

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: Mr. Haripad pathak Date: 8/3/24

Age: 34y Sex: M/F Weight: 69.4 kg Height: 174.4 inc BMI: 22.79

BP: 136/84 mmHg Pulse: 71/m bpm RBS: mg/dl
SPO2: 98%

34/m

K/C RHD
Mild - mod MS
Mod MR
Mild AR
NO AS
Good BV function

K/C Syst. HT

OIE

Jup^o
Che - clear
CVS - MDM+
P/A - soft

Imv.

K⁺ - 5.3

Rx

- T. Bischohart 5 * - - - -
- T. Telvas GI + - - - -
- T. Pennids 400 1 - - - -
- T. Amloz 5 1 - - - -
- To see Dr. Rishi delhija

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

DEPARTMENT OF OPHTHALMOLOGY
OUT PATIENT ASSESSMENT RECORD

HARIPAD RANJAN PATHAK 34Y(S) 0M(S) 0D(S)/M UMR2324039820 8770711405	CONSULT DATE : 08-03-2024 CONSULT ID : OPC2324122393 CONSULT TYPE : VISIT TYPE : NORMAL TRANSACTION TYPE :	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 --

CHIEF COMPLAINTS

ROUTINE CHECK UP

MEDICATION PRESCRIBED

#	Medicine	Route	Dose	Frequency	When	Duration
1	I SOFT EYE DROP	Topical	1-1-1-1	Every Day	NA	2 months
		Instructions : BOTH EYES				
		Composition : SODIUM HYALURONATE 0.1% W/V				

NOTES

GLASS PRESCRIPTION :-
DISTANCE VISION


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

REVIEW

NEAR ADDITION
Follow up Date Surgery Date Anaesthetists Surgeons Surgeries
08-09-2024

RIGHT EYE		00	N6
LEFT EYE		00	N6

REMARK-


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

Printed On :08-03-2024 12:41:

Dr. Rahul Atara
BDS, MDS (Endodontics)
Sr. Consultant Dental Surgeon
Reg. No: A-16347

Name: Mr. Haripad Patil Date: 08/03/24

Age: 54yrs Sex: M/F Weight: _____ kg Height: _____ inc BMI: _____

BP: _____ mmHg Pulse: _____ bpm RBS: _____ mg/dl

Routine Dental Checkup

PMH - K/C/O HTN & ↓ medication for same.

DM NRH

D/E

- Calculus +

- Stains +

- Spacing @ upper ant.

Advice - Oral Prophylaxis

Orthodontic t/t.

Dr. Jitendra



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. HARIPAD RANJAN PATHAK	Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 08:36 am	Report Date : 08-Mar-24 11:29 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	14.7	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		44.3	40.0 - 50.0 %	Calculated
RBC Count		5.00	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		89	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		29.4	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		33.1	31.5 - 35.0 g/l	Calculated
RDW		15.1	11.5 - 14.0 %	Calculated
Platelet count		121	150 - 450 10^3 /cumm	Impedance
WBC Count		5800	4000 - 11000 cells/cumm	Impedance

DIFFERENTIAL COUNT

Neutrophils	45.4	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes	45.3	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils	6.2	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	2633.2	2000 - 7000 /cumm	Calculated



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY**

Patient Name : Mr. HARIPAD RANJAN PATHAK **Age / Gender** : 34 Y(s)/Male
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Received Dt : 08-Mar-24 08:36 am **Report Date** : 08-Mar-24 11:29 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Lymphocyte Count		2627.4	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		359.6	20 - 500 /cumm	Calculated
Absolute Monocyte Count		179.8	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
PERIPHERAL SMEAR				
RBC		Normochromic Normocytic		
WBC		As Above		
Platelets		Mildly Reduced		
ESR		11	0 - 15 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. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. HARIPAD RANJAN PATHAK **Age / Gender** : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820 **Referred By** : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 08:35 am **Report Date** : 08-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	94	< 100 mg/dl	GOD/POD, Colorimetric
Post Prandial Plasma Glucose		68	< 140 mg/dl	GOD/POD, Colorimetric

