RATE	:	60 bpm	SINUS BRADYCARDIA
R-R	:	992 ms	INFERIOR T WAVE ABNORMALITY IS NONSPECIFIC
P-R	:	120 ms	
QRS	:	94 ms	
QT	:	108 ms	
QTc	:	108 ms	
--AXIS--			
P	:	26°	
QRS	:	34°	
T	:	03°	

12 SL: REPORT FORMAT:3x4+1L SM

I   aVR   V1

III   aVF   V3

II   aVL   V2

I   REF:SELF   Dr.

V4

V5   V6

I

Barcode No	: 490488
Patient Name	**: MRS. TANYA NAYAN**
Age/Gender	: 34 Y 0 M 0 D /F
Ref Doctor	: Dr.SELF
Collected By	: Dr.SELF
Sample Type	: WHOLE BLOOD EDTA

Registration	: 03/Sep/2024 04:30PM
Received	: 03/Sep/2024 04:36PM
Reported	: 03/Sep/2024 05:18PM
Client Code	: UP528
Client Add	: INDIRAPURAM

HAEMATOLOGY

Test Description	Observed Value	Unit	Reference Range
ERYTHROCYTE SEDIMENTATION RATE			
ERYTHROCYTE SEDIMENTATION RATE Westergren	**26**	mm/1st hr	0-15

COMMENTS: ESR is an acute phase reactant that indicates the presence and intensity of an inflammatory process. It is never diagnostic of a specific disease. It is used to monitor the course or response to treatment of certain diseases. Extremely high levels are found in cases of malignancy, hematologic diseases, collagen disorders, and renal diseases. · Increased levels may indicate: Chronic renal failure (e.g., nephritis, nephrosis), malignant diseases (e.g., multiple myeloma, Hodgkin disease, advanced Carcinomas), bacterial infections (e.g., abdominal infections, acute pelvic inflammatory disease, syphilis, pneumonia), inflammatory diseases (e.g. temporal arteritis, polymyalgia rheumatic, rheumatoid arthritis, rheumatic fever, systemic lupus erythematosus [SLE]), necrotic diseases (e.g., acute myocardial infarction, necrotic tumor, gangrene of an extremity), diseases associated with increased proteins (e.g., hyperfibrinogenemia, macroglobulinemia), and severe anemias (e.g., iron deficiency or B12 deficiency).
Falsely decreased levels may indicate Sickle cell anemia, spherocytosis, hypofibrinogenemia, or polycythemia vera.

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Barcode No	: 490488	Registration	: 03/Sep/2024 04:30PM
Patient Name	**: MRS. TANYA NAYAN**	Received	: 03/Sep/2024 04:36PM
Age/Gender	: 34 Y 0 M 0 D /F	Reported	: 03/Sep/2024 05:17PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: WHOLE BLOOD EDTA		

HAEMATOLOGY

Test Description	Observed Value	Unit	Reference Range
COMPLETE BLOOD COUNT			
HAEMOGLOBIN (Hb) Colorimetric SLS	**10.2**	gm/dl	12.00-15.00
RED BLOOD CELLS- RBC COUNT Electrical Impedance	5.0	10^6/uL	4.50-5.50
PACKED CELL VOLUME (PCV) -HEMATOCRIT Calculated	**33.0**	%	36 - 46
MCV Calculated	**66.6**	fL	83-101
MCH Calculated	**19.9**	pg	27-32
MCHC Calculated	**29.9**	g/dl	32-36
RED CELL DISTRIBUTION WIDTH (RDW-CV) Whole blood EDTA,Flow Cytometry	**17.4**	%	11.5-14.5
RED CELL DISTRIBUTION WIDTH (RDW - SD) Whole Blood EDTA,Calculated	**37.6**	fl	39.0-46.0
PLATELET COUNT Electrical Impedance	216	10^3/μL	150-410
PLATELET DISTRIBUTION WIDTH (PDW) Whole Blood EDTA,Calculated	15.1	fL	9.00-17.00
PCT(PLATELETCRIT) Whole blood EDTA,Flow Cytometry	0.26	%	0.108-0.282
MEAN PLATELET VOLUME - MPV Calculated	**13**	fL	7.00-12.00
P-LCR	53		
P-LCC Calculated	**114.00**	%	30.0-90.0
TOTAL LEUKOCYTE COUNT (TLC) Laser - Based Flow Cytometry / Microscopy	7.12	10^3/μL	4.0-10.0
DIFFERENTIAL LEUKOCYTE COUNT			
Neutrophils Laser - Based Flow Cytometry / Microscopy	56.6	%	40-80

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Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: WHOLE BLOOD EDTA		

HAEMATOLOGY

Test Description	Observed Value	Unit	Reference Range
Lymphocytes Laser - Based Flow Cytometry / Microscopy	35.7	%	20-40
Eosinophils Laser - Based Flow Cytometry / Microscopy	2.0	%	1-6
Monocytes Laser - Based Flow Cytometry / Microscopy	5.0	%	2-10
Basophils Whole blood EDTA,Flow Cytometry	0.7	%	0.00-1.00
ABSOLUTE NEUTROPHIL COUNT Whole Blood EDTA,Calculated	4.03	10^3/μL	2.00-7.00
ABSOLUTE LYMPHOCYTE COUNT Calculated	2.54	10^3/μL	1.00-3.00
ABSOLUTE EOSINOPHIL COUNT Calculated	0.14	10^3/μL	0.02-0.50
ABSOLUTE MONOCYTE COUNT Calculated	0.36	10^3/μL	0.20-1.00
ABSOLUTE BASOPHIL COUNT Calculated	0.05	10^3/μL	0.02-0.10

