

MEDICAL SUMMARY

NAME:	Mr Anand Tochan	UHID:	
AGE:	20	DATE OF HEALTHCHECK:	9-12-2025
GENDER:	M		

HEIGHT:	169	MARITAL STATUS:	M
WEIGHT:	85.9	NO OF CHILDREN:	1
BMI:	30.1		

C/O: Headache - 10 days,
Itchy around neck

K/C/O:
PRESENT MEDICATION: - No,

P/M/H: - No

P/S/H: - No

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER: - NAD
MOTHER: - NAD

ALCOHOL: - No

TOBACCO/PAN:

O/E:

LYMPHADENOPATHY: -

BP: 110/80 PULSE: 76/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING: -

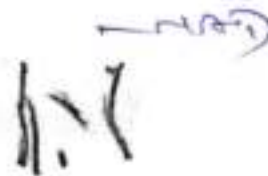
TEMPERATURE: - SCARS: -

OEDEMA: - No

S/E:
RS:



P/A:



CVS: - S2+

Extremities & Spine: - NAD

CNS: - G-wings, vertebrae

ENT: - NAD

Skin: - Scap - fungal infection

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

• ANDHERI • COLABA • NASHIK • VASHI

Findings and Recommendation:

Findings:-

Dyslipidemia Total Cholesterol
208mg/dl
X-ray chest Cardiomegaly
ECG LAD
USG of Fatty Liver

Recommendation:-

Low fat diet
Consult Cardiologist
for further evaluation

DR. PRADNYA P. DANI
(M.B.B.S)
Reg. No. 87541

Signature:
Consultant -

OPHTHALMIC EVALUATION

UHID No.: _____

 Date: 9/12/23

 Name: Mr. Anand Kumar Trehan Age: 40 yrs Gender: Male/Female /

Without Correction :

 Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye _____ Left Eye _____

 Near : Right Eye N-6 Left Eye N-6

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near	+0.50	—	—	—	N-6	+0.50	—	—	—	N-6

 Colour Vision : (PDE) - WNL

 Anterior Segment Examination : (PDE) - WNL

 Pupils : (PDE) - WNL

 Fundus : (PDE) - WNL

Intraocular Pressure : _____

 Diagnosis : (PDE) - WNL

Advice : _____

Re-Check on _____ (This Prescription needs verification every year)

 Dr. Sagarika Dey
 (Consultant Ophthalmologist)

DR. SAGORIKA DEY

M.D. OMS

REGN NO: 2008/04/1182

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: Anand Trehan.	MR NO:
Age/Gender : 40 / M	Date: 9/12/23

Medical history: Diabetes Hypertension _____

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains				
Mobility				
Caries (Cavities)				
a) Class 1 (Occlusal)				
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces	✓	✓	✓	✓
Impacted Tooth				
Missing Tooth				
Existing Denture				

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction	✓	✓	✓	✓

Oral Prophylaxis: Scaling & polishing
 Orthodontic Advice for Braces: Yes / No
 Prosthetic Advice to Replace Missing Teeth: Denture Bridge Implant
 Oral Habits: Tobacco Cigarette Others since ___ years
 Advice to quit any form of tobacco as it can cause cancer.

Other Findings: _____


Adv Opa .

Name : Mr. Anand Kumar Trehan Gender : Male Age : 40 Years
 UHID : FVAH 9694 Bill No : Lab No : V-2155-23
 Ref. by : SELF Sample Col.Dt : 09/12/2023 8:30
 Barcode No : 9278 Reported On : 09/12/2023 18:05

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)		
Haemoglobin(Colorimetric method)	15.4 g/dl	13 - 18
RBC Count (Impedance)	5.22 Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	48.3 %	35 - 55
MCV:(Calculated)	92.4 fl	78 - 98
MCH:(Calculated)	29.4 pg	26 - 34
MCHC:(Calculated)	31.8 gm/dl	30 - 36
RDW-CV:	14.5 %	11.5 - 16.5
Total Leucocyte count(Impedance)	7740 /cumm.	4000 - 10500
Neutrophils:	70 %	40 - 75
Lymphocytes:	23 %	20 - 40
Eosinophils:	04 %	0 - 6
Monocytes:	03 %	2 - 10
Basophils:	00 %	0 - 2
Platelets Count(Impedance method)	3.02 Lakhs/c.mm	1.5 - 4.5
MPV	9.1 fl	6.0 - 11.0
ESR(Westergren Method)	07 mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)		
RBCs:	Normochromic, Normocytic	
WBCs:	Normal	
Platelets	Adequate	
Note:	Test Run on 5 part cell counter. Manual diff performed.	