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

HbA1c		4.8	Non-Diabetic : ≤ 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : ≥ 6.5 %	HPLC
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*** End Of Report ***

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Dr. GAURI HARDAS, MBBS,MD

CONSULTANT PATHOLOGIST

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Phone: +91 0712 6789100

CIN: U74999MH2018PTC303510



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. HARIPAD RANJAN PATHAK **Age / Gender** : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820 **Referred By** : Dr. Vimmi Goel MBBS,MD
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LIPID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	182 < 200 mg/dl	Enzymatic(CHE/CHO/POD)
Triglycerides		116 < 150 mg/dl	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		44 > 40 mg/dl	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		99.46 < 100 mg/dl	Enzymatic
VLDL Cholesterol		23 < 30 mg/dl	Calculated
Tot Chol/HDL Ratio		4 3 - 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	<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

*** End Of Report ***

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**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mr. HARIPAD RANJAN PATHAK
Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 08:36 am
Report Date : 08-Mar-24 11:29 am

LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.85	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.12	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.73	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric
Alkaline Phosphatase		77	38 - 126 U/L	pNPP/AMP buffer
SGPT/ALT		69	10 - 40 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		48	15 - 40 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		9.13	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.97	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		4.16	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.2		

*** End Of Report ***

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CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mr. HARIPAD RANJAN PATHAK
Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 08:36 am
Report Date : 08-Mar-24 11:29 am

RFT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
Blood Urea	Serum	16	19.0 - 43.0 mg/dl	Urease with indicator dye
Creatinine		1.0	0.66 - 1.25 mg/dl	Enzymatic (creatinine amidohydrolase)
GFR		101.3	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		144	136 - 145 mmol/L	Direct ion selective electrode
Potassium		5.30	3.5 - 5.1 mmol/L	Direct ion selective electrode

*** End Of Report ***

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



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

Patient Name : Mr. HARIPAD RANJAN PATHAK	Age /Gender : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 08:36 am	Report Date : 08-Mar-24 11:29 am

THYROID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
T3	Serum	1.46	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.14	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.83	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

*** End Of Report ***

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

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**KIMS-KINGSWAY
HOSPITALS**

**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY**

Patient Name : Mr. HARIPAD RANJAN PATHAK
Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 08:36 am
Report Date : 08-Mar-24 11:50 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
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**Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY**

Patient Name : Mr. HARIPAD RANJAN PATHAK	Age /Gender : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 09:22 am	Report Date : 08-Mar-24 11:45 am

USF(URINE SUGAR FASTING)

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
Urine Glucose	Urine	Negative		STRIP
Comment		Fasting sample. *** End Of Report ***		

Suggested Clinical Correlation * If necessary, Please discuss
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**Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. HARIPAD RANJAN PATHAK	Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 09:22 am	Report Date : 08-Mar-24 11:45 am

URINE MICROSCOPY

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<u>PHYSICAL EXAMINATION</u>			
Volume	Urine	40 ml	
Colour.		Pale yellow	
Appearance		Clear	Clear
<u>CHEMICAL EXAMINATION</u>			
Reaction (pH)		7	4.6 - 8.0
Specific gravity		1.010	1.005 - 1.025
Urine Protein		Negative	Negative
Sugar		Negative	Negative
Bilirubin		Negative	Negative
Ketone Bodies		Negative	Negative
Nitrate		Negative	Negative
Urobilinogen		Normal	Normal
<u>MICROSCOPIC EXAMINATION</u>			
Epithelial Cells		0-1	0 - 4 /hpf
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		0-1	0 - 4 /hpf
Casts		Absent	Absent

Indicators
ion concentration
protein error of pH
indicator
GOD/POD
Diazonium
Legal's est Principle
Ehrlich's Reaction
Manual



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. HARIPAD RANJAN PATHAK **Age /Gender** : 34 Y(s)/Male
Bill No/ UMR No : BIL2324083273/UMR2324039820 **Referred By** : Dr. Vimmi Goel MBBS,MD
Received Dt : 08-Mar-24 09:22 am **Report Date** : 08-Mar-24 11:45 am