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BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
LIVER FUNCTION TEST			
TOTAL BILIRUBIN Diazo	1.11	mg/dL	0.10 - 1.2
CONJUGATED (D. Bilirubin) Diazo	0.23	mg/dL	0.0 - 0.30
UNCONJUGATED (I.D. Bilirubin) Calculated	0.88	mg/dl	0.0 - 1.0
S.G.P.T UV without P5P	27	U/L	0-35
SGOT UV without P5P	21	U/L	0-40
ALKALINE PHOSPHATASE AMP	79.62	U/L	42 - 98
TOTAL PROTEINS Biuret	6.5	g/dL	6.4 - 8.3
ALBUMIN Bromocresol Green	4.1	g/dL	3.5 - 5.2
GLOBULIN Calculated	2.36	g/dL	2.30-4.50
A/G RATIO Calculated	1.74		1.0-2.3

INTERPRETATION
Bilirubin Elevated levels results from increased bilirubin production (eg hemolysis and ineffective erythropoiesis); decreased bilirubin excretion (eg; obstruction and hepatitis); and abnormal bilirubin metabolism (eg; hereditary and neonatal jaundice).
Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in viral hepatitis; drug reactions, alcoholic liver disease conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts tumors & Scarring of the bile ducts.
Increased unconjugated (indirect) bilirubin may be a result of hemolytic or pernicious anemia, transfusion reaction & a common metabolic condition termed Gilbert syndrome.
AST levels increase in viral hepatitis, blockage of the bile duct ,cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. Ast levels may also increase after a heart attck or strenuous activity.
ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.
GGT may be higher with diabetes, heart failure, hyperthyroidism, or pancreatitis. Higher GGT levels also may mean liver damage from heavy, chronic alcohol abuse. GGT levels that are higher than normal may also signal a viral infection
Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyriodism, Leukemia, Lymphoma, paget`s disease, Rickets, Sarcoidosis etc. Elevated serum GGT activity can be found in diseases of the liver, Biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-including drugs etc.
Serum total protein, in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation

Barcode No	: 490490		Registration	: 03/Sep/2024 04:30PM
Patient Name	**: MRS. TANYA NAYAN**		Received	: 03/Sep/2024 04:36PM
Age/Gender	: 34 Y 0 M 0 D /F		Reported	: 03/Sep/2024 05:12PM
Ref Doctor	: Dr.SELF		Client Code	: UP528
Collected By	: Dr.SELF		Client Add	: INDIRAPURAM
Sample Type	: SERUM			

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range

or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstrom's disease. Lower-than-normal levels may be due to:
Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition,

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Sample Type	: SERUM		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
LIPID PROFILE			
TOTAL CHOLESTEROL Cholesterol Oxidase,PAP	140.47	mg/dl	<200 Desirable~200 – 239 Borderline >240 High Risk
TRIGLYCERIDES GPO-TRINDER	90.42	mg/dL	Normal : <161~High : 161 - 199~Hyper Triglyceridemic : 200 - 499~Very High : >499
H D L CHOLESTEROL Direct Enzymatic Colorimetric	42	mg/dl	>40 Recommended Range
L D L CHOLESTEROL Calculated	80.39	mg/dl	70-130
VLDL Spectrophotmetry/Calculated	18.08	mg/dl	0.00-45.0
T. CHOLESTEROL/ HDL RATIO Calculated	**3.34**	Ratio	3.40-4.40
LDL / HDL RATIO Calculated	1.91	Ratio	1.0-3.5

COMMENT :-
(#). A lipid panel measures five different types of lipids from a blood sample, including:
(1). Total cholesterol: This is your overall cholesterol level — the combination of LDL-C, VLDL-C and HDL-C.
(2). Low-density lipoprotein (LDL) cholesterol: This is the type of cholesterol that's known as "bad cholesterol." It can collect in your blood vessels and increase your risk of cardiovascular disease.
(3). Very low-density lipoprotein (VLDL) cholesterol: This is a type of cholesterol that's usually present in very low amounts when the blood sample is a fasting samples since it's mostly comes from food you've recently eaten. An increase in this type of cholesterol in a fasting sample may be a sign of abnormal lipid metabolism.
(4). High-density lipoprotein (HDL) cholesterol: This is the type of cholesterol that's known as "good cholesterol." It helps decrease the buildup of LDL in your blood vessels.
(5).Triglycerides: This is a type of fat from the food we eat. Excess amounts of triglycerides in your blood are associated with cardiovascular disease and pancreatic inflammation.

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Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: Serum		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range

HBA1C

HBA1c HPLC	5.6	%	
ESTIMATED AVG. GLUCOSE	114.02	mg/dl	

Ref Range for HBA1c
Non-Diabetic :- 4.0 – 5.6
Increased Risk:- 5.7 – 6.4
In Diabetics:
Excellent Control: 6.5 – 7.0
Fair To Good Control: 7.0 – 8.0
Unsatisfactory Control:- 8.0 – 10
Poor Control: >10

COMMENT:
The Glycosylated Hemoglobin (HbA1c or A1c) test evaluates the average amount of glucose in the blood over the last 2 to 3 months.
This test is used to monitor treatment in someone who has been diagnosed with diabetes.
It helps to evaluate how well the person's glucose levels have been controlled by treatment over time. This test may be used to screen for and diagnose diabetes or risk of developing diabetes.
Depending on the type of diabetes that a person has, how well their diabetes is controlled, and on doctor recommendations, the HbA1c test may be measured 2 to 4 times each year.
The American Diabetes Association recommends HbA1c testing in diabetics at least twice a year.
When someone is first diagnosed with diabetes or if control is not good, HbA1c may be ordered more frequently.
Note: If a person has anemia, few type of hemoglobinopathy, hemolysis, or heavy bleeding, HbA1c test results may be falsely low.
If someone is iron-deficient, the HbA1c level may be increased.
If a person has had a recent blood transfusion, the HbA1c may be inaccurate and may not accurately reflect glucose control for 2 to 3 months.

