

आयकर विभाग  
INCOME TAX DEPARTMENT

भारत सरकार  
GOVT. OF INDIA

VINEET-KUMAR SHARMA  
RAJNI KANT SHARMA

28/02/1991  
Permanent Account Number  
GQBPS6457J

*Vineet*  
Signature

10032016

*[Handwritten Signature]*

*[Handwritten Signature]*

Dr. U. C. GUPTA  
MBBS, MD (Physician)  
RMC No. 281

इस कार्ड के खोने / पाने पर कृपया सूचित करें / लौटएं:  
आयकर पैन सेवा इकाई, एन एस डी एल  
5 वीं मंजिल, मन्त्री स्टर्लिंग, प्लॉट नं. 341, सर्वे नं. 997/8,  
मॉडल कालोनी, दीप बंगला चौक के पास,  
पुणे - 411 016.

*If this card is lost / someone's lost card is found,  
please inform / return to:*  
Income Tax PAN Services Unit, NSDL  
5th floor, Mantri Sterling,  
Plot No. 341, Survey No. 997/8,  
Model Colony, Near Deep Bungalow Chowk,  
Pune - 411 016.

Tel: 91-20-2721 8080, Fax: 91-20-2721 8081  
e-mail: tininfo@nsdl.co.in



B-14, Vidhyadhar Enclave - II, Near Axis Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
+91 141 4824885 maxcarediagnostics@gmail.com

**General Physical Examination**

Date of Examination: 11/03/2023

Name: Vineet Kumar Sharma Age: 32 DOB: 28/02/1991 Sex: Male

Referred By: Bank of Baroda

Photo ID: PAN CARD ID #: 4103PS64575

Ht: 176 (cm)

Wt: 77 (Kg)

Chest (Expiration): 97 (cm)

Abdomen Circumference: 103 (cm)

Blood Pressure: 125/85 mm Hg

PR: 78 / min

RR: 18 / min

Temp: Affixable

BMI 24

eye vision

Eye Examination: R/E - 6/6, M/6 MCB

L/E 6/6 M/6 MCB

Other: no

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

Signature Of Examinee: [Signature]

Name of Examinee: Vineet Kumar Sharma

Signature Medical Examiner: [Signature]

Name Medical Examiner: Dr. U. C. Gupta

Dr. U. C. GUPTA  
MBBS (Physician)  
RMC No. 291





# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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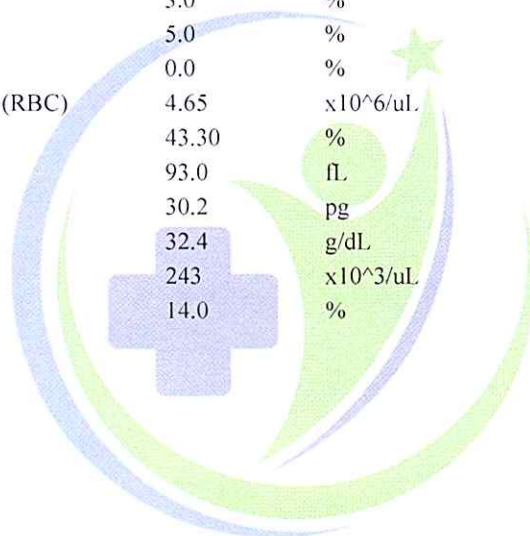


<b>NAME :- Mr. VINEET KUMAR SHARMA</b>	Patient ID :-12223329	Date :- 11/03/2023	10:32:20
Age :- 32 Yrs 11 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 12/03/2023 10:03:40

## HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
<b>FULL BODY HEALTH CHECKUP BELOW 40 MALE</b>			
<b>HAEMOGARAM</b>			
<b>HAEMOGLOBIN (Hb)</b>	14.0	g/dl.	13.0 - 17.0
<b>TOTAL LEUCOCYTE COUNT</b>	5.50	/cumm	4.00 - 10.00
<b>DIFFERENTIAL LEUCOCYTE COUNT</b>			
NEUTROPHIL	62.0	%	40.0 - 80.0
LYMPHOCYTE	30.0	%	20.0 - 40.0
EOSINOPHIL	3.0	%	1.0 - 6.0
MONOCYTE	5.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	4.65	$\times 10^6/\text{ul.}$	4.50 - 5.50
HEMATOCRIT (HCT)	43.30	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	93.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	30.2	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	32.4	g/dL	31.5 - 34.5
<b>PLATELET COUNT</b>	243	$\times 10^3/\text{uL}$	150 - 410
RDW-CV	14.0	%	11.6 - 14.0



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



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## HAEMATOLOGY

### Erythrocyte Sedimentation Rate (ESR)

Method - Westergreen

12

mm in 1st hr

00 - 15

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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Company :- Mr.MEDIWHEEL

(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
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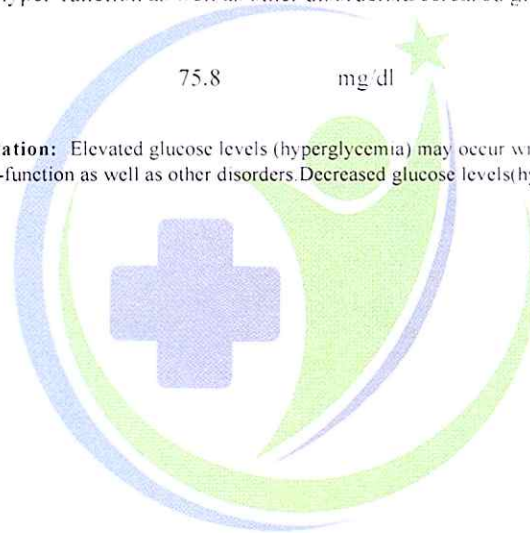
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	77.4	mg/dl	70.0 - 115.0
--	------	-------	--------------

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	75.8	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
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**GLYCOSYLATED HEMOGLOBIN (HbA1C)**

Methord:- CAPILLARY with EDTA

5.7 mg%

Non-Diabetic < 6.0  
Good Control 6.0-7.0  
Weak Control 7.0-8.0  
Poor control > 8.0

**MEAN PLASMA GLUCOSE**

Methord:- Calculated Parameter

117 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 - 8-8 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

**Note:**

- Shortened RBC life span -HbA1c test will not be accurate when a person has a condition that affects the average lifespan of red blood cells (RBCs) such as hemolytic anemia or blood loss. When the lifespan of RBCs in circulation is shortened, the A1c result is falsely low and is an unreliable measurement of a person's average glucose over time.
- Abnormal forms of hemoglobin - The presence of some hemoglobin variants, such as hemoglobin S in sickle cell anemia, may affect certain methods for measuring A1c. In these cases, fructosamine can be used to monitor glucose control.

**Advised:**

- To follow patient for glycemic control test like fructosamine or glycated albumin may be performed instead.
- Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.

estimated Average Glucose (eAG) based on value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria

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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
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**LIPID PROFILE**

TOTAL CHOLESTEROL Method:- CHOD-PAP methodology	220.00	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-TOPS methodology	116.00	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
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**InstrumentName** MISPA PLUS **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:- Selective inhibition Method	80.00	mg/dl	Male 35-80 Female 42-88
--	-------	-------	----------------------------

**Instrument Name** MISPA 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	120.67	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
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VL.DL CHOLESTEROL Method:- Calculated	23.20	mg/dl	0.00 - 80.00
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T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method:- Calculated	2.75		0.00 - 4.90
--	------	--	-------------

LDL / HDL CHOLESTEROL RATIO Method:- Calculated	1.51		0.00 - 3.50
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TOTAL LIPID Method:- CALCULATED	632.84	mg/dl	400.00 - 1000.00
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- Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.
- 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 recommended.
- 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 from peripheral tissues.

**Comments:** 1- ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all VIKARANTJI

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## BIOCHEMISTRY

atherogenic lipoproteins ( mainly LDL & VLDL). The Non HDL Cholesterol is used as a secondary target of therapy in persons with triglycerides  $\geq 200$  mg/dL. The goal for Non HDL Cholesterol in those with increased triglyceride is 30 mg/dL above that set for LDL Cholesterol.

2 -For calculation of CHD risk, history of smoking, any medication for hypertension & current B.P. levels are required.



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## BIOCHEMISTRY

### LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method:- DMSO/Diazo	0.76	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.28	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.48	mg/dl	0.30-0.70
SGOT Method:- IFCC	36.9	U/L	Men- Up to - 37.0 Female - Up to - 31.0
SGPT Method:- IFCC	34.9	U/L	Men- Up to - 40.0 Female- Up to - 31.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	59.00	U/L	53.00 - 141.00
SERUM GAMMA GT Method:- Szasz methodology Instrument Name Randox Rx Imola Interpretation Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 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.	24.60	U/L	10.00 - 45.00
SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	7.19	g/dl	5.10 - 8.00
SERUM ALBUMIN Method:- Bromocresol Green	4.92	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	2.27	gm/dl	2.20 - 3.50
A/G RATIO	2.17		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 anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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**BIOCHEMISTRY**

**RFT / KFT WITH ELECTROLYTES**

SERUM UREA 14.80 mg/dl 10.00 - 50.00  
Method- Urease/GLDH

**InstrumentName:** HORIBA CA 60 **Interpretation :** Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE 1.04 mg/dl Males : 0.6-1.50 mg/dl  
Method- Jaffe's Method 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 5.77 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 136.2 mmol/L 135.0 - 150.0  
Method- ISE

**Interpretation:** Decreased sodium - Hyponatraemia Causes include: fluid or electrolyte loss, Drugs, Oedematous states, Legionnaire's disease and other chest infections, pseudonatremia, Hyperlipidaemias and paraproteinaemias, endocrine diseases, SIADH.

