



NAME	MR , MANISH KUMAR	STUDY DATE	23/03/2024 1:42PM
AGE / SEX	32 y / M	HOSPITAL NO.	MH011795988
ACCESSION NO.	NM12918427	MODALITY	US
REPORTED ON	27/03/2024 1:16PM	REFERRED BY	Health Check MHD

2D Echocardiography Report

	End diastole	End systole
IVS thickness (cm)	0.9	1.2
Left Ventricular Dimension (cm)	4.8	2.8
Left Ventricular Posterior Wall thickness (cm)	0.9	1.2

Aortic Root Diameter (cm)	2.8
Left Atrial Dimension (cm)	3.3
Left Ventricular Ejection Fraction (%)	55%

LEFT VENTRICLE	:	Normal in size. No RWMA. LVEF=55%
RIGHT VENTRICLE	:	Normal in size. Normal RV function.
LEFT ATRIUM	:	Normal in size
RIGHT ATRIUM	:	Normal in size
MITRAL VALVE	:	Trace MR
AORTIC VALVE	:	Normal
TRICUSPID VALVE	:	Trace TR (PASP ~ 22mmHg)
PULMONARY VALVE	:	Normal
MAIN PULMONARY ARTERY & ITS BRANCHES	:	Appears normal.
INTERATRIAL SEPTUM	:	Intact.
INTERVENTRICULAR SEPTUM	:	Intact.
PERICARDIUM	:	No pericardial effusion or thickening



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Sector-6, Dwarka, New Delhi 110 075

GST: 07AAAAH3917LIZM

PAN NO: AAAAH3917L

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DOPPLER STUDY

VALVE	Peak Velocity (cm/sec)	Maximum P.G. (mmHg)	Mean P. G. (mmHg)	Regurgitation	Stenosis
MITRAL	E= 99 A=60	-	-	Trace	Nil
AORTIC	113	-	-	Nil	Nil
TRICUSPID	-	N	N	Trace	Nil
PULMONARY	86	N	N	Nil	Nil

SUMMARY & INTERPRETATION:

- No LV regional wall motion abnormality with LVEF =55 %
- Normal sized RA/RV/LV/LA with no chamber hypertrophy. Normal RV function.
- Trace MR
- Trace TR (PASP ~ 22mmHg)
- Normal mitral inflow pattern.
- IVC normal in size, >50% collapse with inspiration, suggestive of normal RA pressure.
- No clot/vegetation/pericardial effusion.

Please correlate clinically.

**Dr. Samanjoy Mukherjee MBBS, MD, General Medicine, DM(Cardiology) DMC No.12194
Consultant (Cardiology)**

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



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Department Of Laboratory Medicine

Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 31240301277
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 14:24
Receiving Date : 23 Mar 2024 11:30

Department of Transfusion Medicine (Blood Bank)

BLOOD GROUPING, RH TYPING & ANTIBODY SCREEN (TYPE & SCREEN)
Specimen-Blood

Blood Group & Rh Typing (Agglutination by gel/tube technique)

Blood Group & Rh typing O Rh(D) Positive

Antibody Screening (Microtyping in gel cards using reagent red cells)

Final Antibody Screen Result Negative

Technical Note:

ABO grouping and Rh typing is done by cell and serum grouping by microplate / gel technique. Antibody screening is done using a 3 cell panel of reagent red cells coated with Rh, Kell, Duffy, Kidd, Lewis, P, MNS, Lutheran and Xg antigens using gel technique.

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-----END OF REPORT-----



Dr Himanshu Lamba

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Department Of Laboratory Medicine

Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 32240312744
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 12:48
Receiving Date : 23 Mar 2024 11:25

BIOCHEMISTRY

Specimen: EDTA Whole blood

HbA1c (Glycosylated Hemoglobin) 5.5 %

As per American Diabetes Association (ADA) 2010
[4.0-6.5]

HbA1c in %

Non diabetic adults : < 5.7 %

Prediabetes (At Risk) : 5.7 % - 6.4 %

Diabetic Range : > 6.5 %

Estimated Average Glucose (eAG) 111 mg/dl

Use :

1. Monitoring compliance and long-term blood glucose level control in patients with diabetes.
2. Index of diabetic control (direct relationship between poor control and development of complications).
3. Predicting development and progression of diabetic microvascular complications.

