

Medwheat

A10-devali

Dr. Vimmi Goel  
MBBS, MD (Internal Medicine)  
Sr. Consultant Non Invasive Cardiology  
Reg. No: MMC- 2014/01/0113

Preventive Health Check up  
KIMS Kingsway Hospitals  
Nagpur  
Phone No.: 7499913052



Name: Mrs. priyanka Funde Date: 28/

Age: 374 Sex: M/F Weight: 53.7 kg Height: 157.0 inc BMI: 21.8

BP: 134/83 mmHg Pulse: 96/m bpm RBS: mg/dl

SpO2: 99% LMP- 10-2-24.

! No diabetes

Chc  
W  
P/A ~

Adv.

- Gynec (pchg)
- Diet + Exercise

FBS  
PMBS  
HbA1c

after  
3mths

Dr. VIMMI GOEL  
MBBS, MD  
Sr. Consultant Non Invasive Cardiology  
Reg.No.: 2014/01/0113

**DEPARTMENT OF OPHTHALMOLOGY**  
**OUT PATIENT ASSESSMENT RECORD**

<b>PRIYANKA FUNDE</b> 37Y(S) 0M(S) 0D(S)YF UMR2324038839 9923469170 MARRIED	<b>CONSULT DATE</b> : 28-02-2024 <b>CONSULT ID</b> : OPC2324119175 <b>CONSULT TYPE</b> : <b>VISIT TYPE</b> : NORMAL <b>TRANSACTION TYPE</b> :	<b>DR. ASHISH PRAKASHCHANDRA KAMBLE</b> MBBS,MS, FVRS,FICO CONSULTANT DEPT OPHTHALMOLOGY
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**VITALS**

Temp : Pulse : BP (mmHg) : spO2 : Pain Score : Height :  
-- °F -- /min -- %RA -- /10 -- cms

Weight : BMI :  
-- kgs --

**CHIEF COMPLAINTS**

ROUTINE CHECK UP

**MEDICATION PRESCRIBED**

#	Medicine	Route	Dose	Frequency	When	Duration
1	SYSTANE COMPLETE 10ML EYE DROP	Eye	1-1-1-1	Every Day	NA	90 DAYS
Instructions : BOTH EYES						
Composition : PROPYLENE GLYCOL 0.6% WV/GML						

**NOTES**

**GLASS PRESCRIPTION :-**

**DISTANCE VISION**

EYE	SPH	CYL	AXIS	VISION
RIGHT EYE	00	00	00	6/6
LEFT EYE	00	00	00	6/6

**NEAR ADDITION**

RIGHT EYE	+1.00d	N6
LEFT EYE	+1.00d	N6

REMARK- Progressive glass / Bifocal.

**REVIEW**

Follow up Date : 28-08-2024

*A. Kamble*

**Dr. Ashish Prakashchandra Kamble**  
MBBS,MS, FVRS,FICO  
Consultant

Printed On : 28-02-2024 16:15:31



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age / Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 01:51 pm	<b>Report Date</b> : 28-Feb-24 03:29 pm

**HAEMOGRAM**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	<b>11.0</b>	12.0 - 15.0 gm%	Photometric
Haematocrit(PCV)		<b>34.5</b>	36.0 - 46.0 %	Calculated
RBC Count		4.79	3.8 - 4.8 Millions/cumm	Photometric
Mean Cell Volume (MCV)		<b>72</b>	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		<b>23.0</b>	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		32.0	31.5 - 35.0 g/l	Calculated
RDW		<b>18.0</b>	11.5 - 14.0 %	Calculated
Platelet count		281	150 - 450 $10^3$ /cumm	Impedance
WBC Count		9000	4000 - 11000 cells/cumm	Impedance

**DIFFERENTIAL COUNT**

Neutrophils	64.0	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes	30.1	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils	1.2	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes	4.7	2 - 10 %	Flow Cytometry/Light microscopy
Basophils	0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count	5760	2000 - 7000 /cumm	Calculated



**CLINICAL DIAGNOSTIC LABORATORY**  
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<b>Received Dt</b> : 28-Feb-24 01:51 pm	<b>Report Date</b> : 28-Feb-24 03:29 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Lymphocyte Count		2709	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		108	20 - 500 /cumm	Calculated
Absolute Monocyte Count		423	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
<b>PERIPHERAL SMEAR</b>				
RBC		Microcytosis + (Few), Hypochromia + (Few), Anisocytosis + (Few)		Light microscopy
WBC		As Above		
Platelets		Adequate		
<b>ESR</b>		<b>24</b>	0 - 20 mm/hr	Automated Westergren's Method

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

Suggested Clinical Correlation \* If necessary, Please discuss

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Test results related only to the item tested.