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Sample Type	: Serum		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range

FASTING BLOOD SUGAR

Plasma Glucose Fasting	93.1	mg/dL	70 -110

Glucose Oxidase/Peroxidase

INTERPRETATION:

Fasting blood sugar test. A blood sample will be taken after an overnight fasting blood sugar level less than 100mg/dL is normal. A fasting blood sugar level from 100 to 125 mg/dL is considered prediabetes. If it's 126 mg/dL or higher on two separate tests, you have diabetes.

GGT

GGT	35	U/L	12.0-58.0

IFCC

INTERPRETATION:

GGT functions in the body as a transport molecule, helping to move other molecules around the body. It plays a significant role in helping the liver metabolize drugs and other toxins. Increased GGT include overuse of alcohol, chronic viral hepatitis, lack of blood flow to the liver, liver tumor, cirrhosis, or scarred liver, overuse of certain drugs or other toxins, heart failure, diabetes, pancreatitis, fatty liver disease.

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Age/Gender	: 34 Y 0 M 0 D /F	Reported	: 03/Sep/2024 05:12PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
KIDNEY FUNCTION TEST			
SERUM UREA Serum,Urease GLDH	26.10	mg/dL	19.0 - 45.0
SERUM CREATININE Enzymatic	0.75	mg/dL	0.7-1.30
SERUM URIC ACID Serum,Uricase	3.1	mg/dl	2.6 - 6.0
SERUM SODIUM ISE, Direct	139.20	mmol/L	135-150
SERUM POTASSIUM ISE, Direct	4.15	mmol/L	3.5-5.5
SERUM CHLORIDE ISE, Direct	101.24	mmol/L	94-110
Blood Urea Nitrogen (BUN) Calculated	12.2	mg/dl	8.00-23.0
UREA / CREATININE RATIO	34.80		
SERUM TOTAL CALCIUM BAPTA	8.95	mg/dl	8.4-10.6

INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20.
To Differentiate between pre- and postrenal azotemia.
INCREASED RATIO (>20:1) WITH NORMAL CREATININE:
1.Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion,dehydration, blood loss) due to decreased glomerular filtration rate.
2.Catabolic states with increased tissue breakdown.
3.GI hemorrhage.
4.High protein intake.
5.Impaired renal function plus .
6.Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high

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Age/Gender	: 34 Y 0 M 0 D /F	Reported	: 03/Sep/2024 05:12PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range

protein diet, burns,surgery, cachexia, high fever).

7.Urine reabsorption (e.g. ureterocolostomy)

8.Reduced muscle mass (subnormal creatinine production)

9.Certain drugs (e.g. tetracycline, glucocorticoids)

INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:

1.Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).

2.Prerenal azotemia superimposed on renal disease.

DECREASED RATIO (<10:1) WITH DECREASED BUN :

1.Acute tubular necrosis.

2.Low protein diet and starvation.

3.Severe liver disease.

4.Other causes of decreased urea synthesis.

5.Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).

6.Inherited hyperammonemias (urea is virtually absent in blood).

7.SIADH (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea.

8.Pregnancy.

DECREASED RATIO (<10:1) WITH INCREASED CREATININE:

1.Phenacimide therapy (accelerates conversion of creatine to creatinine).

2.Rhabdomyolysis (releases muscle creatinine).

3.Muscular patients who develop renal failure.

INAPPROPIATE RATIO:

1.Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies,resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).

2.Cephalosporin therapy (interferes with creatinine measurement).

Barcode No	: 490487		Registration	: 03/Sep/2024 04:30PM
Patient Name	**: MRS. TANYA NAYAN**		Received	: 03/Sep/2024 04:36PM
Age/Gender	: 34 Y 0 M 0 D /F		Reported	: 03/Sep/2024 05:30PM
Ref Doctor	: Dr.SELF		Client Code	: UP528
Collected By	: Dr.SELF		Client Add	: INDIRAPURAM
Sample Type	: Urine			

CLINICAL PATHOLOGY

Test Description	Observed Value	Unit	Reference Range

URINE FOR SUGAR - FASTING

Result	NIL		Nil
Benedicts test			

INTERPRETATION:

When the glucose level in blood exceeds the renal thresholds of glucose (160-180mg/dl) glucose starts to appear in urine. Glucose in urine gets excreted in diabetes mellitus. Elevated level of glucose in urine may also be a result of renal glucosuria. Other causes of glucose in urine are hyperthyroidism, high sugar diet, liver cirrhosis.
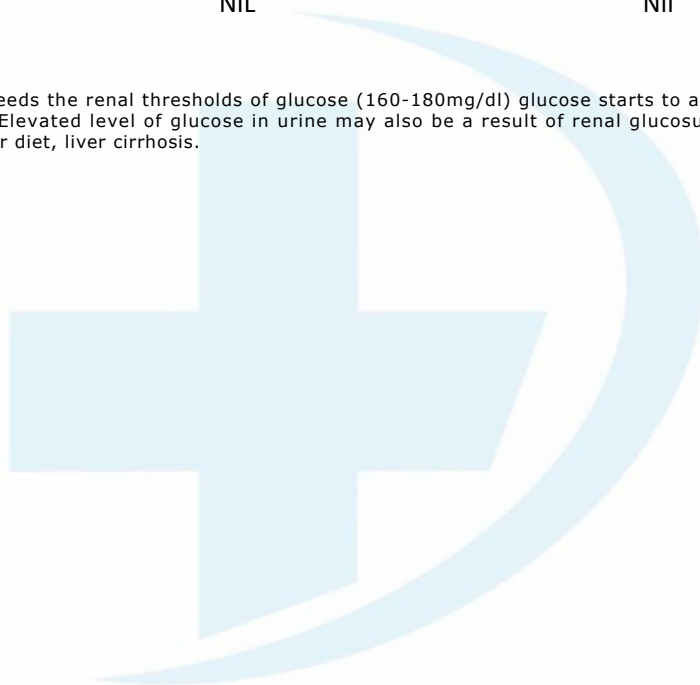
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Barcode No : 490490	Registration	: 03/Sep/2024 04:30PM
Patient Name : MRS. TANYA NAYAN	Received	: 03/Sep/2024 04:36PM
Age/Gender : 34 Y 0 M 0 D /F	Reported	: 03/Sep/2024 05:32PM
Ref Doctor : Dr.SELF	Client Code	: UP528
Collected By : Dr.SELF	Client Add	: INDIRAPURAM
Sample Type : SERUM		