POTASSIUM 4.25 mmol/L 3.50 - 5.50  
Method- ISE

**Interpretation:** A. Elevated potassium (hyperkalaemia)• Artefactual, Physiologic, Medication, Drugs, Pathological states, Renal failure, Adrenocortical insufficiency, metabolic acidoses, very high platelet or white cell counts B. Decreased potassium (hypokalaemia) Drugs, Liquoric, Diarrhoea and vomiting, Metabolic alkalosis, Corticosteroid excess, Oedematous state, Anorexia nervosa/bulimia

CHLORIDE 109.2 mmol/L 94.0 - 110.0  
Method- ISE

**Interpretation:** Used for Electrolyte monitoring.

SERUM CALCIUM 9.48 mg/dl 8.10 - 11.50  
Method- Colorimetric method

**InstrumentName** Rx Daytona 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 7.19 g/dl 5.10 - 8.00  
Method- Biuret Reagent

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**BIOCHEMISTRY**

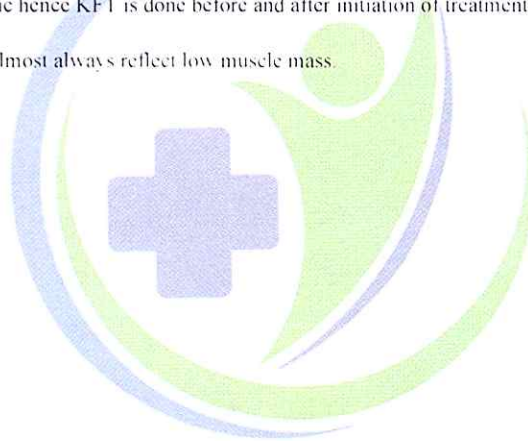
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SERUM GLOBULIN Method:- CALCULATION	2.27	gm/dl	2.20 - 3.50
A/G RATIO	2.17		1.30 - 2.50

**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.

**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-hour collections 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 blood increases. 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.



VIKARANTJI

**Technologist**

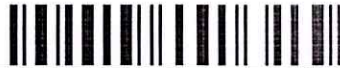
Page No: 11 of 16

*Tanu Rungta*

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



B-14, Vidhyadhar Enclave - II, Near Axis Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
+91 141 4824885 maxcarediagnostics1@gmail.com



<b>NAME :- Mr. VINEET KUMAR SHARMA</b>	Patient ID :-12223329	Date :- 11/03/2023	10:32:20
Age :- 32 Yrs 11 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- Mr MEDIWHEEL		

Final Authentication 12/03/2023 10 03 40

**TOTAL THYROID PROFILE**

**IMMUNOASSAY**

Test Name	Value	Unit	Biological Ref Interval
<b>THYROID-TRIiodothyronine T3</b> Method:- ECLIA	0.75	ng/mL	0.70 - 2.04

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 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. Simultaneous 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 Hashimoto's 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 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 Hypo

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.

<b>THYROID-PHYROXINE (T4)</b> Method:- ECLIA	8.67	µIU/mL	5.10 - 14.10
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NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 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. Simultaneous 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 Hashimoto's 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 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 Hypo

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.

<b>TSH</b> Method:- ECLIA	1.222	µIU/mL	0.350 - 5.500
------------------------------	-------	--------	---------------

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 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. Simultaneous 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

**Technologist**  
Page No: 15 of 16

*Tanu*  
**DR. TANU RUNGTA**  
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<b>NAME :- Mr. VINEET KUMAR SHARMA</b>	Patient ID :-12223329	Date :- 11/03/2023	10:32:20
Age :- 32 Yrs 11 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 12/03/2023 10 03 40

**IMMUNOASSAY**

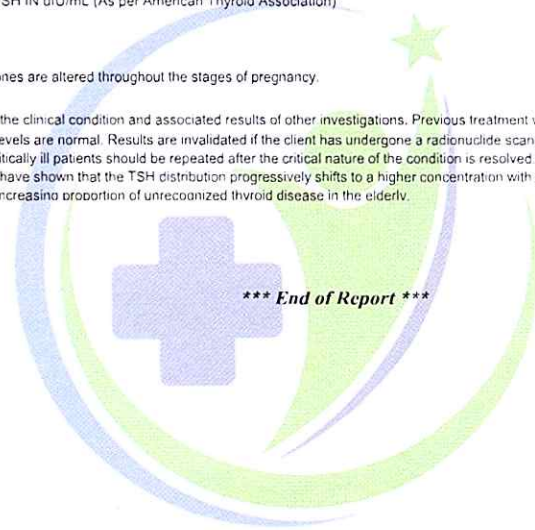
- 2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease
- 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter
- 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis
- 5.HighTSH,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 propranolol.
- 14.Although ↑ TSH levels are nearly always indicative of Primary Hypothyroidism ,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 \*\*\*

VIKARANTJI

**Technologist**

Page No: 16 of 16

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



# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave - II, Near Axis Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
+91 141 4824885 maxcarediagnostics1@gmail.com



<b>NAME :- Mr. VINEET KUMAR SHARMA</b>	Patient ID :-12223329	Date :- 11/03/2023	10:32:20
Age :- 32 Yrs 11 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- Mr MEDIWHEEL		

Final Authentication : 12/03/2023 10:03:40

## CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
<b>Urine Routine</b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
REACTION(PH)	6.0		5.0 - 7.5
SPECIFIC GRAVITY	1.010		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<b><u>MICROSCOPY EXAMINATION</u></b>			
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		ABSENT

VIKARANTJI

**Technologist**

Page No: 12 of 16

**DR.TANU RUNGTA**

MD (Pathology)  
RMC No. 17226





# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

- 📍 B-14, Vidhyadhar Enclave - II, Near Axis Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
☎ +91 141 4824885 ✉ maxcarediagnostics1@gmail.com



NAME:	MR. VINEET KUMAR SHARMA	AGE/SEX	32 YRS/M
REF.BY	BANK OF BARODA	DATE	11/03/2023

## 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



MR. VINEET KUMAR SHARMA	32 Y/Male
Registration Date: 11/03/2023	Ref. by: BANK OF BARODA

**ULTRASOUND OF WHOLE ABDOMEN**

**Liver** is of normal size (12.8 cm). Echo-texture is normal. 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 (9.7 cm). Echotexture is normal. No focal lesion is seen.

**Kidneys** are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. Collecting system does not show any calculus or dilatation.

**Right kidney** is measuring approx. 10.9 x 4.5 cm.

**Left kidney** is measuring approx. 12.4 x 4.9 cm.

**Urinary bladder** does not show any calculus or mass lesion.

**Prostate** is normal in size with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.  
No significant free fluid is seen in pelvis.

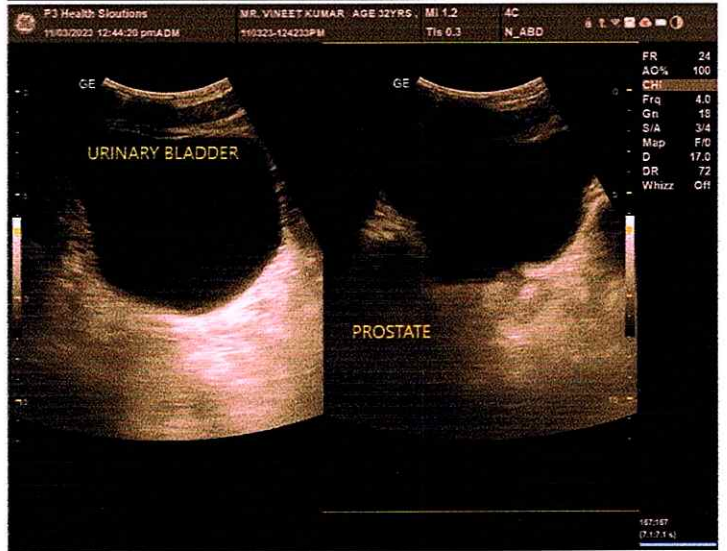
**IMPRESSION:- No significant abnormality is detected.**

**DR.SHALINI GOEL**

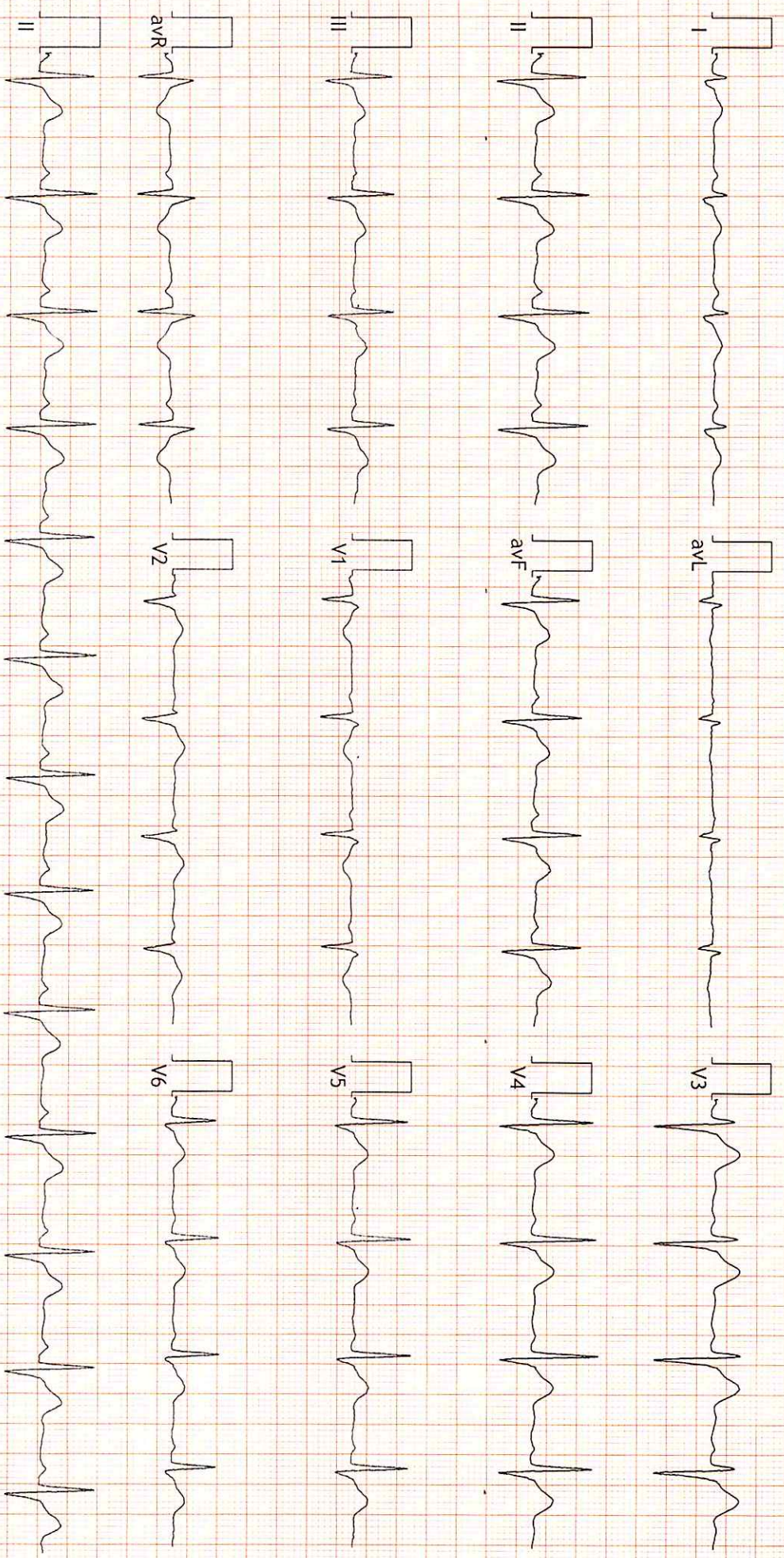
M.B.B.S, D.N.B (Radiodiagnosis)