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**Dr. VAIDEHEE NAIK, MBBS,MD**  
**CONSULTANT PATHOLOGIST**





**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age /Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 01:51 pm	<b>Report Date</b> : 28-Feb-24 03:26 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	93	< 100 mg/dl	GOD/POD,Colorimetric
<b>GLYCOSYLATED HAEMOGLOBIN (HbA1c)</b>				
<b>HbA1c</b>		5.6	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

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

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**Dr. VAIDEHEE NAIK, MBBS,MD**

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Phone: +91 0712 6789100

CIN: U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age / Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 04:00 pm	<b>Report Date</b> : 28-Feb-24 06:13 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Post Prandial Plasma Glucose	Plasma	<b>193</b>	< 140 mg/dl	GOD/POD, Colorimetric

**Interpretation:**

Clinical Decision Value as per ADA Guidelines 2021

Diabetes Mellites If,

Fasting  $\geq$  126 mg/dl

Random/2Hrs. OGTT  $\geq$  200 mg/dl

Impaired Fasting = 100-125 mg/dl

Impaired Glucose Tolerance = 140-199 mg/dl

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

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**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age / Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 01:51 pm	<b>Report Date</b> : 28-Feb-24 04:01 pm

**LIPID PROFILE**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	200	Enzymatic(CHE/CHO/PO D)
Triglycerides		134	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		<b>38</b>	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		<b>118.92</b>	Enzymatic
VLDL Cholesterol		27	Calculated
Tot Chol/HDL Ratio		5	Calculation

<u>Intiate therapeutic</u>	<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	>130, optional at 100-129
Multiple major risk factors conferring 10 yrs CHD risk >20%	>130	10 yrs risk 10-20 % >130
Two or more additional major risk factors, 10 yrs CHD risk <20%	>160	10 yrs risk <10% >160
No additional major risk or one additional major risk factor		>190, optional at 160-189

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

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**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mrs. PRIYANKA FUNDE **Age /Gender** : 37 Y(s)/Female  
**Bill No/ UMR No** : BIL2324080953/UMR2324038839 **Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 28-Feb-24 01:51 pm **Report Date** : 28-Feb-24 04:01 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>RFT</b>				
Blood Urea	Serum	14	15.0 - 36.0 mg/dl	Urease with indicator dye
Creatinine		0.6	0.52 - 1.04 mg/dl	Enzymatic ( creatinine amidohydrolase)
GFR		118.5	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		143	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.31	3.5 - 5.1 mmol/L	Direct ion selective electrode
<b>THYROID PROFILE</b>				
T3		1.48	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.20	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		2.12	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

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

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**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age /Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 01:51 pm	<b>Report Date</b> : 28-Feb-24 04:01 pm

**LIVER FUNCTION TEST(LFT)**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.44	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.16	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.28	0.1 - 1.1 mg/dl	Dual wavelength spectrophotometric
Alkaline Phosphatase		114	38 - 126 U/L	pNPP/AMP buffer
SGPT/ALT		26	13 - 45 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		26	13 - 35 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		<b>8.28</b>	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.48	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.79	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.2		

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

Suggested Clinical Correlation \* If necessary, Please discuss

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**Dr. VAIDEHEE NAIK, MBBS,MD**  
**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age /Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
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**Dr. VAIDEHEE NAIK, MBBS,MD  
CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age / Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 02:05 pm	<b>Report Date</b> : 28-Feb-24 04:38 pm