HORMONE ASSAYS

Test Description	Observed Value	Unit	Reference Range

THYROID PROFILE. (T3,T4,TSH)

TRIODOTHYRONINE TOTAL (T3) CLIA	1.05	ng/mL	0.8 - 1.9

Summary & Interpretation:.

Triiodothyronine (T3) is the hormone principally responsible for the development of the effects of the thyroid hormones on the various target organsT3 is mainly formed extrathyroidally , particularly in the liver, by deiodination of T4. A reduction in the conversion of T4 to T3 results in a fall in the T3 concentration.It Occurs under the influence of medicaments such as propanolol, glucocorticoids or amiodarone and in severe non-thyroidal illness (NTI). The determination of T3 is utilized in the diagnosis of T3-hyperthyroidism, the detection of early stages of hyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

THYROXINE TOTAL (T4) CLIA	9.6	ug/dL	5.0 - 13.0

Summary & Interpretation:

The hormons thyroxime (T4) is the main product secreted by the thyroid gland. The major part of total thyroxime (T4) in serum is present in protein-bound form. As the concentration of the transport proteins in serum are subject to exogenous and endogenous effects, the status of the binding proteins must also be taken in to account in the assessment of the thyroid hormone concentration in serum. The determination of T4 can be utilized for the following indications : the detection of hyperthyroidism, the detection of primary and secondary hypothyroidism and the monitoring of TSH-suppression therapy.

THYROID STIMULATING HORMONE (TSH) CLIA	3.425	µIU/mL	0.35 - 4.75

Summary & Interpretation

TSH is formed in specific basophil cells of the anterior pituitary and is subject to a circardian secretion sequence.The determination of TSH serves as the initial test in thyroid diagnostics, Accordingly, TSH is a very sensitive and specific parameter for assessing thyroid function and is particularl suitable for early detection or exclusion of disorders in the central regulating circuit between the hypothalamus, pituitary and thyroid.

Note:

1.TSH levels are subject to circadian variation, reaching peak levels between 2 - 4.a.m. and at a minimum between6-10 pm .The variation is of the order of 50% . hence time of the day has influence on the measured serum TSH concentrations

2. Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.

3. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy. 4. Clinical Use: Primary Hypothyroidism, Hyperthyroidism, Hypothalamic – Pituitary hypothyroidism, Inappropriate TSH secretion, Nonthyroidal illness, Autoimmune thyroid disease, Pregnancy associated thyroid disorders.

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL
1st Trimester	0.05 – 3.70
2nd Trimester	0.31 – 4.35
3rd Trimester	0.41– 5.18

*** End Of Report ***

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HEALIC MULTISPECIALITY CLINIC

ExStart

TANYA / 34 Yrs / F / 0 Cms / 0 Kg / HR : 91

Date: 03 - 09 - 2024   METS: **1.0/ 91** bpm **49%** of THR   BP: **---/--- mmHg**   Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/LF 35   Hz