RMC no.: 21954









FINDINGS: Normal Sinus Rhythm

Vent Rate : 76 bpm; PR Interval : 160 ms; QRS Duration: 136 ms; QT/QTc Int : 247/279 ms

P-QRS-T axis: 51 • 86 • 60 • (Deg)

Comments :

TUL

*[Signature]*

DR. Vineet Kumar Mohanka

MR. VINAY KUMAR (S)

ABSA, DIP, GATEWAY

U. E-mail: [vinay@healthsolutionsllp.com](mailto:vinay@healthsolutionsllp.com)



**JS HEALTH SOLUTIONS LLP**  
**B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur**  
 1322464/MR VINET KUMAR SHARMA 32 Yrs/Male 0 Kg/0 Cms  
 Date: 11-Mar-2023 02:45:14 PM  
 Ref. By : BANK OF BARODA  
 Medication :  
 Objective :

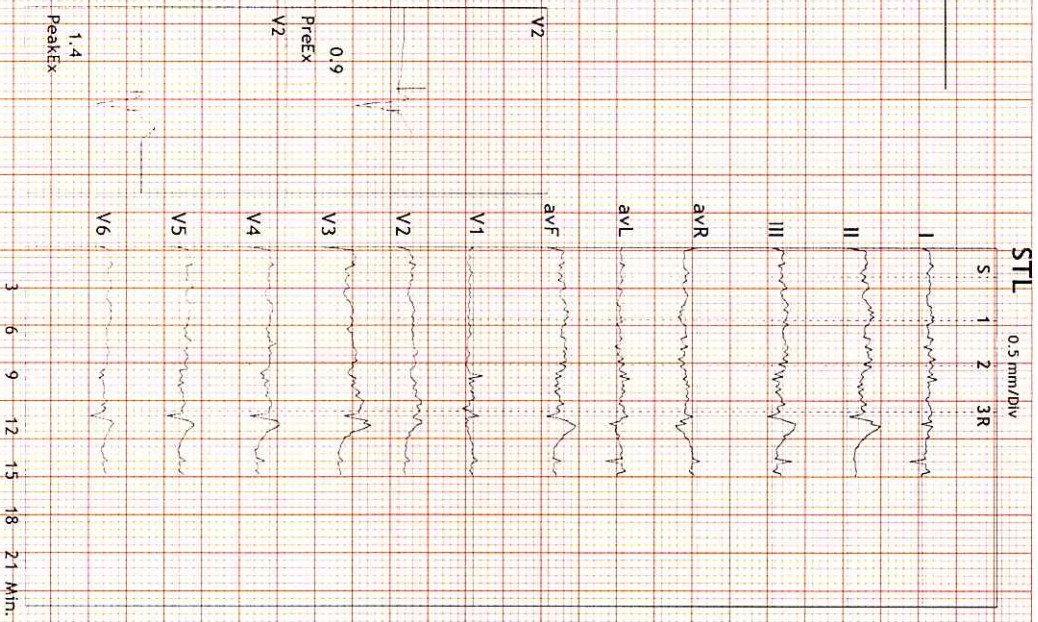
Protocol : BRUCE  
 History :

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	80	125/85	100	-	
Standing					1.0	82	125/85	102	-	
HV					1.0	79	125/85	98	-	
ExStart					1.0	91	125/85	113	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	118	135/85	159	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	141	145/90	204	-	
Stage 3	3:01	9:02	3.4	14.0	10.2	168	155/90	260	-	
PeakEx	0:14	9:15	4.2	16.0	10.5	168	155/90	260	-	
Recovery	1:00		0.0	0.0	4.3	119	155/90	184	-	
Recovery	2:00		0.0	0.0	1.0	107	165/95	176	-	
Recovery	3:00		0.0	0.0	1.0	102	155/90	158	-	
Recovery	4:00		0.0	0.0	1.0	101	145/90	146	-	

**Findings :**

Exercise Time : 09:14  
 Max HR Attained : 168 bpm 89% of Max Predictable HR 188  
 Max BP : 165/95(mmHg)  
 Max Workload attained : 10.5 (Good Effort Tolerance)

*TMT is Negative for RM1*



**Dr. Nareesh Kumar Mohanka**  
 RMC No.: 35703  
 RMC CARDIO (SCORPS)  
 MBBS, D.P.CARDIO (JN)  
 D.E.M. (CCG-JN)

Advice/Comments:





1322464/ VINET KUMAR SHARMA  
 32 Yrs/Male  
 0 Kg/0 Cms  
 Date: 11-Mar-2023 02:45:14 PM  
 4X 80 ms Post J

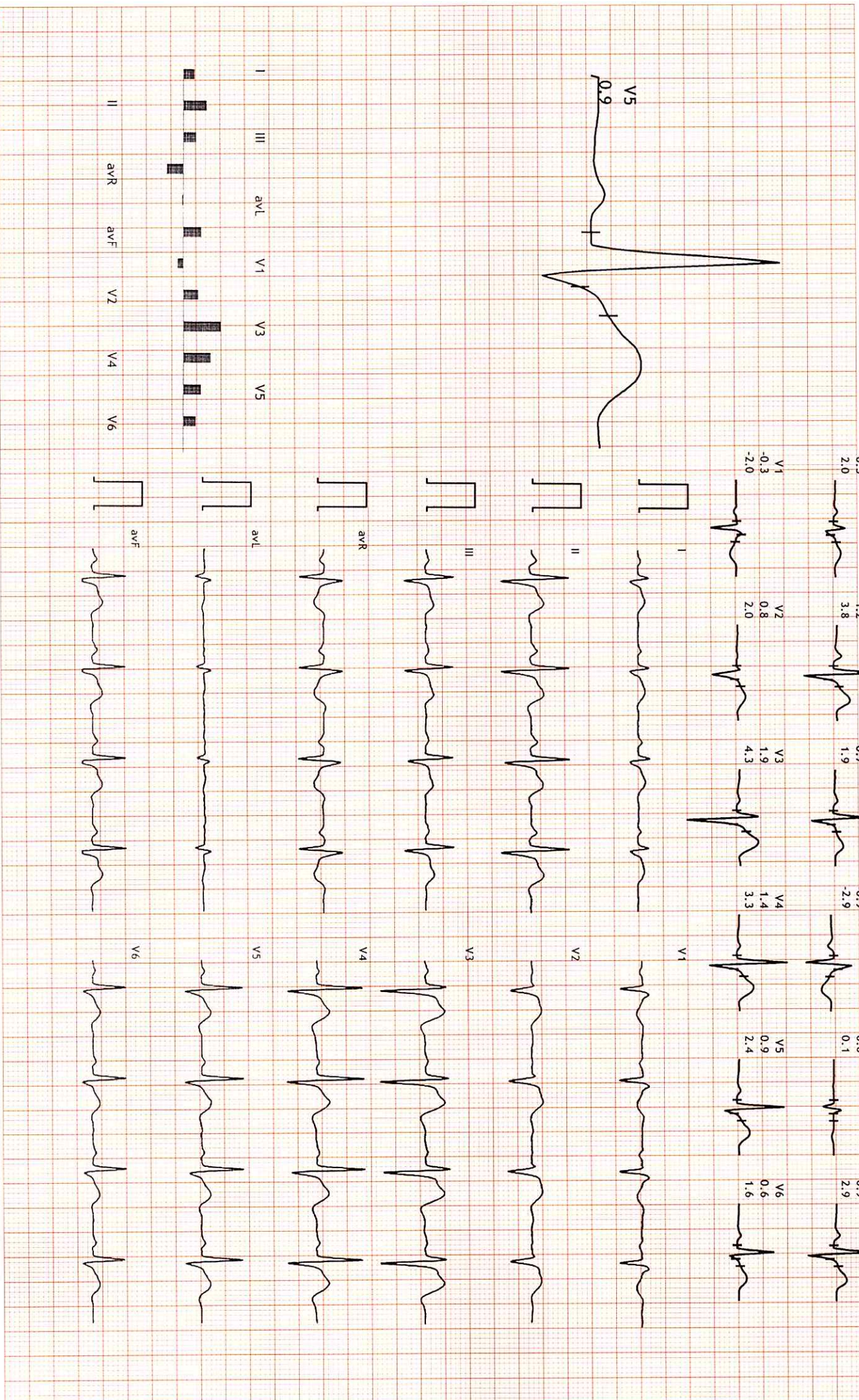
HR: 79 bpm  
 METS: 1.0  
 BP: 125/85

MPHR: 42% of 188  
 Speed: 0.0 mph  
 Grade: 0.0%

Raw ECG  
 BRUCE  
 (1.0-35)/Hz

-Ex Time 00:35  
 BLC : On  
 Notch : On

Supine  
 10.0 mm/mV  
 25 mm/Sec.





