

Name: Mr. Ramesh Kumar Singh Date: 7/3/24

Age: 51Y Sex: M/F Weight: 67.0 kg Height: 171.5 inc BMI: 22.8

BP: 147/81 mmHg Pulse: 87 /m bpm RBS: _____ mg/dl

SpO2: 98%

S/M

NIDDM - Glucosam G 2 1 - - - 1
Teneligliptin 20 * - - - 1
Dapavel 10 1 - - - -
Kipaglyn 4 * - - - -
Rosulest F * - - - 1
(10)

Inw.

HbA1c - 6.7
Fatty liver
Mod prostaticomegaly

O/E

JVP°
Cv
Lvs
P/A | N.

Adv.

- Ct. all
- Rosulest 10 * - - - 1
A/D
- R/A Glucose = FBS
PMBS
HbA1c
FLP


DR. VIMMI GOEL
Sr. Consultant Non Invasive Cardiology

DEPARTMENT OF OPHTHALMOLOGY
OUT PATIENT ASSESSMENT RECORD

RAMESH KUMAR SINGH 51Y(S) 0M(S) 0D(S)M UMR2324039681 9889888171	CONSULT DATE : 07-03-2024 CONSULT ID : OPC2324122067 CONSULT TYPE : VISIT TYPE : NORMAL TRANSACTION TYPE : CASH	DR. ASHISH PRAKASHCHANDRA KAMBLE 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 -

DIAGNOSIS

RE-
LE-

CHIEF COMPLAINTS

ROUTINE CHECK UP

MEDICATION PRESCRIBED

#	Medicine	Route	Dose	Frequency	When	Duration
1	MAXMOIST 10ML DROPS	Eye	1-1-1-1	Every Day	NA	2 months
Instructions : BOTH EYES						
Composition : D-PANFENOL 0.1MG+HYALURONIC ACID 10MG						

NOTES

GLASS PRESCRIPTION :-
DISTANCE VISION

EYE	SPH	CYL	AXIS	VISION
-----	-----	-----	------	--------

RIGHT EYE	00	-1.00	85	6/6
-----------	----	-------	----	-----

LEFT EYE	-0.25	-0.50	85	6/6
----------	-------	-------	----	-----

NEAR ADDITION

RIGHT EYE	+1.50D			N6
-----------	--------	--	--	----

LEFT EYE	+1.50D			N6
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REMARK- WITH OLD GLASSES



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

Printed On :07-03-2024 11:27:15

Name: Mr. Ramesh Kumar Singh Date: 07 03 24
Age: 47 Sex: M/F Weight: _____ kg Height: _____ Inc: _____ BMI: _____
BP: _____ mmHg Pulse: _____ bpm RBS: _____ mg/dl

KLIO DM 4 II E

ME Calculus mixed
Strain

Parthum c $7^6 \frac{91}{4}$

KPD c $\frac{11}{11}$

RP c $\frac{17}{17}$

Ulcer on cheek & buccal mucosa Distal to $\frac{17}{17}$ sym

Adv Scaling
Replacement of $\frac{17}{17}$ fix Parthum c $\frac{11}{11}$

R

1) Mucopur gel for LA
x 3 days

1.0 7 days Review for ulcer

Vishy



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. RAMESH KUMAR SINGH	Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:04 am	Report Date : 07-Mar-24 11:14 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	14.8	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		44.5	40.0 - 50.0 %	Calculated
RBC Count		5.23	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		85	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		28.3	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		33.3	31.5 - 35.0 g/l	Calculated
RDW		17.2	11.5 - 14.0 %	Calculated
Platelet count		110 PTO	150 - 450 10^3 /cumm	Impedance
WBC Count		5600	4000 - 11000 cells/cumm	Impedance

DIFFERENTIAL COUNT

Neutrophils	62.0	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes	30.4	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils	4.5	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes	3.1	2 - 10 %	Flow Cytometry/Light microscopy
Basophils	0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count	3472	2000 - 7000 /cumm	Calculated



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DEPARTMENT OF PATHOLOGY

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Parameter	Specimen	Results	Biological Reference	Method
Absolute Lymphocyte Count		1702.4	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		252	20 - 500 /cumm	Calculated
Absolute Monocyte Count		173.6	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
PERIPHERAL SMEAR				
RBC		Normochromic		
Anisocytosis		Normocytic		
WBC		Anisocytosis		
Platelets		+(Few)		
		As Above		
		Mildly Reduced.		
		Manual platelet		
		count: 1.4 lakh to		
		1.5 lakh/cumm.		
		Giant platelets are		
		seen.		
ESR		04	0 - 20 mm/hr	Automated Westergren's Method