4X   **80 mS Post J**

ExTime: **00:00   0.0** mph,   **0.0%**
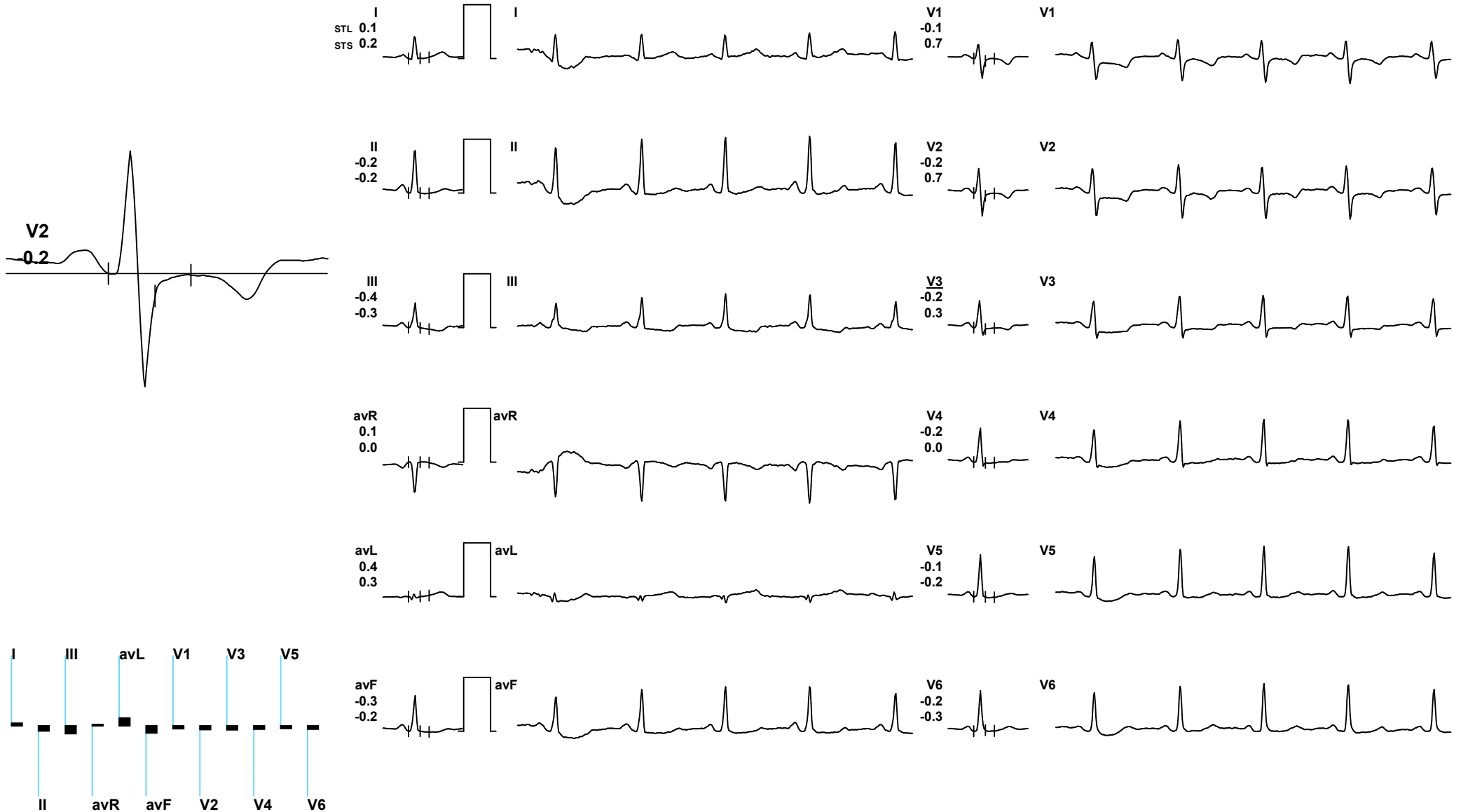
25 mm/Sec.   1.0 Cm/mV

REMARKS:

TANYA / 34 Yrs / F / 0 Cms / 0 Kg / HR : 120

Date: 03 - 09 - 2024   METS: **4.7/ 120** bpm **65%** of THR   BP: **100/67 mmHg**   Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/LF 35   Hz   ExTime: **03:00** 1.7 mph, **10.0%**

4X   **80 mS Post J**   25 mm/Sec.   1.0 Cm/mV

V2
-0.3

Lead	STL/STS values		Lead	values
I	STL -0.1 / STS 0.6		V1	0.0 / 0.2
II	-0.6 / 0.1		V2	-0.3 / 0.3
III	-0.6 / -0.4		V3	-0.5 / 0.0
avR	0.3 / -0.3		V4	-0.6 / -0.1
avL	0.0 / 0.2		V5	-0.6 / -0.3
avF	-0.6 / -0.1		V6	-0.6 / -0.2

I   III   avL   V1   V3   V5

II   avR   avF   V2   V4   V6
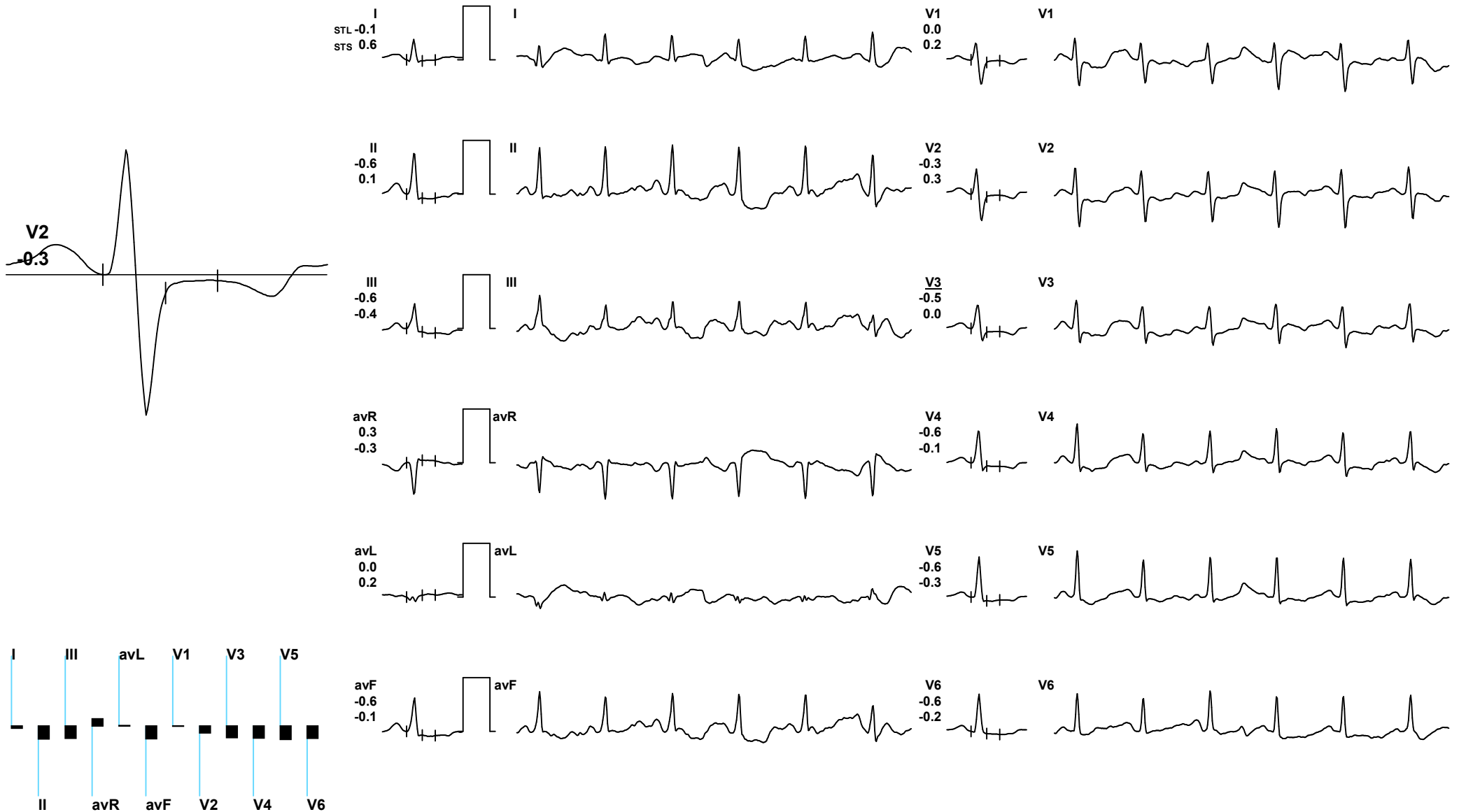
REMARKS:

TANYA / 34 Yrs / F / 0 Cms / 0 Kg / HR : 144

Date: 03 - 09 - 2024   METS: **7.1**/ **144** bpm **77%** of THR   BP: **101/68 mmHg**   Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/LF 35   Hz   ExTime: **06:00** **2.5** mph, **12.0%**

4X   **60 mS Post J**   **25 mm/Sec.   1.0 Cm/mV**

V2
1.6

I
STL -1.3
STS 0.0

I

V1
-0.7
2.0

V1

II
-3.6
0.3

II

V2
-1.6
2.2

V2

III
-2.1
0.7

III

V3
-2.5
1.0

V3

avR
2.5
0.1

avR

V4
-2.4
0.6

V4

avL
0.4
-0.3

avL

V5
-2.2
0.5

V5

I III avL V1 V3 V5

II avR avF V2 V4 V6

avF
-2.8
0.5

avF

V6
-2.1
-0.4

V6

REMARKS:

HEALIC MULTISPECIALITY CLINIC

PeakEx
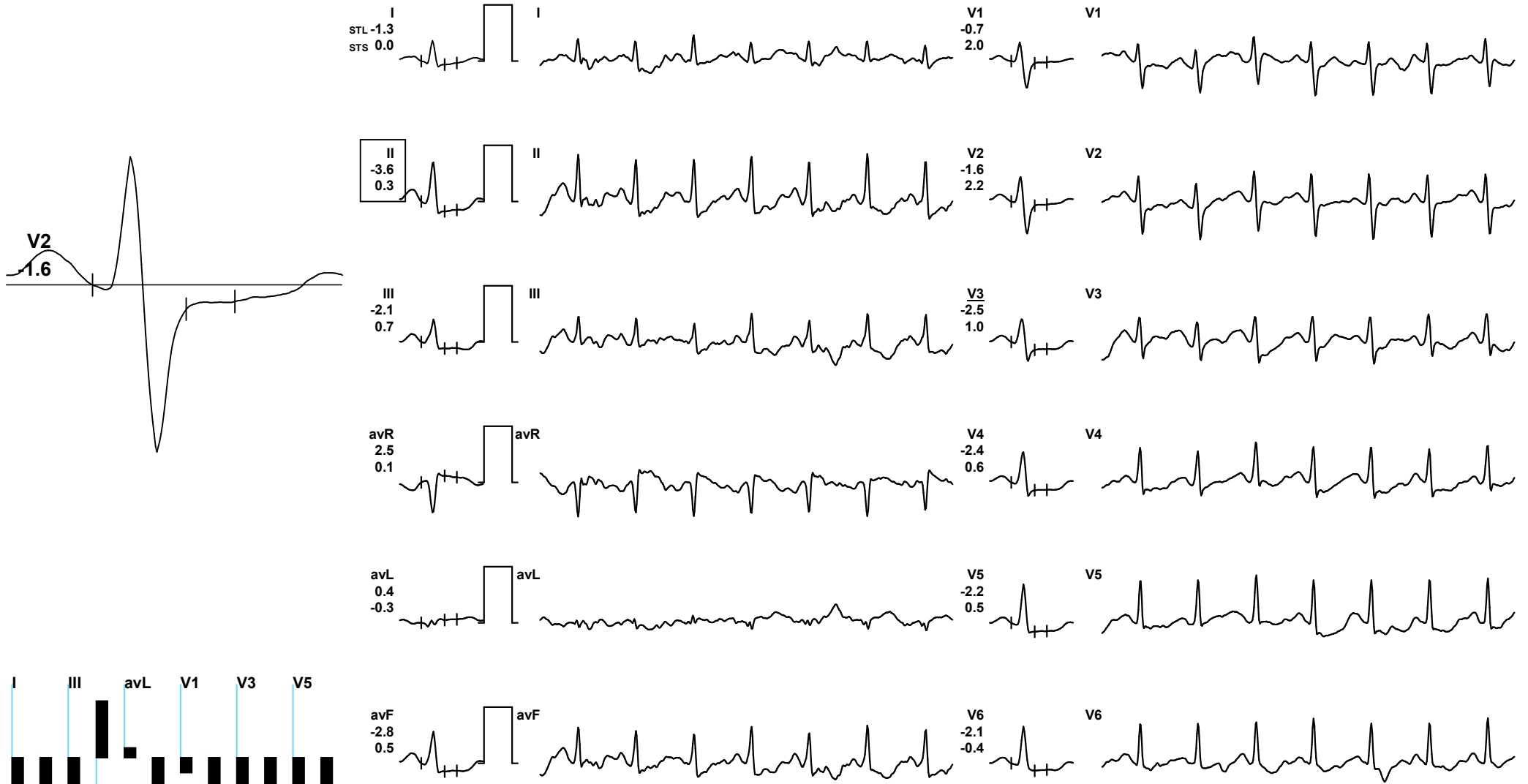
TANYA / 34 Yrs / F / 0 Cms / 0 Kg / HR : 150