Limitations :

1. A1C values may be falsely elevated or decreased in those with chronic kidney disease.
2. False elevations may be due in part to analytical interference from carbamylated hemoglobin formed in the presence of elevated concentrations of urea, with some assays.
3. False decreases in measured A1C may occur with hemodialysis and altered red cell turnover, especially in the setting of erythropoietin treatment

References : Rao.L.V.,Michael snyder.L.(2021).Wallach's Interpretation of Diagnostic Tests. 11th Edition. Wolterkluwer. NaderRifai,Andrea Rita Horvath,Carl T.wittwer.

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of Clinical Chemistry and Molecular Diagnostics.First edition,Elsevier,South Asia.

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Department Of Laboratory Medicine

Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 32240312744
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 13:56
Receiving Date : 23 Mar 2024 11:29

BIOCHEMISTRY

Lipid Profile (Serum)

TOTAL CHOLESTEROL (CHOD/POD)	199	mg/dl	[<200] Moderate risk:200-239 High risk:>240
TRIGLYCERIDES (GPO/POD)	95	mg/dl	[<150] Borderline high:151-199 High: 200 - 499 Very high:>500
HDL - CHOLESTEROL (Direct) Methodology: Homogenous Enzymatic	41	mg/dl	[30-60]
VLDL - Cholesterol (Calculated)	19	mg/dl	[10-40]
(CALCULATED) LDL- CHOLESTEROL	139	#mg/dl	[<100] Near/Above optimal-100-129 Borderline High:130-159 High Risk:160-189
T.Chol/HDL.Chol ratio	4.9		<4.0 Optimal 4.0-5.0 Borderline >6 High Risk
LDL.CHOL/HDL.CHOL Ratio	3.4		<3 Optimal 3-4 Borderline >6 High Risk

Note:
Reference ranges based on ATP III Classifications.
Recommended to do fasting Lipid Profile after a minimum of 8 hours of overnight fasting.

Technical Notes:
Lipid profile is a panel of blood tests that serves as initial broad medical screening tool for abnormalities in lipids, the results of these tests can identify certain genetic

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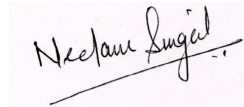
Name	: MR MANISH KUMAR	Age	: 32 Yr(s) Sex :Male
Registration No	: MH011795988	Lab No	: 32240312744
Patient Episode	: H03000061584	Collection Date	: 23 Mar 2024 10:33
Referred By	: HEALTH CHECK MHD	Reporting Date	: 23 Mar 2024 13:56
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BIOCHEMISTRY

diseases and determine approximate risks for cardiovascular disease, certain forms of pancreatitis and other diseases.

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-----END OF REPORT-----



Dr. Neelam Singal
CONSULTANT BIOCHEMISTRY

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Department Of Laboratory Medicine

Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 32240312744
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 18:17
Receiving Date : 23 Mar 2024 11:29

BIOCHEMISTRY

THYROID PROFILE, Serum

Specimen Type : Serum

T3 - Triiodothyronine (ECLIA)	1.270	ng/ml	[0.800-2.040]
T4 - Thyroxine (ECLIA)	8.450	µg/dl	[4.600-10.500]
Thyroid Stimulating Hormone (ECLIA)	3.510	µIU/mL	[0.340-4.250]

Note : TSH levels are subject to circadian variation, reaching peak levels between 2-4.a.m.and at a minimum between 6-10 pm.Factors such as change of seasons hormonal fluctuations,Ca or Fe supplements,high fibre diet,stress and illness affect TSH results.

* References ranges recommended by the American Thyroid Association

1) Thyroid. 2011 Oct;21(10):1081-125.PMID .21787128

2) <http://www.thyroid-info.com/articles/tsh-fluctuating.html>

Test Name	Result	Unit	Biological Ref. Interval
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LIVER FUNCTION TEST (Serum)

BILIRUBIN-TOTAL (Diazonium Ion)	0.59	mg/dl	[0.10-1.20]
BILIRUBIN - DIRECT (Diazotization)	0.20	mg/dl	[0.00-0.30]
BILIRUBIN - INDIRECT (Calculated)	0.39	mg/dl	[0.20-1.00]
SGOT/ AST (UV without P5P)	20.9	U/L	[10.0-50.0]
SGPT/ ALT (UV without P5P)	24.1	U/L	[0.0-41.0]
ALP (p-NPP,kinetic)*	69	U/L	[45-135]
TOTAL PROTEIN (Biuret)	7.5	g/dl	[6.0-8.2]
SERUM ALBUMIN (BCG-dye)	4.6	g/dl	[3.5-5.2]
SERUM GLOBULIN (Calculated)	2.9	g/dl	[1.8-3.4]
ALB/GLOB (A/G) Ratio(Calculated)	1.59		[1.10-1.80]