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100245

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**

Patient Name : Mr. RAMESH KUMAR SINGH	Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:03 am	Report Date : 07-Mar-24 10:14 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	84	< 100 mg/dl	GOD/POD, Colorimetric
Post Prandial Plasma Glucose		167	< 140 mg/dl	GOD/POD, Colorimetric
GLYCOSYLATED HAEMOGLOBIN (HbA1c)				
HbA1c		6.7	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

CONSULTANT PATHOLOGIST

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24, Perwane Dwarer, Kingsway, Nagpur - 440001, Maharashtra, India

Phone: +91 0712 6789100

CIN: U74909MH2019PTC303510



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. RAMESH KUMAR SINGH	Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:04 am	Report Date : 07-Mar-24 11:42 am

LIPID PROFILE

Parameter	Specimen	Results	Method
Total Cholesterol	Serum	114 < 200 mg/dl	Enzymatic(CHE/CHO/POD)
Triglycerides		102 < 150 mg/dl	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		36 > 40 mg/dl	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		63.52 < 100 mg/dl	Enzymatic
VLDL Cholesterol		20 < 30 mg/dl	Calculated
Tot Chol/HDL Ratio		3 3 - 5	Calculation

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

*** 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**

Patient Name : Mr. RAMESH KUMAR SINGH
Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:04 am
Report Date : 07-Mar-24 11:42 am

LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.81	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.25	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.56	0.1 - 1.1 mg/dl	Dual wavelength spectrophotometric pNPP/AMP buffer
Alkaline Phosphatase		70	38 - 126 U/L	Kinetic with pyridoxal 5 phosphate
SGPT/ALT		52	10 - 40 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		43	15 - 40 U/L	Biuret (Alkaline cupric sulphate)
Serum Total Protein		7.63	6.3 - 8.2 gm/dl	Bromocresol green Dye
Albumin Serum		4.81	3.5 - 5.0 gm/dl	Binding
Globulin		2.82	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.71		

*** 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

Patient Name : Mr. RAMESH KUMAR SINGH
Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:04 am
Report Date : 07-Mar-24 11:42 am

RFT

Parameter

Blood Urea

Creatinine

GFR

Sodium

Potassium

Specimen

Serum

Result Values

26

0.90

103.4

142

4.56

Biological Reference

19.0 - 43.0 mg/dl

0.66 - 1.25 mg/dl

>90 mL/min/1.73m square.

136 - 145 mmol/L

3.5 - 5.1 mmol/L

Method

Urease with indicator dye

Enzymatic (creatinine amidohydrolase)

Calculation by CKD-EPI 2021

Direct ion selective electrode

Direct ion selective electrode

*** 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**

Patient Name : Mr. RAMESH KUMAR SINGH
Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:04 am
Report Date : 07-Mar-24 11:42 am

Parameter
THYROID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
T3	Serum	1.62	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.23	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		0.920	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence
PSA (Total)		0.670	< 4 ng/ml	Enhanced chemiluminescence

*** End Of Report ***

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Dr. VAIDEHEE NAIK, MBBS,MD

CONSULTANT PATHOLOGIST

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Phone: +91 0712 6789100

CIN: U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY**

Patient Name : Mr. RAMESH KUMAR SINGH
Bill No/ UMR No : BIL2324082962/UMR2324039681
Received Dt : 07-Mar-24 09:37 am

Age / Gender : 51 Y(s)/Male
Referred By : Dr. Vimmi Goel MBBS,MD
Report Date : 07-Mar-24 11:09 am

URINE MICROSCOPY

Parameter

Parameter	Specimen	Results	Method
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PHYSICAL EXAMINATION

Volume	Urine	40 ml	
Colour.		Pale yellow	
Appearance		Clear	Clear

CHEMICAL EXAMINATION

Reaction (pH)		6.5	4.6 - 8.0	Indicators
Specific gravity		1.010	1.005 - 1.025	ion concentration
Urine Protein		Negative	Negative	protein error of pH indicator
Sugar		4+ (Approx 1000mg/dl)	Negative	GOO/POD
Bilirubin		Negative	Negative	Diazonium
Ketone Bodies		Negative	Negative	Legal's est Principle
Nitrate		Negative	Negative	
Urobilinogen		Normal	Normal	Ehrlich's Reaction

