1.25	69 A
	-3.00	-1.50	69 A
AUE	-3.00	-1.50	69
<L>	SPH	CYL	AX
	-2.75	-2.00	87
	-3.25	-1.50	78 A
	-3.00	-1.50	83 A
AUE	-3.00	-1.50	83

1/2 c 6/6.  
glass < 6/6

Coloured

BE Asym  
RLE  
Clear lens

Fundus: D<sub>s</sub> (n)  
PR + ut

Adv  
CT Glasses

BE Eyeist forte  
eds 0000

**Dr Shreya Shah**  
Consultant Ophthalmologist &  
Phaco Surgeon  
REG NO:-G 26895

# SHRIMATI JAYABEN MODY HOSPITAL

REGD. No. F/106/BHARUCH

MANAGED BY :

Ankleshwar Industrial Development Society, Ankleshwar

VALIA ROAD, GIDC, ANKLESHWAR - 393 002. PHONE : 222220, 224550

---

NAME OF PATIENT : PEEYUSH KALRA  
DATE : 30/03/2023

## USG OF ABDOMEN AND PELVIS

Liver appears normal in size, shape and shows fatty echotexture suggestive of grade II fatty liver. No evidence of focal SOL or dilation of IHBR seen.

Porta hepatis is appears normal.

Gallbladder appears normal. Multiple gallbladder calculi noted, largest approximately measuring 8 mm. Wall thickness appears normal.

Pancreas appears normal in size and echotexture.

Spleen appears normal in size and echotexture.

Aorta appears normal. No para aortic lymphnodes seen.

Right kidney appears normal in size, location and echotexture.

Cortex and collecting system of right kidney appears normal.

No calculi or obsrtuctive uropathy.

Left kidney appears normal in size, location and echotexture.

Cortex and collecting system of left kidney appears normal.

No calculi or obsrtuctive uropathy.

Bladder & Prostate appears normal.No calculi seen.

Terminal ileum and ceacum appears normal.

Appendix is not seen due to bowel gas, no evidence of probe tenderness.

No evidence of free fluid or collection is seen in peritoneal spaces.

## COMMENTS:

- Cholelithiasis without changes of cholecystitis.
- Grade II fatty liver.

THANKS FOR THE REFERENCE

DR. JANAKI RAJ (M.D)  
CONSULTANT RADIOLOGIST

30.03.2023 12:56:47  
SARF PAT HOSPITAL  
CHIN, ADI  
ANKLESHWAR

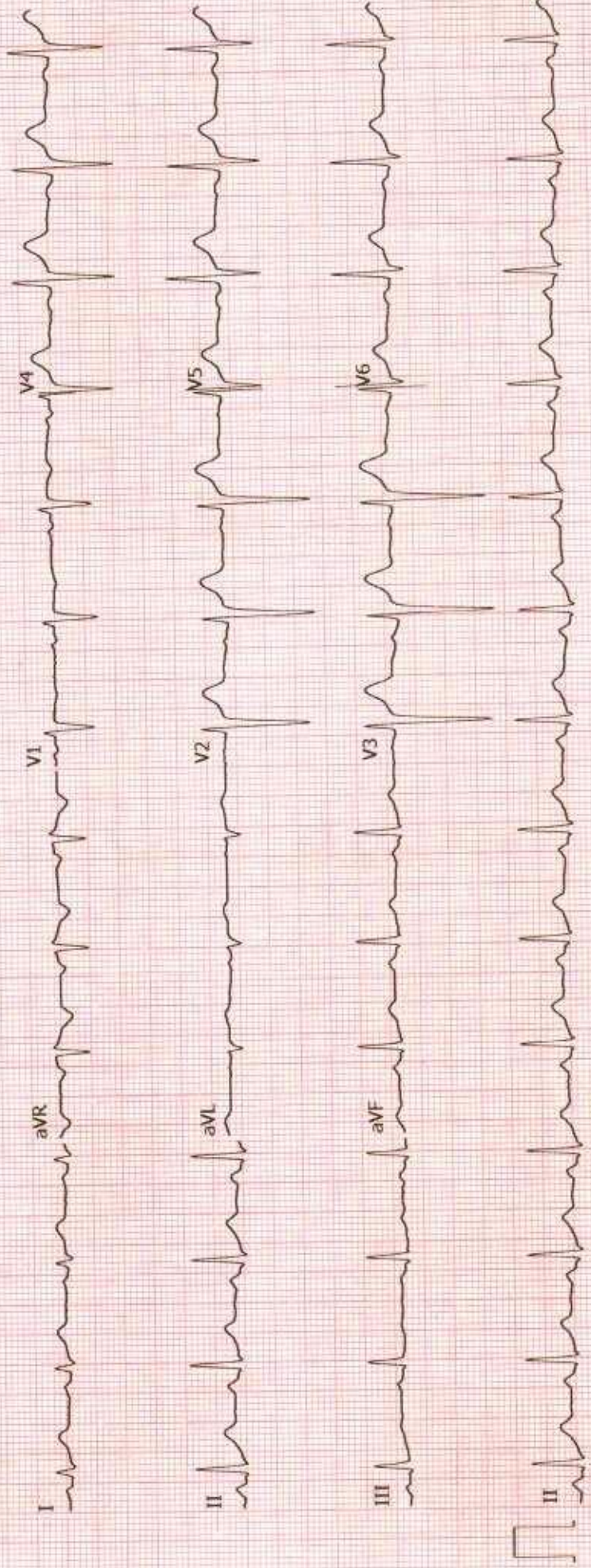
Location:  
Nun  
Indication:  
Medication 1:  
Medication 2:  
Medication 3:

Room:  
82 bpm  
Feeyush kalbe

Technician:  
Ordering Ph:  
Referring Ph:  
Attending Ph:

QRS : 98 ms  
QT / QTcBaz : 374 / 436 ms  
PR : 154 ms  
P : 104 ms  
RR / PP : 728 / 731 ms  
P / QRS / T : 52 / 77 / 39 degrees

Normal sinus rhythm  
Normal ECG



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



**OPD INITIAL ASSESSMENT FORM**

(To be filled by Nursing Staff)

Patient Name: - Peeyush Kalra UHID Number: - 44169

Consultant Name: DR. Kaipesh Vaidya Date: - 30/3/23 Start Time: - 5:15 Age: - 32 (Years)

Sex: - M (M/F)

Height: - \_\_\_\_\_ cms, Weight: - \_\_\_\_\_ kgs. Temp. \_\_\_\_\_, Pulse: - \_\_\_\_\_ (Per minute), SPO2 \_\_\_\_\_

B.P. :- \_\_\_\_\_ (mm of Hg), RBS:- \_\_\_\_\_ First Visit / Follow Up

Visit: First Visit

Nursing Staff Name & Signature: - Sudhy End Time:- \_\_\_\_\_

**Past History: - (TICK MARK)**

Diabetes, Hypertension, IHD, COPD, Asthma, TB, Smoker, Alcoholic, Hypothyroidism

Other:- NO

Family History:- \_\_\_\_\_ Nutritional Screening:- \_\_\_\_\_

Psychosocial Assessment:- \_\_\_\_\_ Immunization Status:- \_\_\_\_\_

To be filled by Clinician) Start Time:- \_\_\_\_\_

**Clinical Findings:-**

good for health check up

no constipation  
occasional

GI P/A - soft stools  
RFA

**Diagnosis:-**

**Investigations and Advice:-**

0.5 abdominal  
rotax