HR: 82 bpm

MEFS: 1.0

BP: 125/85

MPHR: 43% of 188

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

Ex Time 00:46

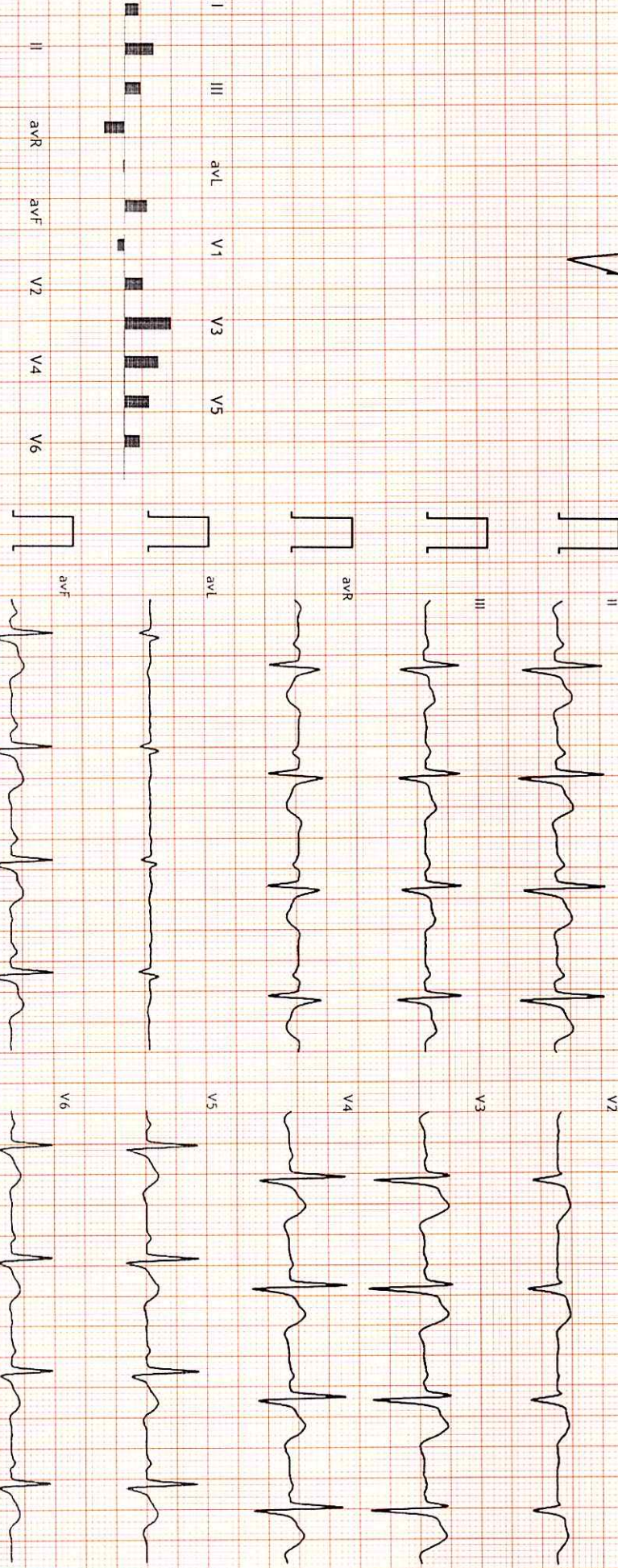
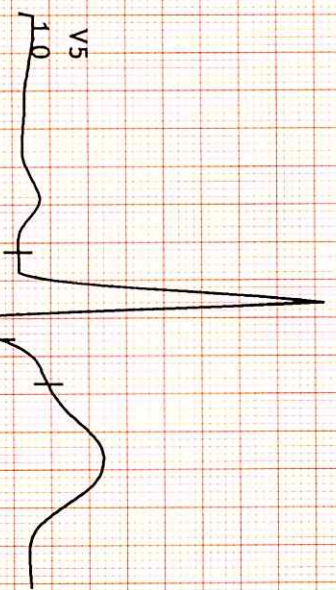
BLC : On

Notch : On

Standing

10.0 mm/mV

25 mm/Sec.





1322464/ VINET KUMAR SHARMA  
 32 Yrs/Male  
 0 Kg/0 Cms  
 Date: 11-Mar-2023 02:45:14 PM  
 4X 80 ms Post J

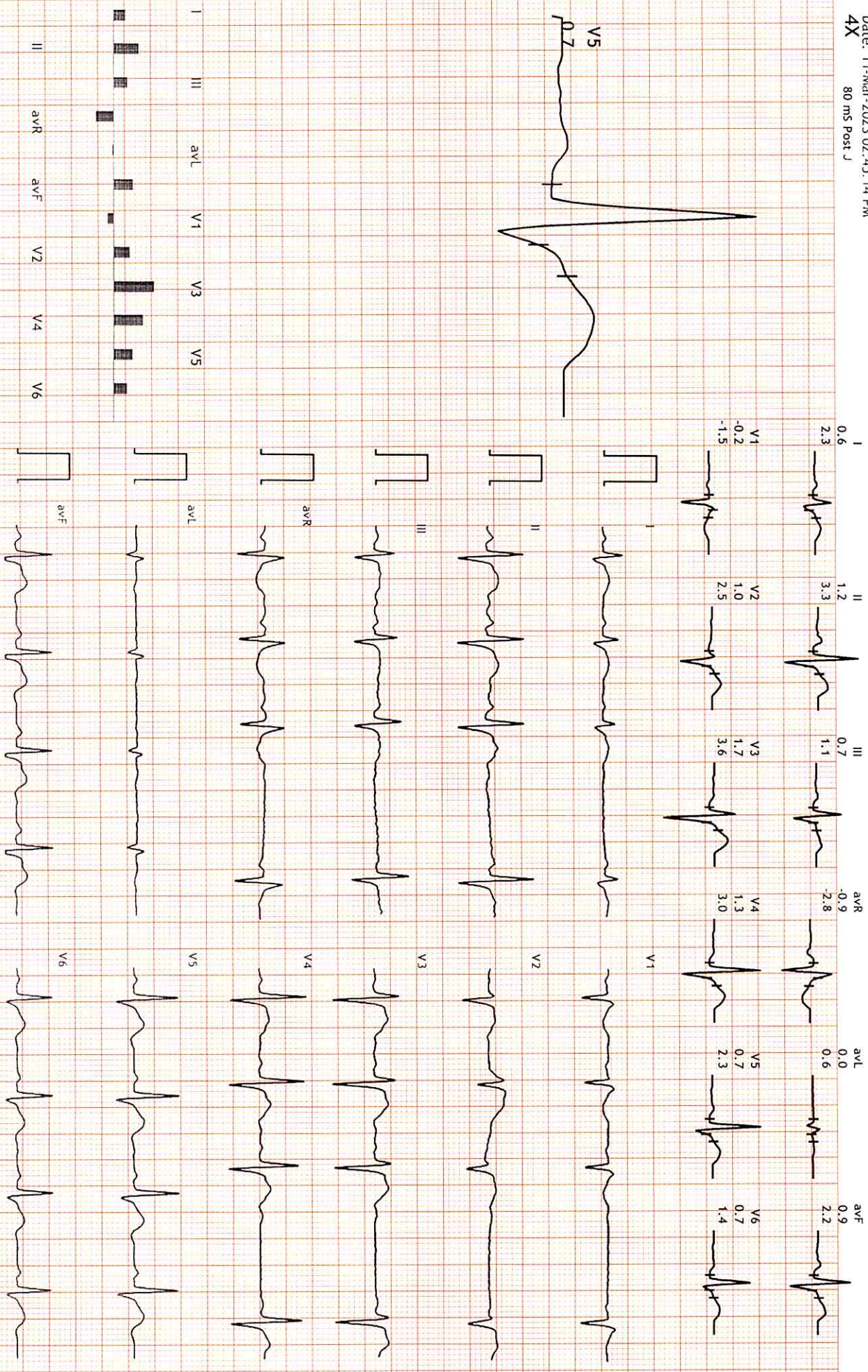
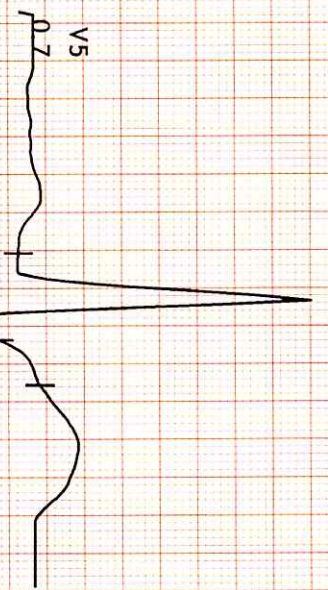
HR: 84 bpm  
 METS: 1.0  
 BP: 125/85

MpHR: 44% of 188  
 Speed: 0.0 mph  
 Grade: 0.0%

Raw ECG  
 BRUCE  
 (1.0-35)Hz

Ex Time 01:19  
 BLC : On  
 Notch : On

HV  
 10.0 mm/mV  
 25 mm/Sec.





HR: 118 bpm

MEFS: 4.7

BP: 135/85

MPHR: 62% of 188

Speed: 1.7 mph

Grade: 10.0%

Raw ECG

BRUCE

(1.0-35)Hz

Ex Time 02:59

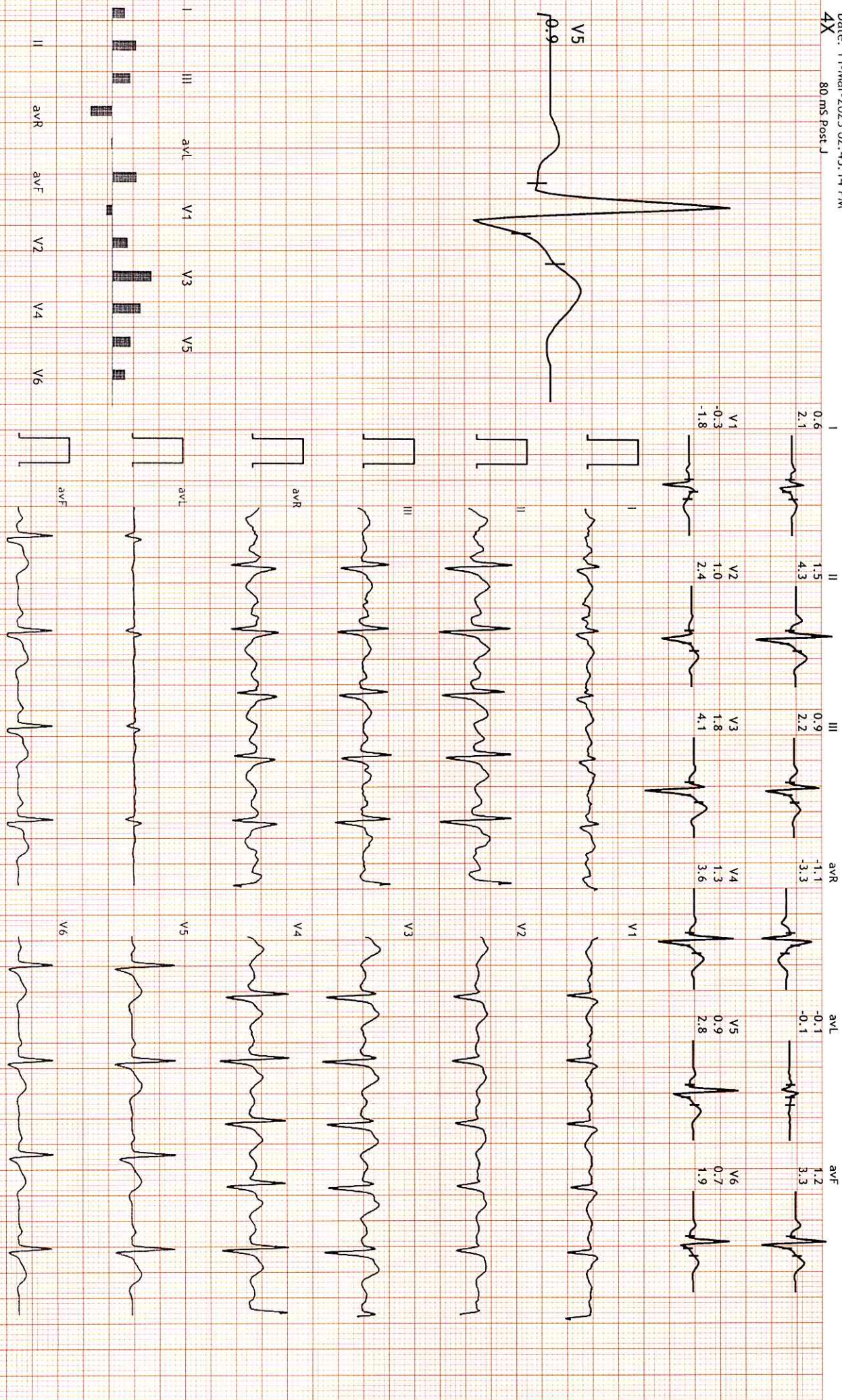
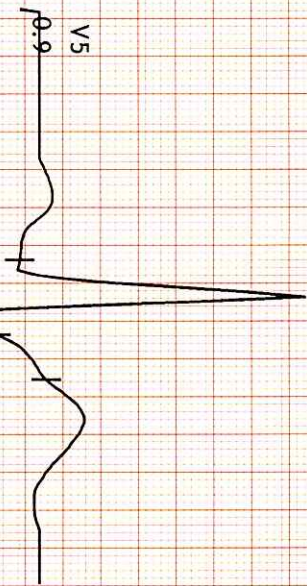
BLC: On