MICROSCOPIC EXAMINATION

Epithelial Cells		0-1	0 - 4 /hpf	Manual
R.B.C.		Absent	0 - 4 /hpf	
Pus Cells		0-1	0 - 4 /hpf	



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY**

Patient Name : Mr. RAMESH KUMAR SINGH
Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:37 am
Report Date : 07-Mar-24 11:09 am

<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

Verified By : : 11100908

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



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mr. RAMESH KUMAR SINGH	Age / Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 11:44 am	Report Date : 07-Mar-24 01:49 pm

URINE SUGAR

Parameter

Urine Glucose

NOTE:

Result Values

Negative

post meal urine sugar

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100908

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**Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY

Patient Name : Mr. RAMESH KUMAR SINGH	Age /Gender : 51 Y(s)/Male
Bill No/ UMR No : BIL2324082962/UMR2324039681	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 07-Mar-24 09:04 am	Report Date : 07-Mar-24 11:47 am

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

Verified By : : 11100245

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Dr. VAIDEHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	RAMESH KUMAR SINGH	STUDY DATE	07-03-2024 09:57:19
AGE/ SEX	51 Y / M	HOSPITAL NO.	UMR2324039681
ACCESSION NO.	BH.2324082962-17	MODALITY	DX
REPORTED ON	07-03-2024 10:15	REFERRED BY	Dr. Vinmi Goel

X-RAY CHEST PA VIEW

Both the lung fields are clear.

Heart and Aorta are normal.

Both hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

IMPRESSION -No pleuro-parenchymal abnormality seen.



DR R.R KHANDELWAL

SENIOR CONSULTANT

MD, RADIODIAGNOSIS [MMC-55870]

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.

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Phone: +91 0712 8789100
CIN: U74999MH2018PTC300510

PATIENT NAME:	MR. RAMESH SINGH	AGE /SEX:	51 YRS/M
UMR NO:	2324039681	BILL NO:	2324082962
REF BY	DR. VIMMI GOEL	DATE:	07/03/2024

USG WHOLE ABDOMEN

LIVER is enlarged in size (16.2 cm) and show raised parenchymal 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 sludge or calculus seen.
Wall thickness is within normal limits.

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

SPLEEN is borderline enlarged in size (12.7 cm.). No focal lesion seen.

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

BLADDER is partially distended. No calculus or mass lesion seen.

Prostate is enlarged in size (volume – 51 cc).

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

Mild hepatomegaly with grade I fatty liver.
Borderline splenomegaly.
Moderate prostatomegaly.
No other significant abnormality seen.
Suggest clinical correlation / further evaluation.



DR. ANIKET KUSRAM
MBBS, MD, DNB (Radio-diagnosis)
Reg no: 2017094427

2D ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT

Patient Name : Mr. Ramesh Kumar Singh
 Age : 51 years / Male
 UMR : UMR2324039681
 Date : 07/03/2024
 Done by : Dr. Vimmi Goel
 ECG : NSR, WNL
 Blood pressure: 147/81 mm Hg (Right arm, Supine position)
 BSA : 1.78 m²

Impression:

Normal chambers dimensions
Borderline left ventricular hypertrophy
No RWMA of LV at rest
Good LV systolic function, LVEF 66%
LV diastolic dysfunction, Grade I (E<A)
E/A is 0.6
E/E' is 7.8 (Normal filling pressure)
Valves are normal
Trivial AR
No pulmonary hypertension
IVC is normal in size and collapsing well with respiration
No clots or pericardial effusion

Comments:

Sector echocardiography was performed in various conventional views (PLAX, SSAX, AP4 CH and 5 CH views). LV size normal. Borderline left ventricular hypertrophy. There is no RWMA of LV seen at rest. Good LV systolic function. LVEF 66%. LV diastolic dysfunction, Grade I (E<A). E Velocity is 61 cm/s, A Velocity is 90 cm/s. E/A is 0.6. Valves are normal. Trivial AR. No Pulmonary Hypertension. IVC normal in size and collapsing well with respiration. Pericardium is normal. No clots or pericardial effusion seen. E' at medial mitral annulus is 6.6 cm/sec & at lateral mitral annulus is 9.3 cm/sec. E/E' is 7.8 (Average).