**URINE MICROSCOPY**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<b><u>PHYSICAL EXAMINATION</u></b>			
Volume	Urine	20 ml	
Colour.		Pale yellow	
Appearance		Clear	Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
Reaction (pH)		6	4.6 - 8.0
Specific gravity		1.020	1.005 - 1.025
Urine Protein		Negative	Negative
Sugar		Negative	Negative
Bilirubin		Negative	Negative
Ketone Bodies		3+ (Approx 50mg/dl)	Negative
Nitrate		Negative	Negative
Urobilinogen		Normal	Normal
<b><u>MICROSCOPIC EXAMINATION</u></b>			
Epithelial Cells		0-1	0 - 4 /hpf
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		0-1	0 - 4 /hpf



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age / Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 02:05 pm	<b>Report Date</b> : 28-Feb-24 04:38 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Casts		Absent	Absent
Crystals		Absent	
*** End Of Report ***			

Suggested Clinical Correlation \* If necessary, Please discuss

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**DR. VAIDEHEE NAIK, MBBS,MD**  
**CONSULTANT PATHOLOGIST**





**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF IMMUNO HAEMATOLOGY**

<b>Patient Name</b> : Mrs. PRIYANKA FUNDE	<b>Age /Gender</b> : 37 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2324080953/UMR2324038839	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 28-Feb-24 01:51 pm	<b>Report Date</b> : 28-Feb-24 04:35 pm

**BLOOD GROUPING AND RH**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
BLOOD GROUP.	EDTA Whole Blood & Plasma/ Serum	" B "	Gel Card Method
Rh (D) Typing.		" Positive "(+Ve)	

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

Suggested Clinical Correlation \* If necessary, Please discuss

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**Dr. VAIDEHEE NAIK, MBBS,MD**  
**CONSULTANT PATHOLOGIST**

**DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE**

NAME	PRIYANKA FUNDE	STUDY DATE	28-02-2024 15:38:26
AGE/SEX	37Y / F	HOSPITAL NO.	UMR2324038839
ACCESSION NO.	BL2324080953-10	MODALITY	DX
REPORTED ON	28-02-2024 17:47	REFERRED BY	Dr. Vimmi Goel

**X-RAY CHEST PA VIEW**

Both the lung fields are clear.

Heart and Aorta are normal

Hilar shadows appear normal

Diaphragm domes and CP angles are clear.

Bony cage is normal

**IMPRESSION:**

No pleuro-parenchymal abnormality seen.



**DR NAVEEN PUGALIA**  
MBBS, MD [076125]  
SENIOR CONSULTANT RADIOLOGIST.

N.B: This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations. Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

PATIENT NAME:	PRIYANKA FUNDE	AGE /SEX:	37 YRS/FEMALE
UMR NO:	UMR2324038839	BILL NO:	2324080953
REFERRED BY	DR VIMMI GOEL	DATE	28-FEB-2024

**USG ABDOMEN AND PELVIS**

LIVER is normal in size and echotexture. No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated. PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No stones or sludge seen within it. Wall thickness is within normal limits.

Visualized head and body of PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in size, shape and echotexture. No focal lesion seen.

Both KIDNEYS are normal in shape, size and echotexture. No evidence of calculus or hydronephrosis seen. URETERS are not dilated.

URINARY BLADDER is well distended. No calculus or mass lesion seen.

Uterus is anteverted and normal.  
No focal myometrial lesion seen.  
Endometrial echo-complex appear normal.  
Right ovary is not seen separately.  
Left ovary appears normal.  
A simple anechoic cyst of size 5.8 x 2.9 x 4.5 cm is seen at right adnexa.

There is no free fluid or abdominal lymphadenopathy seen.

**IMPRESSION:**

- Simple right ovarian cyst.
  - No other significant visceral abnormality seen.
- Suggest clinical correlation / further evaluation.



**DR. ANIKET KUSRAM**  
MBBS, MD, DNB  
CONSULTANT RADIOLOGIST

**2D ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT**

Patient Name : Mrs. Priyanka Funde  
Age : 37 years / Female  
UHID : UMR2324038839  
Date : 28/02/2024  
Done by : Dr. Vimmi Goel  
ECG : NSR, Minor ST-T changes  
Blood pressure: 134/83 mm Hg (Right arm, Supine position)  
BSA : 1.53 m<sup>2</sup>

**Impression:**

**Normal 2D Echocardiography**

- Normal chambers dimensions
- No RWMA of LV at rest
- Good LV systolic function with LVEF – 65%
- Normal LV diastolic function
- E Velocity is 99 cm/s, A Velocity is 57 cm/s, E/A is 1.7
- Medial E' is 11.6 cm/sec, Lateral E' is 14.9 cm/sec, E/E' is 7.6 (Average)
- Valves are normal
- No pulmonary hypertension
- No clots / Pericardial effusion
- IVC – Normal in size and collapsing well with respiration

  
**Dr. Vimmi Goel**  
**MD, Sr. Consultant**  
**Non-invasive Cardiology**



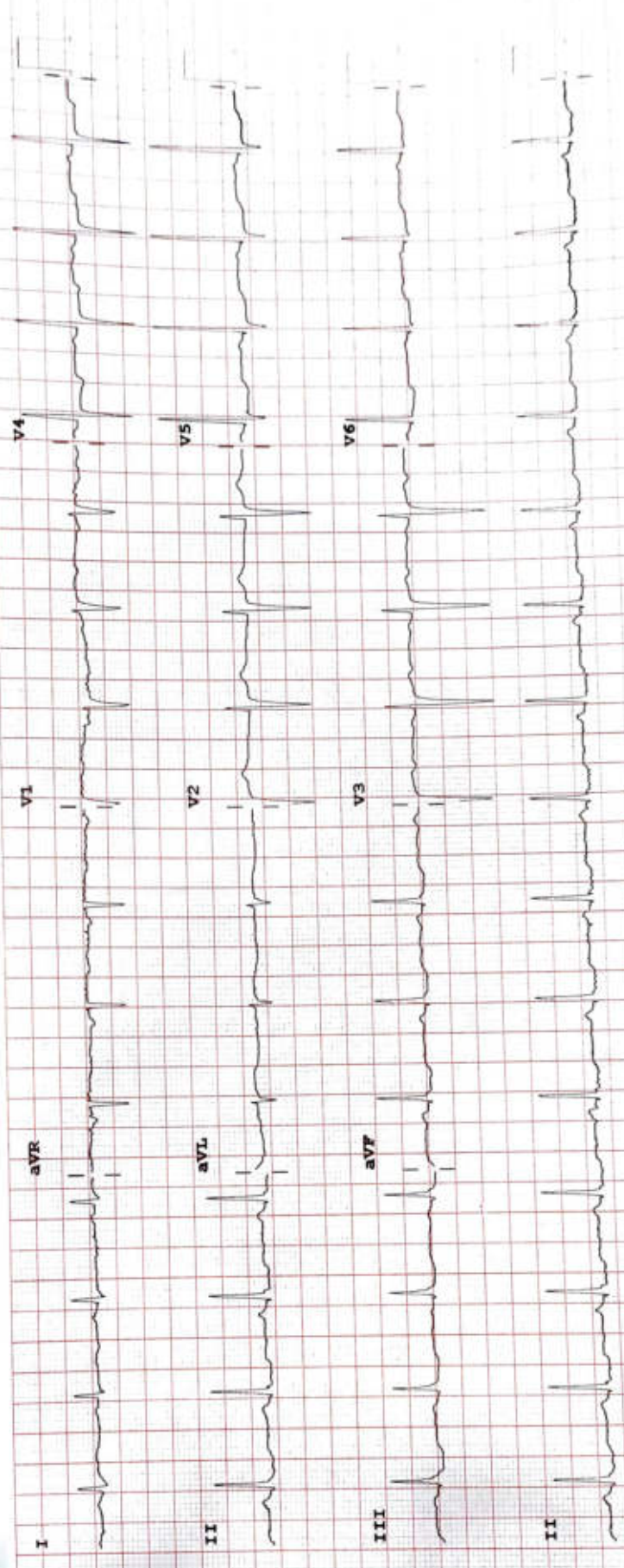
37 Years

Rate 92 Sinus rhythm.....normal P axis, V-rate 50-99  
 PR 140 Borderline repolarization abnormality.....ST dep & abnormal T  
 QRS 90 Baseline wander in lead(s) V1  
 QT 326  
 QTc 404

--AXIS--  
 P 57  
 QRS 71  
 T -83  
 12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Chest: 10.0 mm/mV  
 Limb: 10 mm/mV  
 F 50~ 0.50-150 Hz W 100B CL F7  
 PHILIPS  
 RECORDERS • M-1011A