Vasanti Gondal
Entered By

Ms Kaveri Gaonkar
Verified By

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 Dr. Milind Patwardhan
 M.D(Path)
 Chief Pathologist

End of Report
 Results are to be correlated clinically

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TEST

RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group: **:B:**
Rh Type: **Positive**
Method : Matrix gel card method (forward and reverse)

Pooja Surve
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	106	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	112	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LIPID PROFILE - Serum

S. Cholesterol(Oxidase)	208	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	167	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	33.4	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	38.6	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	136	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	5.4		3.5 - 5
Ratio of LDL/HDL	3.5		2.5 - 3.5

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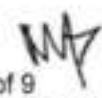
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.82	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.49	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.33	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.35		0.9 - 2
S.Total Bilirubin (DPD):	0.61	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.19	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.42	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	21	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	28	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	103	U/L	40 - 129
S.GGT(IFCC Kinetic):	32	U/L	11 - 50

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	2.21	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	97.98	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	3.78	□IU/ml	Euthyroid : 0.35 - 5.50 □IU/ml Hyperthyroid : < 0.35 □IU/ml Hypothyroid : > 5.50 □IU/ml

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e.g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	23.0 mg/dl	10.0 - 45.0
BUN (Calculated)	10.73 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	1.00 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	10.73	9:1 - 23:1
S.Uric Acid(Uricase Method)	5.9 mg/dl	3.4 - 7.0

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
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URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)

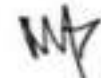
REACTION(PH)	6.0		4.6 - 8.0
SPECIFIC GRAVITY	1.005		1.005 - 1.030
URINE ALBUMIN	Absent		Absent
URINE SUGAR(Qualitative)	Absent		Absent
KETONES	Absent		Absent
BILE SALTS	Absent		Absent
BILE PIGMENTS	Absent		Absent
UROBILINOGEN	Normal(<1 mg/dl)		Normal
OCCULT BLOOD	Absent		Absent
Nitrites	Absent		Absent

MICROSCOPIC EXAMINATION

PUS CELLS	Occasional		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	Occasional		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

Anushka Chavan
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M.D(Path)

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End of Report
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40 Years