Notch: On

BRUCE: Stage 1 (3:00)

10.0 mm/mv

25 mm/Sec.





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

1322464/ VINIET KUMAR SHARMA

32 Yrs/Male

0 Kg/0 Cms

Date: 11-Mar-2023 02:45:14 PM

4X 80 ms Post J

MPHR: 75% of 188

Speed: 2.5 mph

Grade: 12.0%

Raw ECG

BRUCE

(1.0-35)Hz

EX Time 05:59

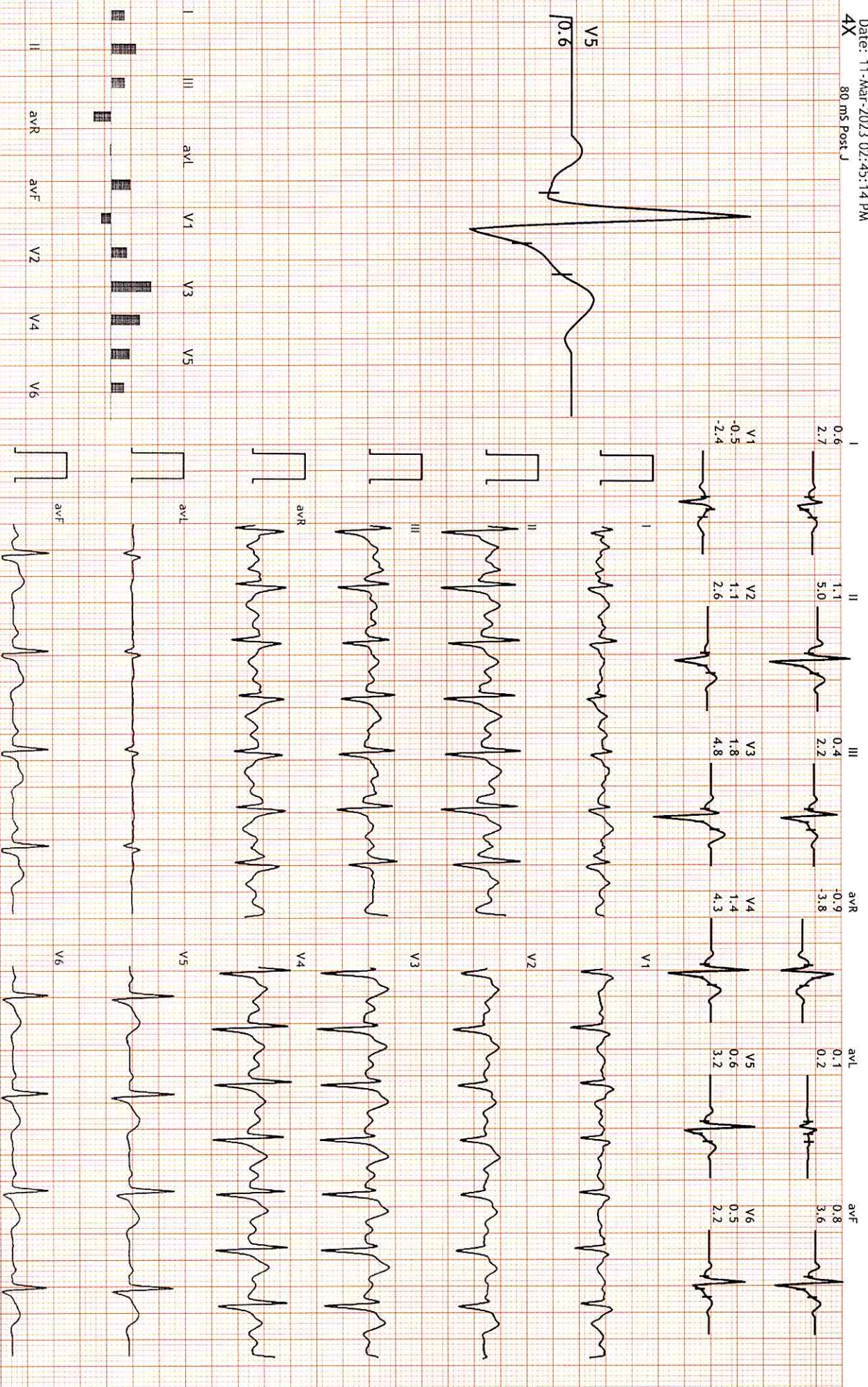
BLC : On

Notch : On

BRUCE: Stage 2(3:00)

10.0 mm/mV

25 mm/Sec.





3 HEALTH SOLUTIONS LLP  
 B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur  
 1322464/ VINIET KUMAR SHARMA  
 32 Yrs/Male  
 0 Kg/0 Cms  
 Date: 11-Mar-2023 02:45:14 PM  
 4X 80 ms Post J

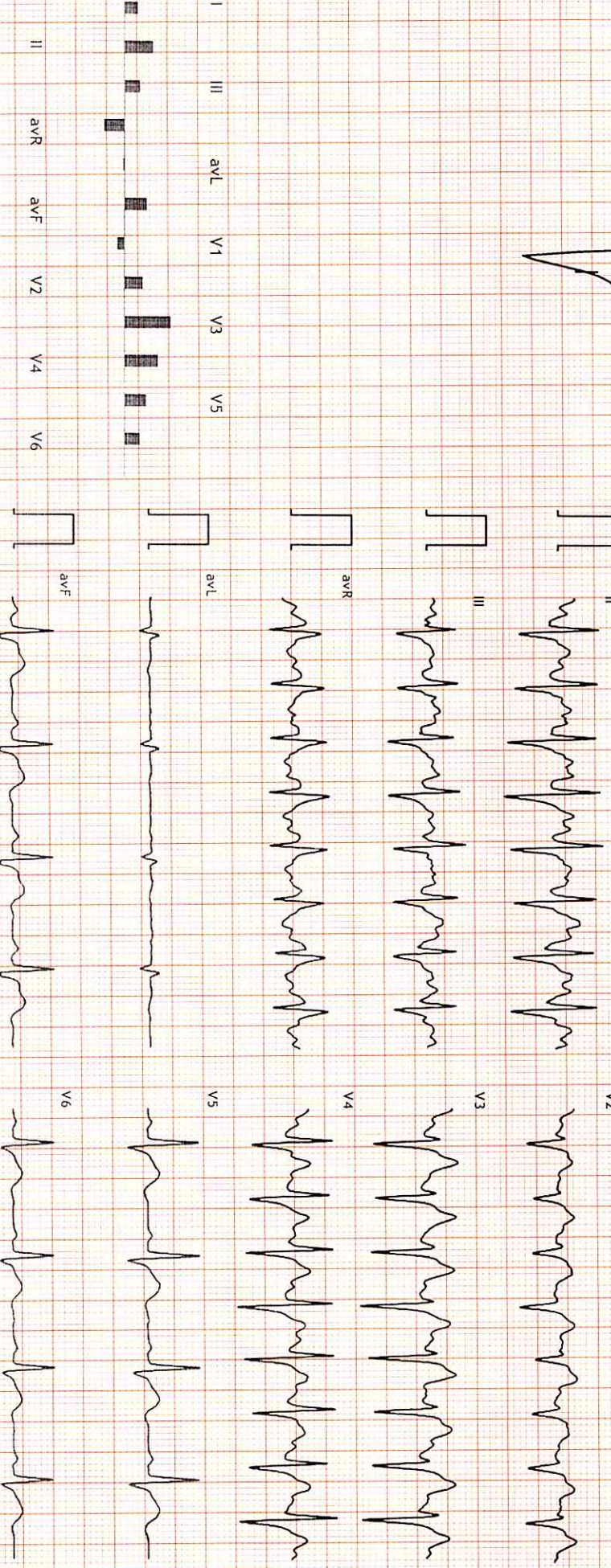
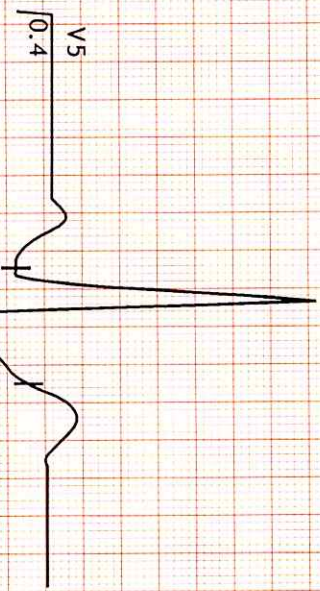
HR: 167 bpm  
 METS: 10.2  
 BP: 155/90