Date: 03 - 09 - 2024   METS: **7.9/ 150** bpm **81%** of THR   BP: **101/68 mmHg**   Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/LF 35   Hz   ExTime: **06:48** **3.4** mph, **14.0%**

4X   **60 mS Post J**   **25 mm/Sec. 1.0 Cm/mV**

V2
-0.4

Lead	STL	STS
I	0.4	1.3
II	-1.1	0.4
III	-1.5	-0.5
avR	0.4	-0.7
avL	1.2	1.4
avF	-1.3	-0.1
V1	-0.1	1.7
V2	-0.4	1.8
V3	-1.0	0.9
V4	-1.4	0.3
V5	-1.3	0.7
V6	-1.3	-0.2

I   III   avL   V1   V3   V5

II   avR   avF   V2   V4   V6

REMARKS:

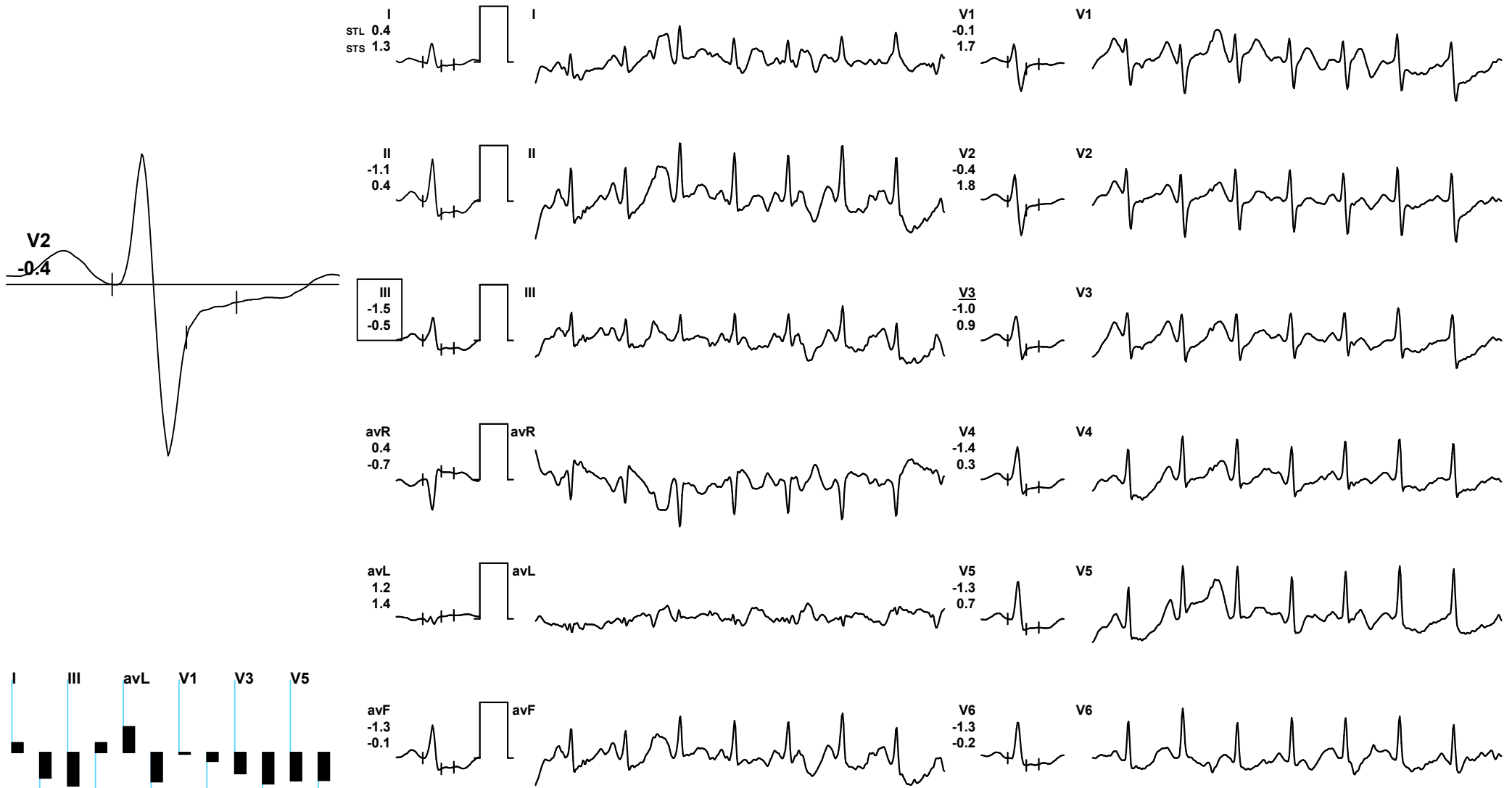*TANYA / 34 Yrs / F / 0 Cms / 0 Kg / HR : 152*

Date: 03 - 09 - 2024   METS: **5.9/ 152** bpm **82%** of THR   BP: **101/68 mmHg**   Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/LF 35   Hz   ExTime: **06:48   0.0** mph,   **0.0%**