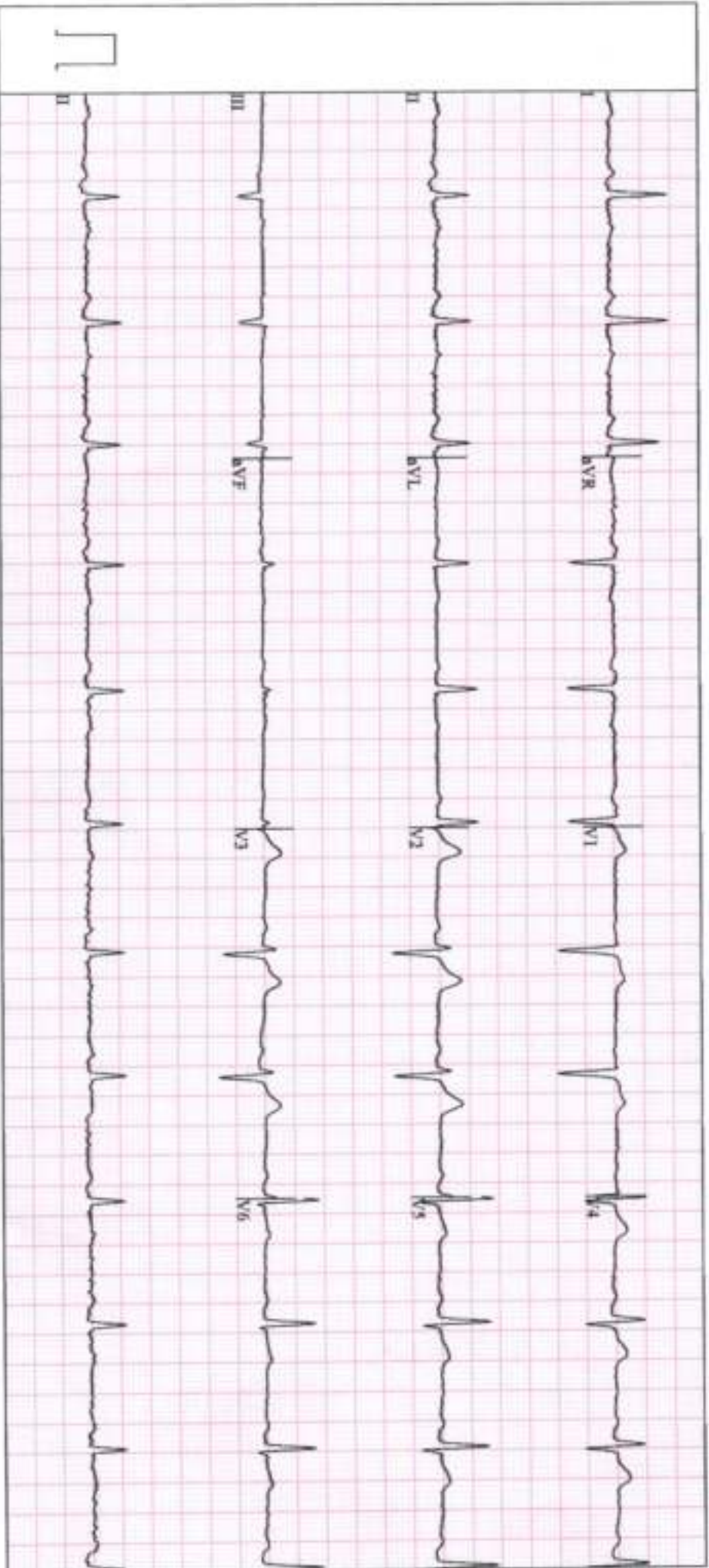
Male

Wash left Axis Deviation
--/-- mmHg

QRS	84 ms
QT / QTc/ Baz	346 / 375 ms
PR	154 ms
P	76 ms
RR / PP	846 / 845 ms
P / QRS / T	16 / 14 / 38 degrees

Normal sinus rhythm
Normal ECG

[Signature]
Dr. Chaitanya K. Kulkarni
 Consultant Physician
 MBBS, DNB Medicine
 Reg. No. - 2014/04/1349



2 D Transthoracic Echocardiography and Colour Doppler

PATIENT'S NAME	ANAND K TREHAN	AGE :- 40 y/M
UHID	9694	DATE :- 09-12-23

ECHO FINDINGS

Normal sized Cardiac Chambers

No Regional Wall Motion Abnormality

LVEF is 60%

Normal Diastolic Function

Normal Valves Morphology and Function

No PAH

IAS & IVS Intact

No Thrombus/ Vegetation/ Pericardial Effusion

Normal IVC size and collapsibility



DR PRASHANT PAWAR

MBBS, DNB (MED), DNB (CARDIOLOGY)

AFESC (EUROPE) , FSCAI (USA)

INTERVENTIONAL CARDIOLOGIST

MEASUREMENTS (mm)

LA	34
AORTA	27
LVID (d)	40
LVID (s)	24
IVS (d)	10
PW (d)	12
LVEF %	60 %

COLOUR DOPPLER

E	0.6
A	0.6
E/A	1.4
AOPG	2.7 mm hg
PVMAX	0.7 m/sec
RA	29 mm
RV	18 mm

• ANDHERI • COLABA • NASHIK • VASHI

PATIENT'S NAME	ANAND K TREHAN	AGE :- 40Y/M
UHID	9694	9 Dec 2023

X-RAY CHEST PA VEIW

OBSERVATION:

Bilateral lung fields are clear.

Both hila are normal.

Bilateral cardiophrenic and costophrenic angles are normal.

The trachea is central.

Aorta appears normal.

Cardiomegaly seen.

The mediastinal and cardiac silhouette are normal.

Soft tissues of the chest wall are normal.

Bony thorax is normal.

IMPRESSION:

- **Cardiomegaly seen.**



DR. DISHA MINOCHA
DMRE (RADIOLOGIST)

PATIENT'S NAME	ANAND K TREHAN	AGE :- 40y/M
UHID NO	9694	9 Dec 2023

USG WHOLE ABDOMEN

LIVER is normal in size, shape and shows bright echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

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

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

RIGHT KIDNEY measures 11.4 x 4.0 cm. **LEFT KIDNEY** measures 11.3 x 4.5 cm.

Urinary Bladder is adequately distended; no e/o any obvious wall thickening or mass or calculi seen.

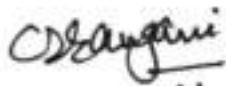
PROSTATE is normal in size, shape & echotexture.

Visualised bowel loops appear normal. There is no free fluid seen.

IMPRESSION –

- **Grade I fatty liver.**
- **No other significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE. THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



DR. CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg: No. 073826