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Department Of Laboratory Medicine

Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 32240312744
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 13:56
Receiving Date : 23 Mar 2024 11:29

BIOCHEMISTRY

Technical Notes:

Liver function test aids in diagnosis of various pre hepatic, hepatic and post hepatic causes of dysfunction like hemolytic anemia's, viral and alcoholic hepatitis and cholestasis of obstructive causes.

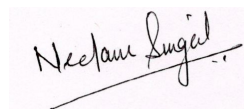
Test Name	Result	Unit	Biological Ref. Interval
KIDNEY PROFILE (Serum)			
BUN (Urease/GLDH)	9.00	mg/dl	[6.00-20.00]
SERUM CREATININE (Jaffe's method)	0.83	mg/dl	[0.80-1.60]
SERUM URIC ACID (Uricase)	5.3	mg/dl	[3.5-7.2]
SERUM CALCIUM (NM-BAPTA)	9.36	mg/dl	[8.00-10.50]
SERUM PHOSPHORUS (Molybdate, UV)	3.6	mg/dl	[2.5-4.5]
SERUM SODIUM (ISE)	140.0	mmol/l	[134.0-145.0]
SERUM POTASSIUM (ISE)	4.33	mmol/l	[3.50-5.20]
SERUM CHLORIDE (ISE Indirect)	103.9	mmol/L	[95.0-105.0]
eGFR	116.4	ml/min/1.73sq.m	[>60.0]

Technical Note

eGFR which is primarily based on Serum Creatinine is a derivation of CKD-EPI 2009 equation normalized to 1.73 sq.m BSA and is not applicable to individuals below 18 years. eGFR tends to be less accurate when Serum Creatinine estimation is indeterminate e.g. patients at extremes of muscle mass, on unusual diets etc. and samples with severe Hemolysis / Icterus / Lipemia.

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-----END OF REPORT-----



Dr. Neelam Singal
CONSULTANT BIOCHEMISTRY

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Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 32240312747
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:32
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 12:36
Receiving Date : 23 Mar 2024 11:33

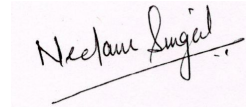
BIOCHEMISTRY

Specimen Type : Serum/Plasma

Plasma GLUCOSE-Fasting (Hexokinase) 95 mg/dl [74-106]

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-----END OF REPORT-----



Dr. Neelam Singal
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Department Of Laboratory Medicine

Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 33240307958
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 13:18
Receiving Date : 23 Mar 2024 11:12

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (Automated) Specimen-Whole Blood

ESR 10.0 mm/1sthour [0.0-10.0]

Interpretation :

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week postpartum.

ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives).

It is especially low (0 -1mm) in polycythemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Test Name	Result	Unit	Biological Ref. Interval
COMPLETE BLOOD COUNT (EDTA Blood)			
WBC Count (Flow cytometry)	5980	/cu.mm	[4000-10000]
RBC Count (Impedence)	5.05	million/cu.mm	[4.50-5.50]
Haemoglobin (SLS Method)	12.9 #	g/dL	[13.0-17.0]
Haematocrit (PCV) (RBC Pulse Height Detector Method)	42.9	%	[40.0-50.0]
MCV (Calculated)	85.0	fL	[83.0-101.0]
MCH (Calculated)	25.5	pg	[25.0-32.0]
MCHC (Calculated)	30.1 #	g/dL	[31.5-34.5]
Platelet Count (Impedence)	227000	/cu.mm	[150000-410000]
RDW-CV (Calculated)	12.7	%	[11.6-14.0]
DIFFERENTIAL COUNT			
Neutrophils (Flowcytometry)	48.8	%	[40.0-80.0]
Lymphocytes (Flowcytometry)	31.8	%	[20.0-40.0]

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Department Of Laboratory Medicine

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Registration No : MH011795988 **Lab No** : 33240307958
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 11:31
Receiving Date : 23 Mar 2024 11:12