MP-HR: 88% of 188  
 Speed: 3.4 mph  
 Grade: 14.0%

Raw ECG  
 BRUCE (1.0-35)Hz

Ex Time 08:59  
 BLC : On  
 Notch : On

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





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

1322464/ VINET KUMAR SHARMA

32 Yrs/Male

0 Kg/0 Cms

Date: 11-Mar-2023 02:45:14 PM

4X 80 ms Post J

HR: 167 bpm

MEETS: 10.5

BP: 155/90

MPHR: 88% of 188

Speed: 4.2 mph

Grade: 16.0%

Raw ECG

BRUCE

(1.0-35)Hz

Ex Time 09:12

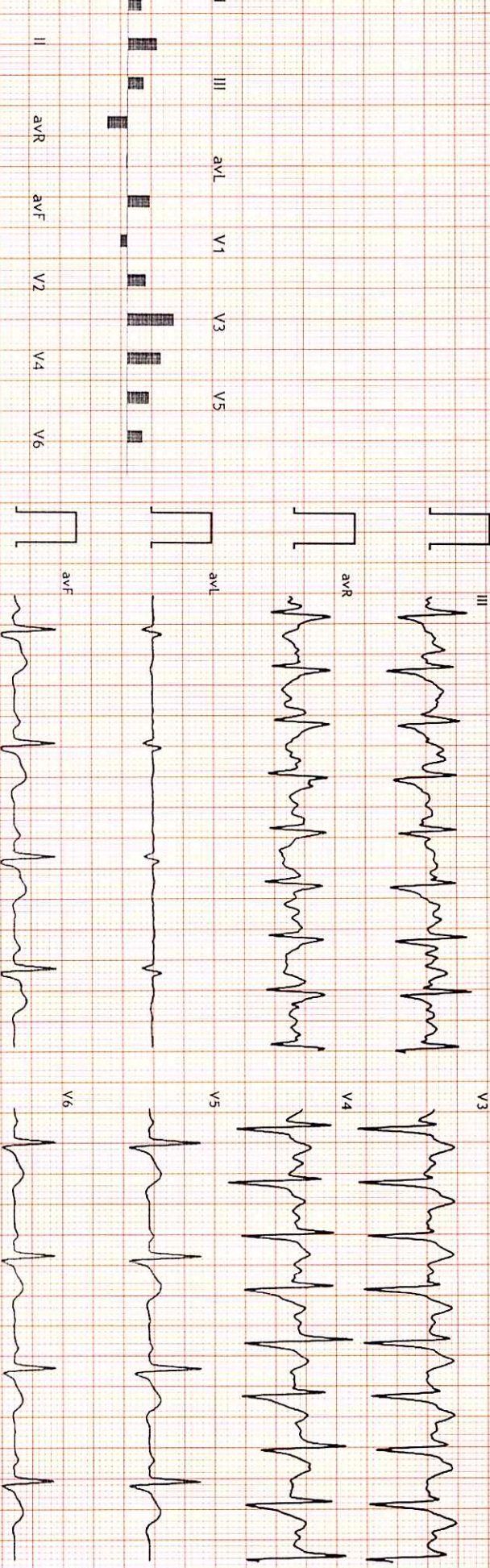
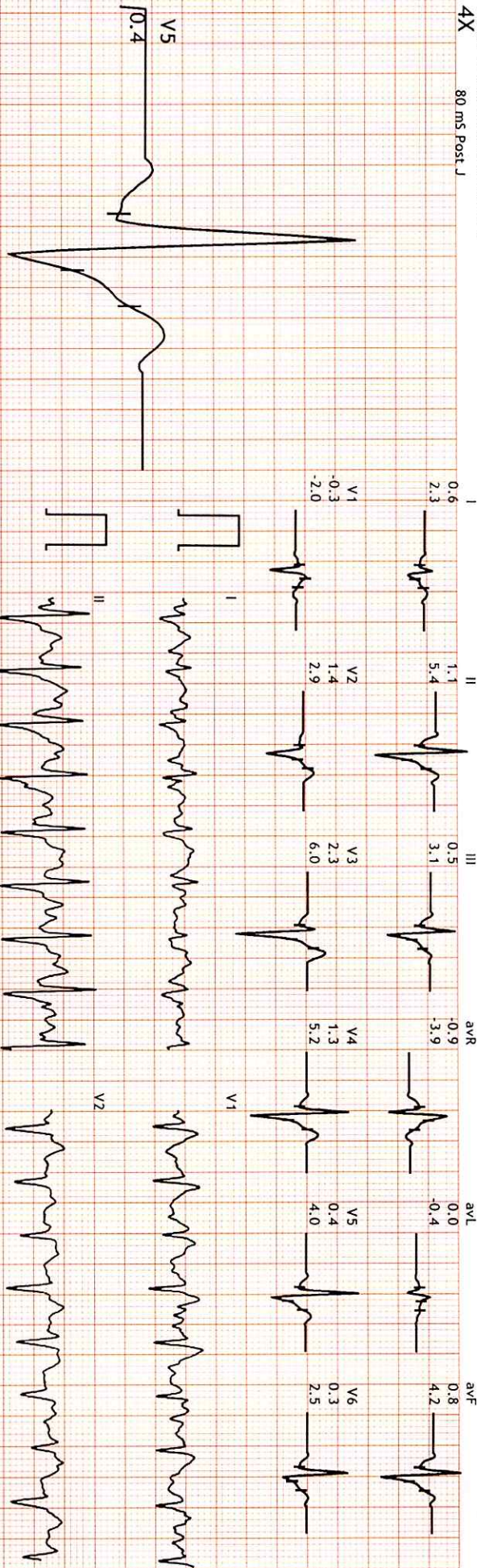
BLC : On

Notch : On

BRUCE: PeakEx(0:12)

10.0 mm/mv

25 mm/Sec.





'S HEALTH SOLUTIONS LLP  
B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur  
1322464/ VINJET KUMAR SHARMA  
32 Yrs/Male  
0 Kg/0 Cms  
Date: 11-Mar-2023 02:45:14 PM  
4X 80 ms Post J

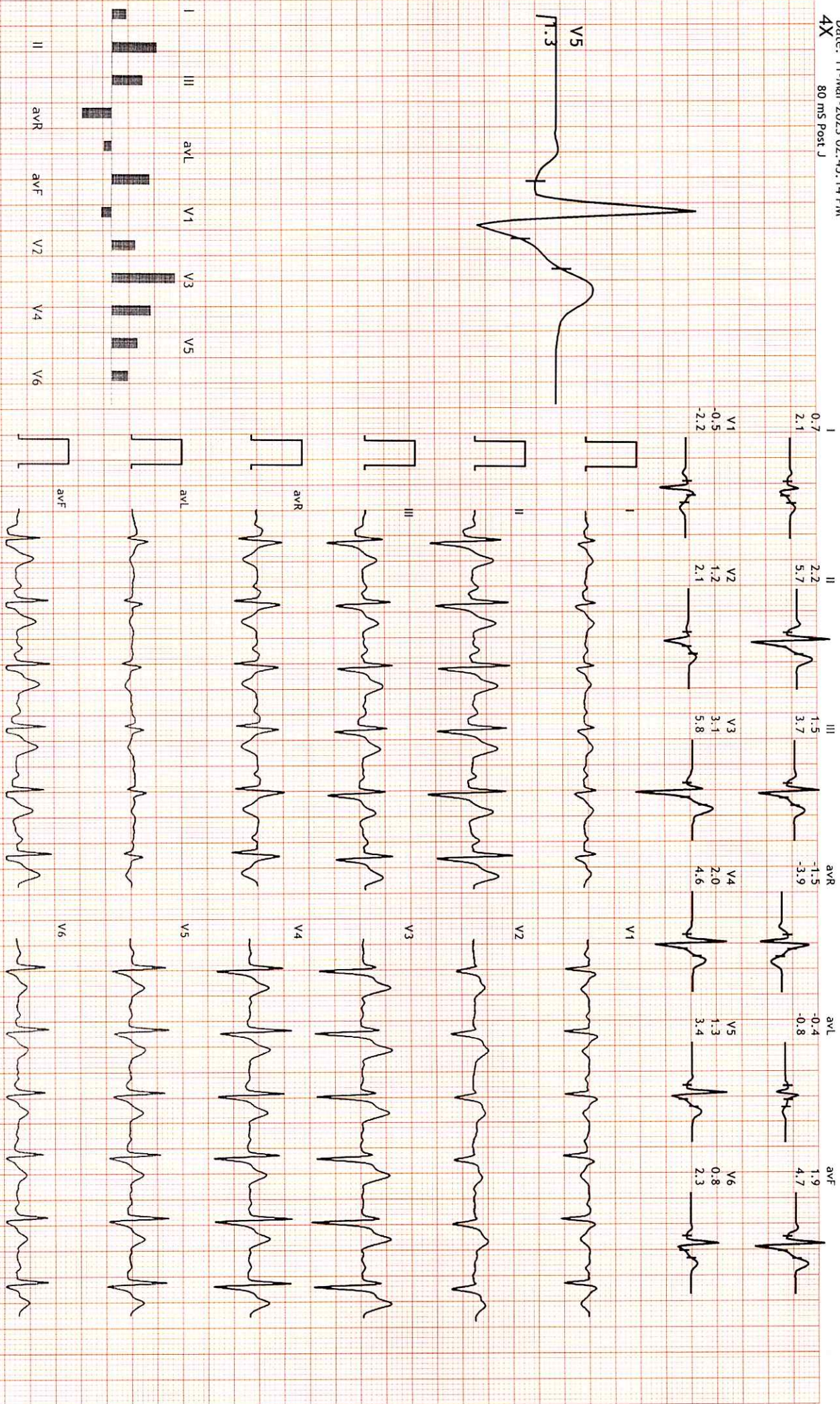
HR: 120 bpm  
MEFS: 4.4  
BP: 155/90

MPHR: 63% of 188  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
(1.0-35)Hz