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

Suggested Clinical Correlation * If neccessary, Please discuss

Verified By : : 11100908

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Page 2 of 2

Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	HARIPAD RANJAN PATHAK	STUDY DATE	08-03-2024 09:58:36
AGE/ SEX	34Y 1D / M	HOSPITAL NO.	UMR2324039820
ACCESSION NO.	BH.2324083273-9	MODALITY	DX
REPORTED ON	08-03-2024 10:29	REFERRED BY	Dr. Vimmi 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. ANIKET KUSRAM
MBBS, MD, DNB
CONSULTANT RADIOLOGIST

PATIENT NAME:	MR. HARIPAD RANJAN PATHAK	AGE /SEX:	34 YRS/F
UMR NO:	2324039820	BILL NO:	2324082969
REFERRED BY	DR. VIMMI GOEL	DATE	08/03/2024

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 partially distended. No calculus or mass lesion seen.

Prostate is normal in size, shape and echotexture.
There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

No significant visceral abnormality seen.
Suggest clinical correlation / further evaluation.



DR. R.R. KHANDELWAL
SENIOR CONSULTANT
MD RADIO DIAGNOSIS [MMC-55870]

DR. JUHI MESHAM
JUNIOR RESIDENT

2D ECHOCARDIOGRAPHY AND COLOR DOPPLER
 **KINGSWAY HOSPITALS**

Patient Name : Mr. Haripad Ranjan Pathak
 Age : 34 years / Male
 UMR : UMR2324039820
 Date : 08/03/2024
 Done by : Dr. Vimmi Goel
 ECG : NSR, LVH
 Blood pressure: 136/84 mm Hg (Right arm, Supine position)
 BSA : 1.83 m²

Impression: Rheumatic Heart Disease

Mild to moderate mitral stenosis, Moderate MR
Mitral valve gradients are 28/10 mmHg (Peak/ Mean)
Mitral valve area by PHT is 1.16 cm² and by planimetry is 1.7 cm²
Mild AR
Peak systolic gradient across aortic valve is 17 mmHg
Normal LV dimensions
LA is enlarged
Borderline left ventricular hypertrophy
No RWMA of LV at rest
Good LV systolic function, LVEF 62%
Mild TR, 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. LA is enlarged. Borderline left ventricular hypertrophy. There is no RWMA of LV seen at rest. Good LV systolic function. LVEF 62%.. Moderate mitral stenosis. Moderate MR. Aortic valve gradients are 28/10 mmHg (Peak/ Mean). Mild AR. Peak systolic gradient across aortic valve is 17 mmHg. Mild TR. No Pulmonary Hypertension. IVC normal in size and collapsing well with respiration. Pericardium is normal. No clots or pericardial effusion seen.

M Mode echocardiography and dimension:

	Normal range (mm)		Observed (mm)
	(adults)	(children)	
Left atrium	19-40	7-37	55
Aortic root	20-37	7-28	29
LVIDd	35-55	8-47	51
LVIDs	23-39	6-28	32
IVS (d)	6-11	4-8	11
LVPW (d)	6-11	4-8	11
LVEF %	~ 60%	~60%	62%
Fractional Shortening			32%