4X   **60 mS Post J**   25 mm/Sec.   1.0 Cm/mV

V2
−0.4

Lead	STL	STS
I	-0.2	0.7
II	-1.7	0.7
III	-1.5	0.1
avR	1.0	-0.7
avL	0.5	0.1
avF	-1.6	0.4
V1	-0.1	1.6
V2	-0.4	2.2
V3	-0.9	1.3
V4	-1.2	1.0
V5	-1.4	0.3
V6	-1.3	0.2

I   III   avL   V1   V3   V5
II   avR   avF   V2   V4   V6

REMARKS:

HEALIC MULTISPECIALITY CLINIC

Report

C-3, PLOT NO GH-11, AHINSHA KHAND-2, INDRAPURAM EMail:

TANYA / 34 Yrs / F / 0 Cms / 0 Kg
Date: 03 - 09 - 2024
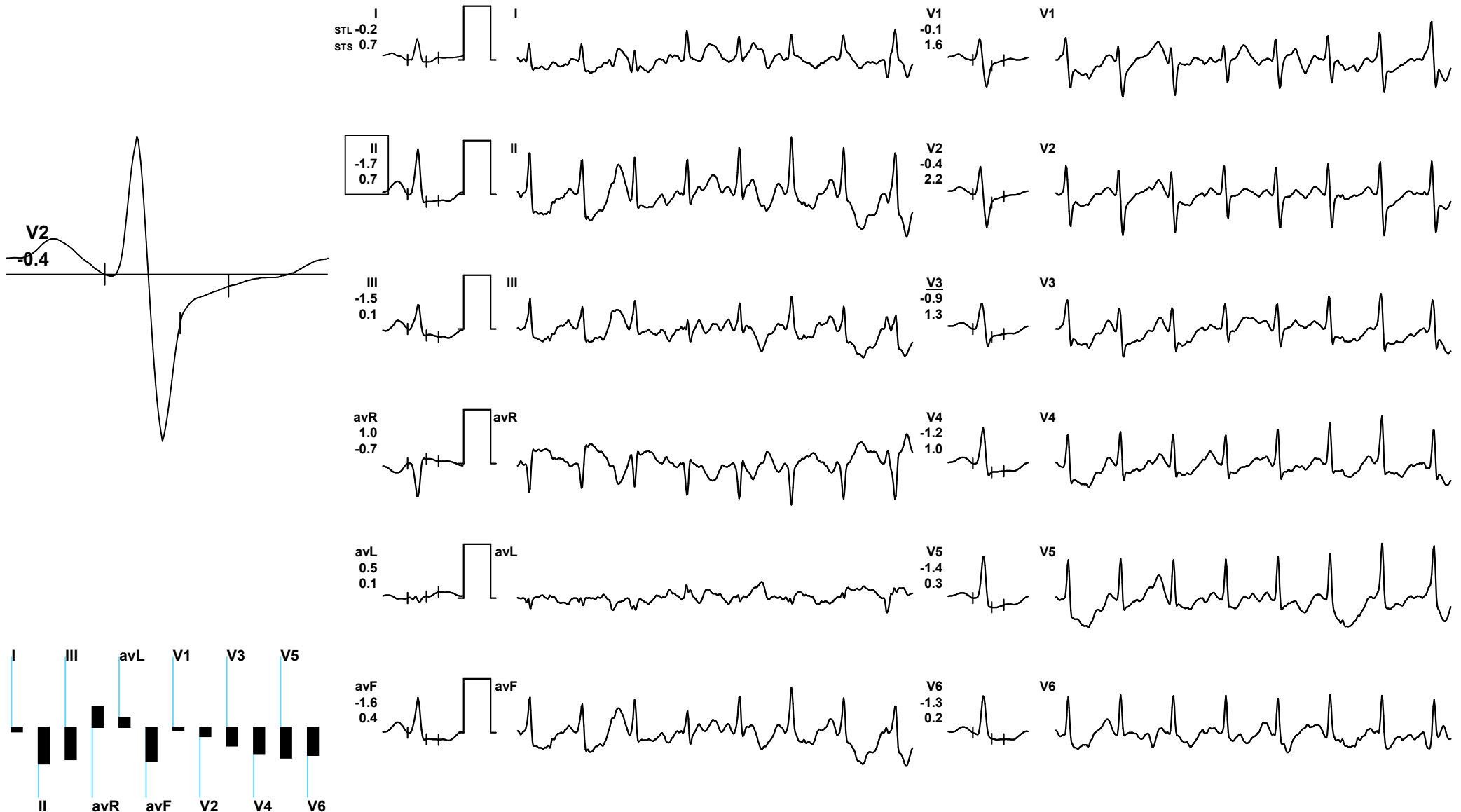
Stage	Time	Duration	Speed(mph)	Elevation	METs	Rate	% THR	BP	RPP	PVC	Comments
ExStart	01:03	1:03	00.0	00.0	01.0	091	49 %	---/---	000	00	
BRUCE Stage 1	04:03	3:00	01.7	10.0	04.7	120	65 %	100/67	120	00	
BRUCE Stage 2	07:03	3:00	02.5	12.0	07.1	144	77 %	101/68	145	00	
PeakEx	07:51	0:48	03.4	14.0	07.9	150	81 %	101/68	151	00	
Recovery	08:03	0:12	00.0	00.0	05.9	152	82 %	101/68	153	00	

FINDINGS :

Exercise Time	: 06:48	
Initial HR (ExStrt)	: 91 bpm 49% of Target 186	**Max HR Attained** 152 bpm 82% of Target 186
Initial BP (ExStrt)	: 0/0 (mm/Hg)	**Max BP Attained** 101/68 (mm/Hg)
Max WorkLoad Attained	: 7.9 Fair response to induced stress	
Max ST Dep Lead & Avg ST Value	: III & -1.5 mm in Recovery	
Test End Reasons	: Test Complete	

REPORT :

Doctor : BIRENDRA