Ex Time 09:14  
BLC: On  
Notch: On

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





HR: 107 bpm

METS: 1.0

BP: 165/95

MPHR: 56% of 188

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)HZ

EX Time 09:14

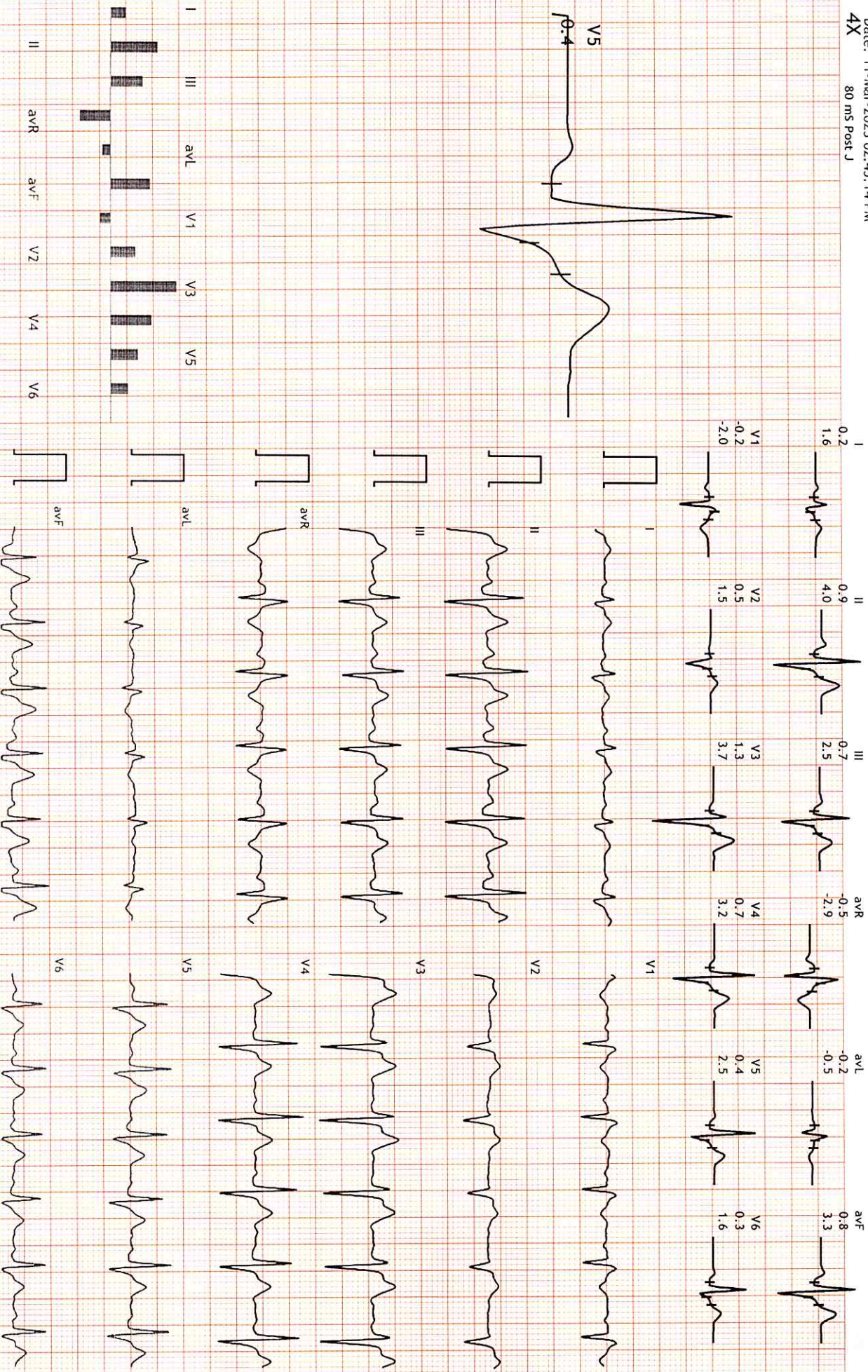
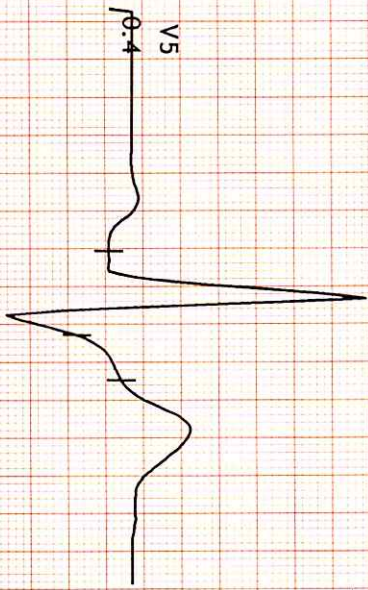
BLC : On

Notch : On

Recovery(2:00)

10.0 mm/mv

25 mm/Sec.





'S HEALTH SOLUTIONS LLP  
B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur

1322464/ VINET KUMAR SHARMA

32 Yrs/Male

0 Kg/0 Cms

Date: 11-Mar-2023 02:45:14 PM

4X 80 ms Post J

MPHR:54% of 188

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

Ex Time 09:14

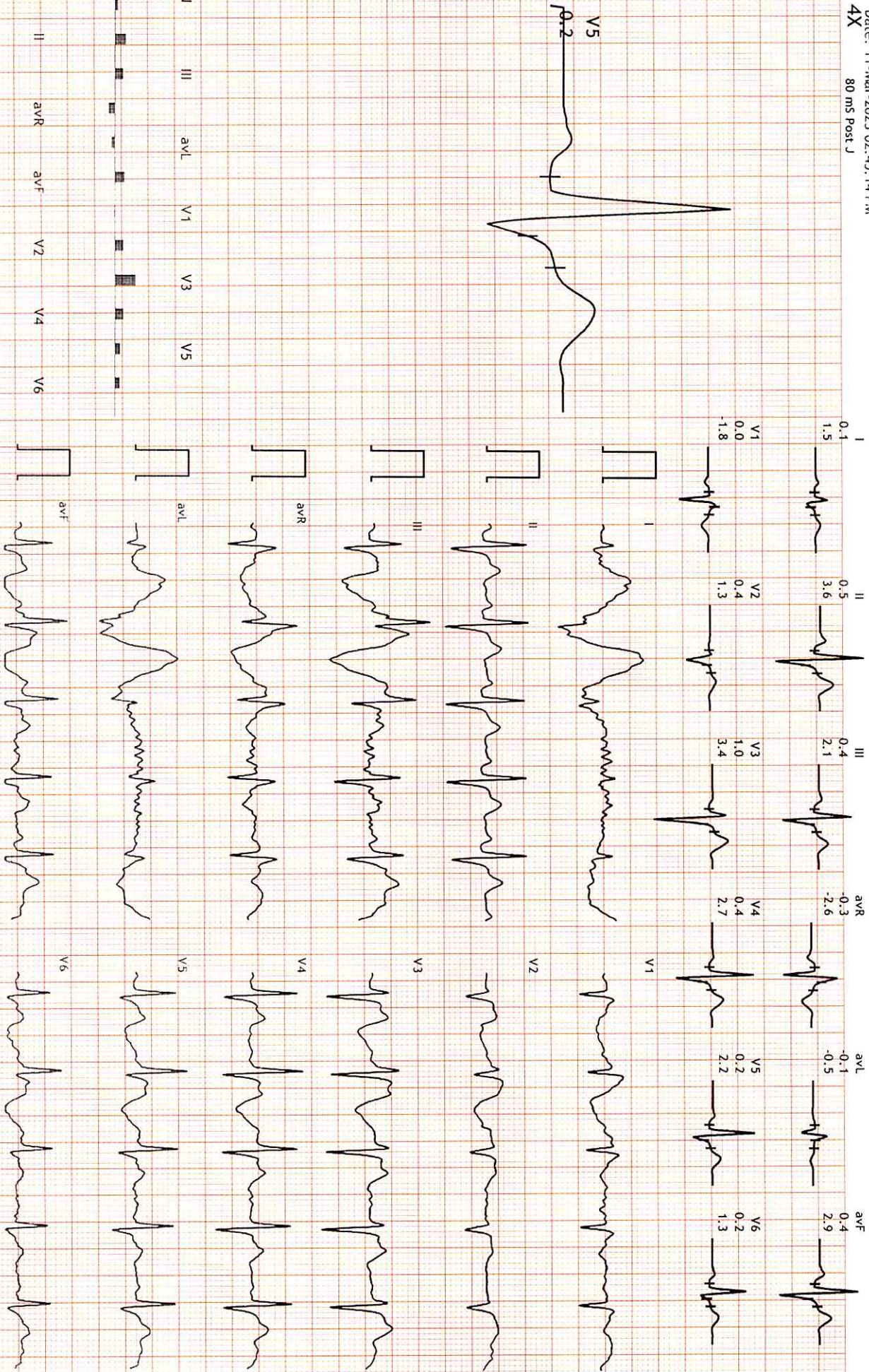
BLC: On

Notch: On

Recovery(3:00)

10.0 mm/mV

25 mm/Sec.





1322464/ VINET KUMAR SHARMA  
 32 Yrs/Male  
 0 Kg/0 Cms

Date: 11-Mar-2023 02:45:14 PM

4X 80 ms Post J

HR: 102 bpm  
 METS: 1.0  
 BP: 145/90

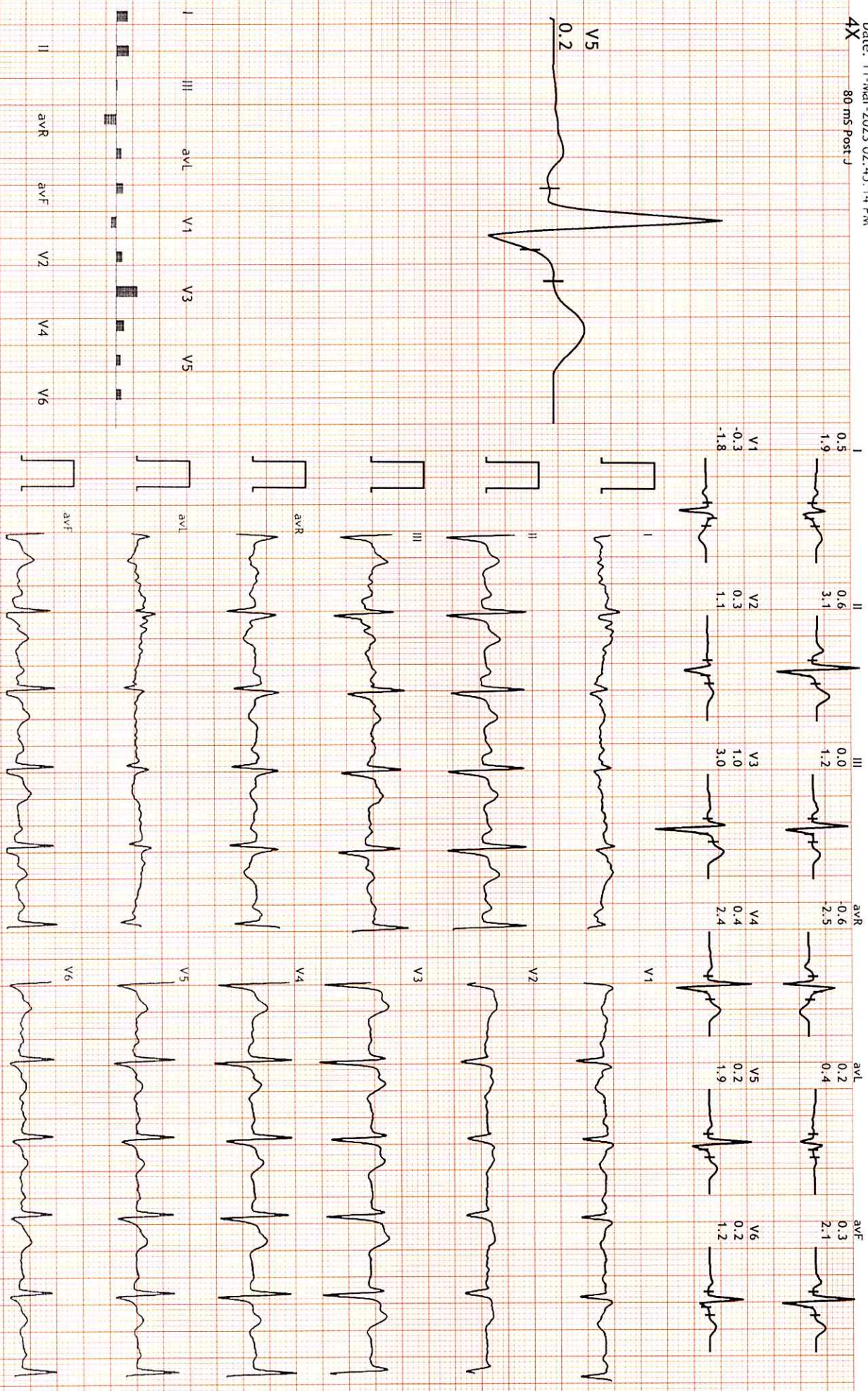
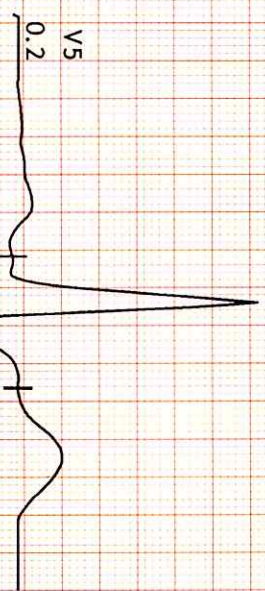
MPHR: 5.4% of 188  
 Speed: 0.0 mph  
 Grade: 0.0%

Raw ECG  
 BRUCE  
 (1.0-35)Hz

Ex Time 09:14  
 BLC: On  
 Notch: On

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

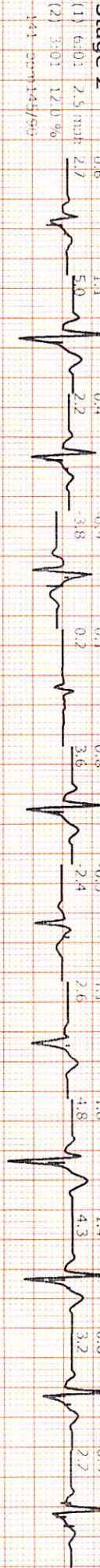
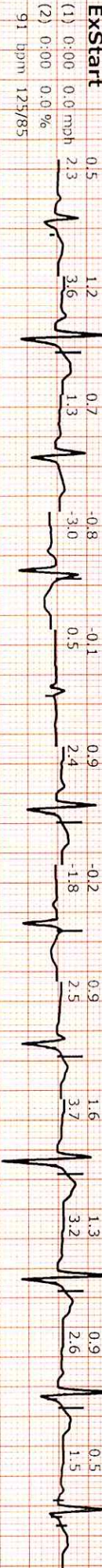
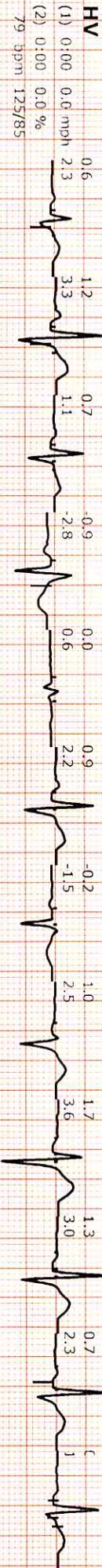
12 Lead + Median







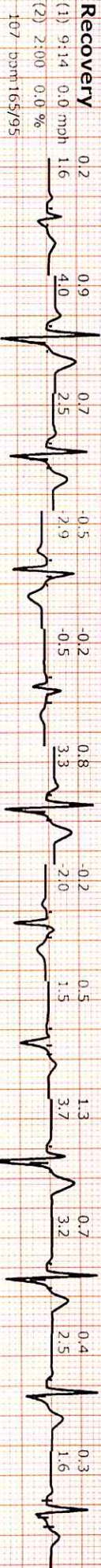
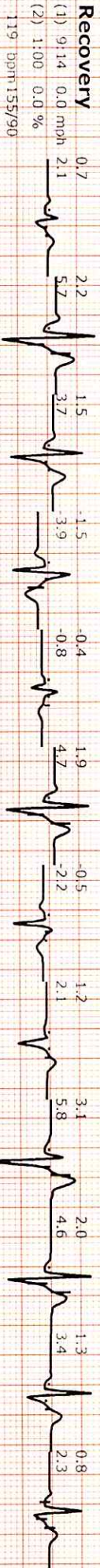
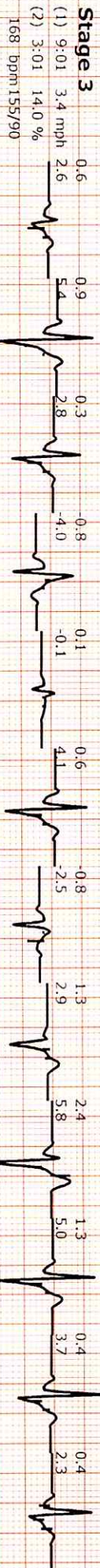
I II III aVR aVL aVF V1 V2 V3 V4 V5 V6





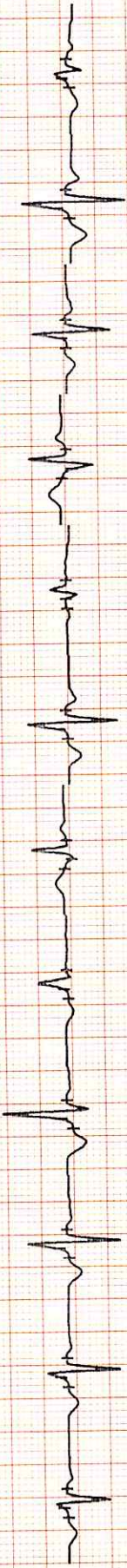


I II III aVR aVL aVF V1 V2 V3 V4 V5 V6

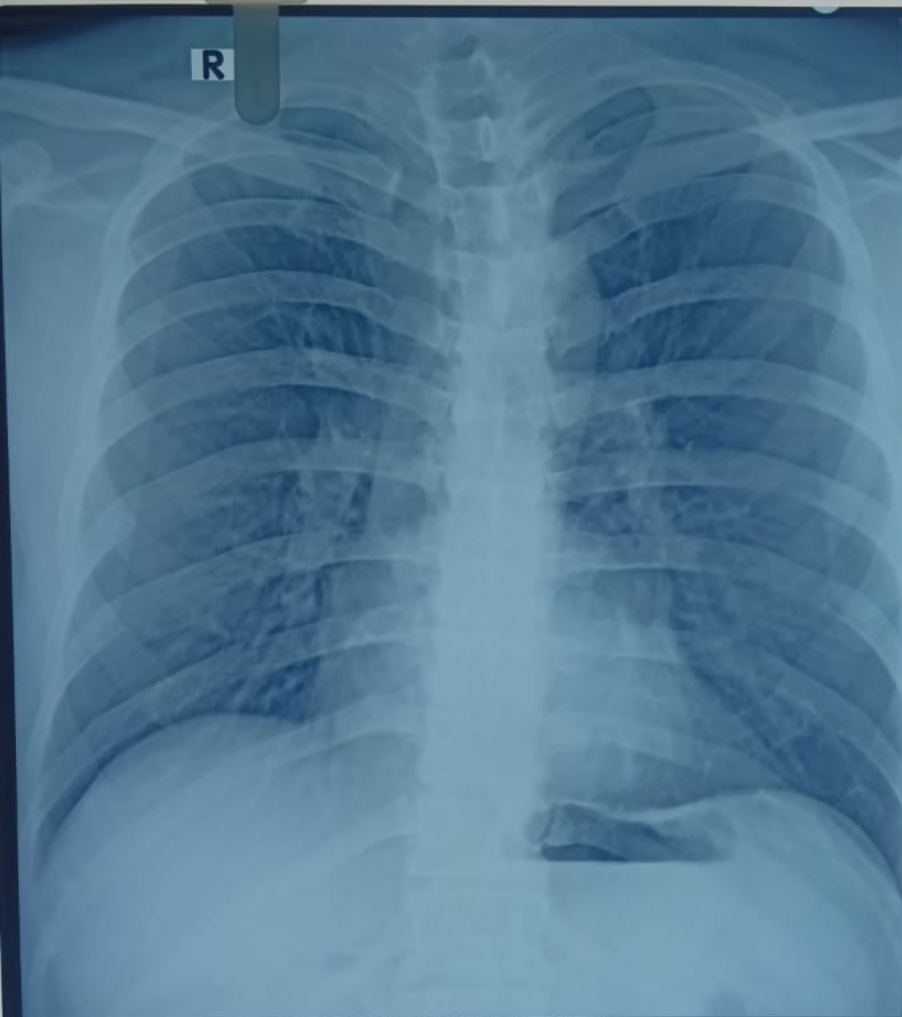




(27) 4:00 0.0 %  
101 521145.90







R

12223329 MR.VINEET KUMAR SHARMA 32YRS BANK OF BARODA M  
11.MAR.2023  
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)