HAEMATOLOGY

Monocytes (Flowcytometry)	13.2 #	%	[2.0-10.0]
Eosinophils (Flowcytometry)	5.7	%	[1.0-6.0]
Basophils (Flowcytometry)	0.5 #	%	[1.0-2.0]
IG	0.20	%	
Neutrophil Absolute(Flourescence flow cytometry)	2.9	/cu mm	[2.0-7.0]x10 ³
Lymphocyte Absolute(Flourescence flow cytometry)	1.9	/cu mm	[1.0-3.0]x10 ³
Monocyte Absolute(Flourescence flow cytometry)	0.8	/cu mm	[0.2-1.2]x10 ³
Eosinophil Absolute(Flourescence flow cytometry)	0.3	/cu mm	[0.0-0.5]x10 ³
Basophil Absolute(Flourescence flow cytometry)	0.0	/cu mm	[0.0-0.1]x10 ³

Complete Blood Count is used to evaluate wide range of health disorders, including anemia, infection, and leukemia. Abnormal increase or decrease in cell counts as revealed may indicate that an underlying medical condition that calls for further evaluation.

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-----END OF REPORT-----

Dr. Shalakha Agrawal
Associate Consultant, M.B.B.S, M.D. Pathology
--2020



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Department Of Laboratory Medicine

Name : MR MANISH KUMAR **Age** : 32 Yr(s) Sex :Male
Registration No : MH011795988 **Lab No** : 38240302977
Patient Episode : H03000061584 **Collection Date** : 23 Mar 2024 10:33
Referred By : HEALTH CHECK MHD **Reporting Date** : 23 Mar 2024 13:22
Receiving Date : 23 Mar 2024 12:30

CLINICAL PATHOLOGY

Test Name	Result	Biological Ref. Interval
ROUTINE URINE ANALYSIS		
MACROSCOPIC DESCRIPTION		
Colour (Visual)	PALE YELLOW	(Pale Yellow - Yellow)
Appearance (Visual)	CLEAR	
CHEMICAL EXAMINATION		
Reaction[pH] (Reflectancephotometry (Indicator Method))	5.0	(5.0-9.0)
Specific Gravity (Reflectancephotometry (Indicator Method))	1.010	(1.003-1.035)
Bilirubin	Negative	NEGATIVE
Protein/Albumin (Reflectance photometry (Indicator Method)/Manual SSA)	Negative	(NEGATIVE-TRACE)
Glucose (Reflectance photometry (GOD-POD/Benedict Method))	NOT DETECTED	(NEGATIVE)
Ketone Bodies (Reflectance photometry (Legal's Test)/Manual Rotheras)	NOT DETECTED	(NEGATIVE)
Urobilinogen Reflectance photometry/Diazonium salt reaction	NORMAL	(NORMAL)
Nitrite Reflectance photometry/Griess test	NEGATIVE	NEGATIVE
Leukocytes Reflectance photometry/Action of Esterase	NIL	NEGATIVE
BLOOD (Reflectance photometry (peroxidase))	NIL	NEGATIVE
MICROSCOPIC EXAMINATION (Manual) Method: Light microscopy on centrifuged urine		
WBC/Pus Cells	1-2 /hpf	(4-6)
Red Blood Cells	NIL	(1-2)
Epithelial Cells	1-2 /hpf	(2-4)
Casts	NIL	(NIL)
Crystals	NIL	(NIL)
Bacteria	NIL	
Yeast cells	NIL	

Interpretation:

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CLINICAL PATHOLOGY

URINALYSIS--Routine urine analysis assists in screening and diagnosis of various metabolic , urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine.

Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine.

Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most Common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased Specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decrease Specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in case of hemolytic anemia.

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--2020

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Sector-6, Dwarka, New Delhi 110 075

GST: 07AAAAH3917LIZM

PAN NO: AAAAH3917L

NAME	MR , MANISH KUMAR	STUDY DATE	23/03/2024 10:30AM
AGE / SEX	32 y / M	HOSPITAL NO.	MH011795988
ACCESSION NO.	R7109410	MODALITY	CR
REPORTED ON	26/03/2024 3:33PM	REFERRED BY	Health Check MHD

X-RAY CHEST - PA VIEW

Results:

Visualized lung fields appear clear.

Both hilar shadows appear normal.

Cardiothoracic ratio is within normal limits.

Both hemidiaphragmatic outlines appear normal.

Both costophrenic angles are clear.

Kindly correlate clinically.

Aarushi

Dr. Aarushi MBBS, MD, DNB DMC NO.03291

CONSULTANT RADIOLOGIST

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



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