M Mode echocardiography and dimension:

	Normal range (mm)		Observed (mm)
	(adults)	(children)	
Left atrium	19-40	7-37	36
Aortic root	20-37	7-28	29
LVIDd	35-55	8-47	39
LVIDs	23-39	6-28	25
IVS (d)	6-11	4-8	11
LVPW (d)	6-11	4-8	11
LVEF %	~ 60%	~60%	66%
Fractional Shortening			36%

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

P.T.O

PBC DEPT.

51 Years

Rate 87 - Sinus rhythm..... normal P axis, V-rate 50-99
 - ST elev. probable normal early repol pattern.....
 - Baseline wander in lead(s) I, III, aVR, aVL, aVF, V2, V5, V6

PR 134
 QRSD 79
 QT 343
 QTc 413

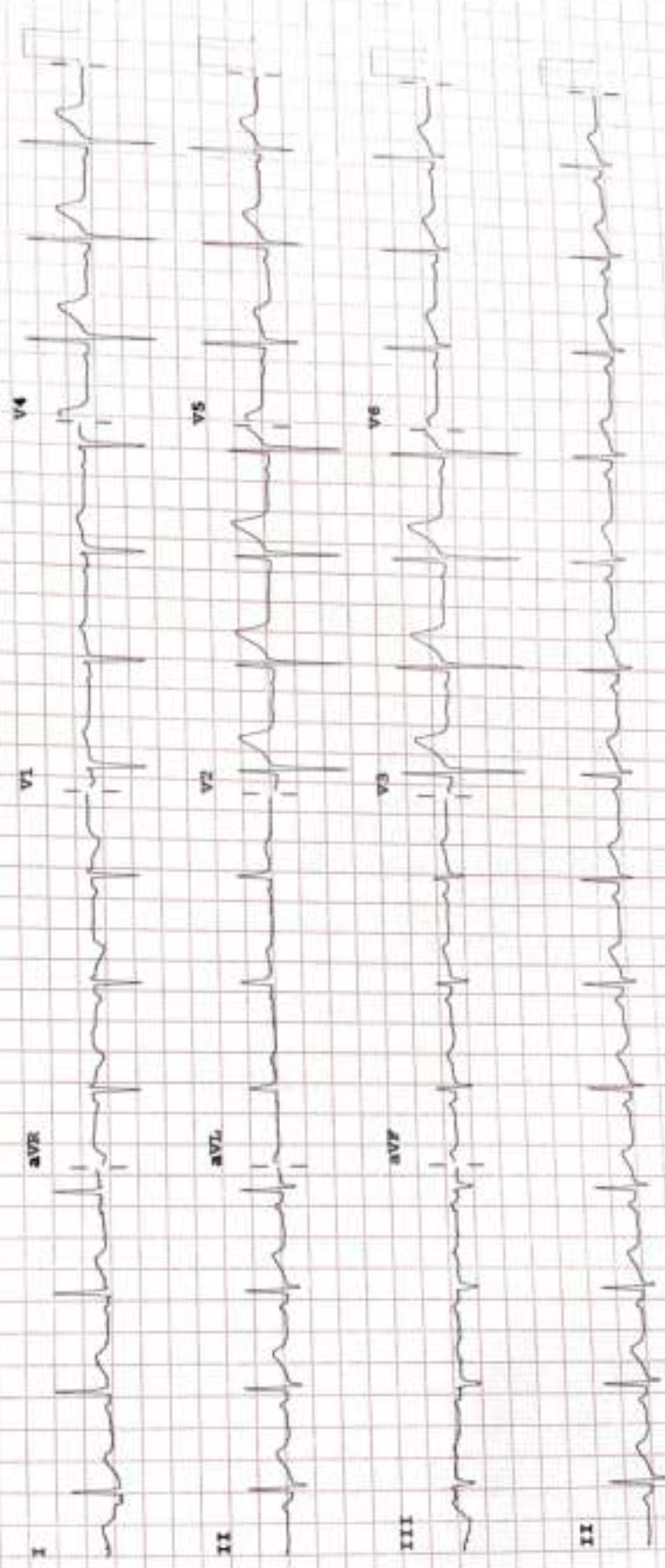
--AXIS--

P 60
 QRS 4
 T 33

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



P 50- 0.50-150 Br W 100B CL P?

Speed: 25 mm/sec Chest: 10.0 mm/mV

Liab: 10 mm/mV

PHILIPS