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

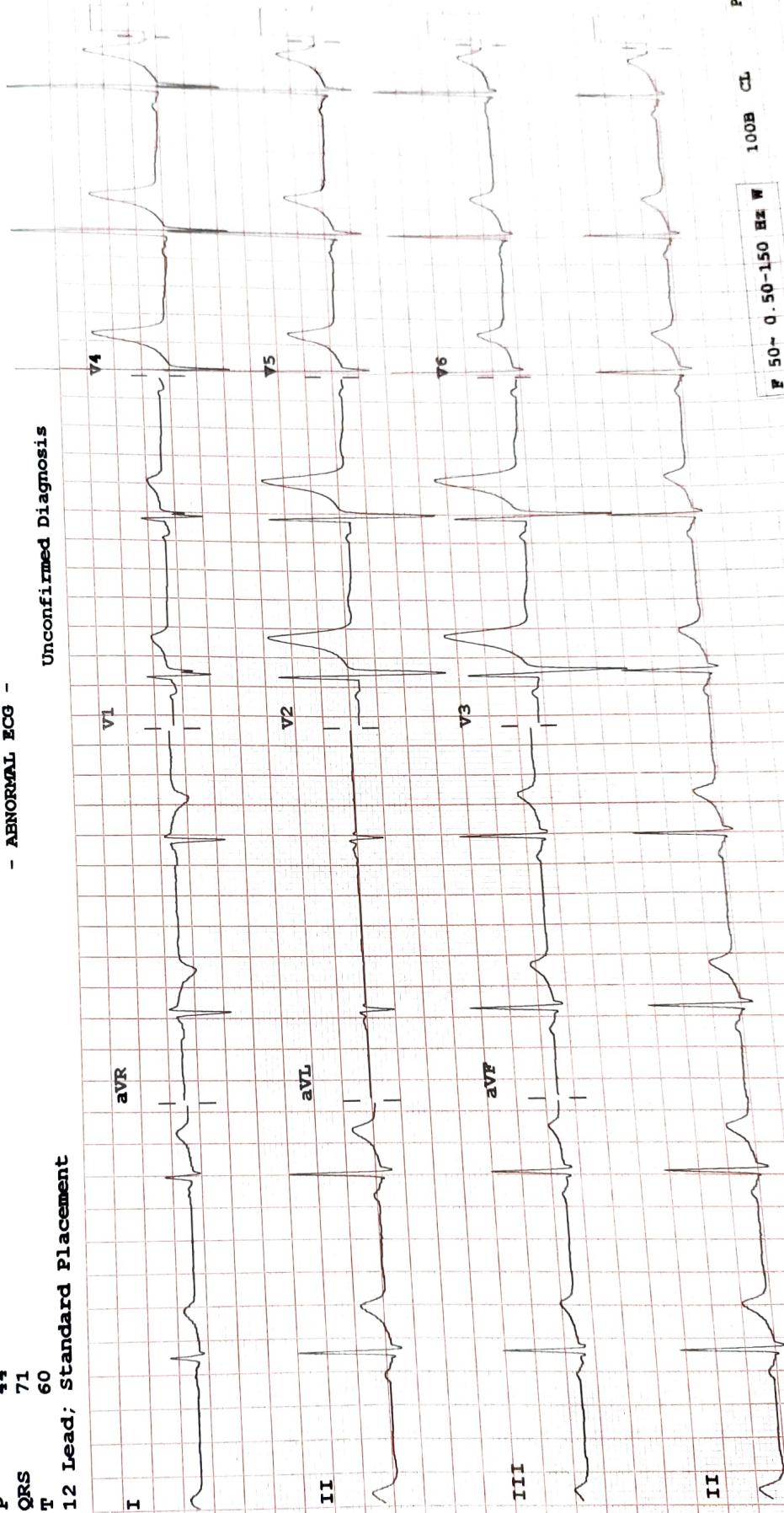
P.T.O

- Rate 56
 - PR 145
 - QRS 92
 - QT 420
 - QTc 406
- AXIS--
P 44
QRS 71
T 60
- 12 Lead; Standard Placement

- Sinus rhythm.....normal P axis, V-rate 50-99
- Probable left atrial enlargement.....P >50ms, <-0.10mV V1
- Left ventricular hypertrophy.....multiple voltage criteria
- ST elev, probable normal early repol pattern.....ST elevation, age<55
- Tall T, consider metabolic/ischemic abnrm.....T >1.2mV

- ABNORMAL ECG -

Unconfirmed Diagnosis



P?

100B CL

F 50- 0.50-150 Hz W

Chest: 10.0 mm/mV

Limb: 10 mm/mV

Speed: 25 mm/sec

PHILIPS

Device: