



Crystalcare Hospitals

Reg. No.: DHO Thane - 09/2022-23

INDUSTRIAL HEALTH SERVICES

26/8/2023

Mr. Parag Sontakke.
40/m

Height - 174 cm

Weight - 93 kg

BMI - 30.7 kg/m²
obese class-1

B.P. - 150/100

CXR - O.K.
ECG - O.K.

USG - feetly done

Kidney HTN on Rx : 1 yr.
& DM on Rx : 6 months.

no any allergy to any medicines

family H/O father suffering from HTN/DM.

Adv

- Blood test
- Echo

Adv

- salt restricted
- diet
- exercise

pt fit & he can perform his normal duties.

↑ cholesterol, HBA1c ↑

Please consult physician.



Neera Arcade, opp. to Gurudwara on Mumbai Nashik Highway, Asangaon, Shahapur, Thane PIN - 421601
E : ohs.crystalcare@gmail.com W : www.crystalcarehospitals.com T : 080 6901 5530 M : 9769545533

Male
Years
Req. No. :

26-08-2023 09:02:55 AM

HR	: 76	bpm
P	: 103	ms
PR	: 148	ms
QRS	: 84	ms
QT/QTcBz	: 365/413	ms
P/QRS/T	: 21/41/21	ms
RV5/SV1	: 1.22/0.563	mV

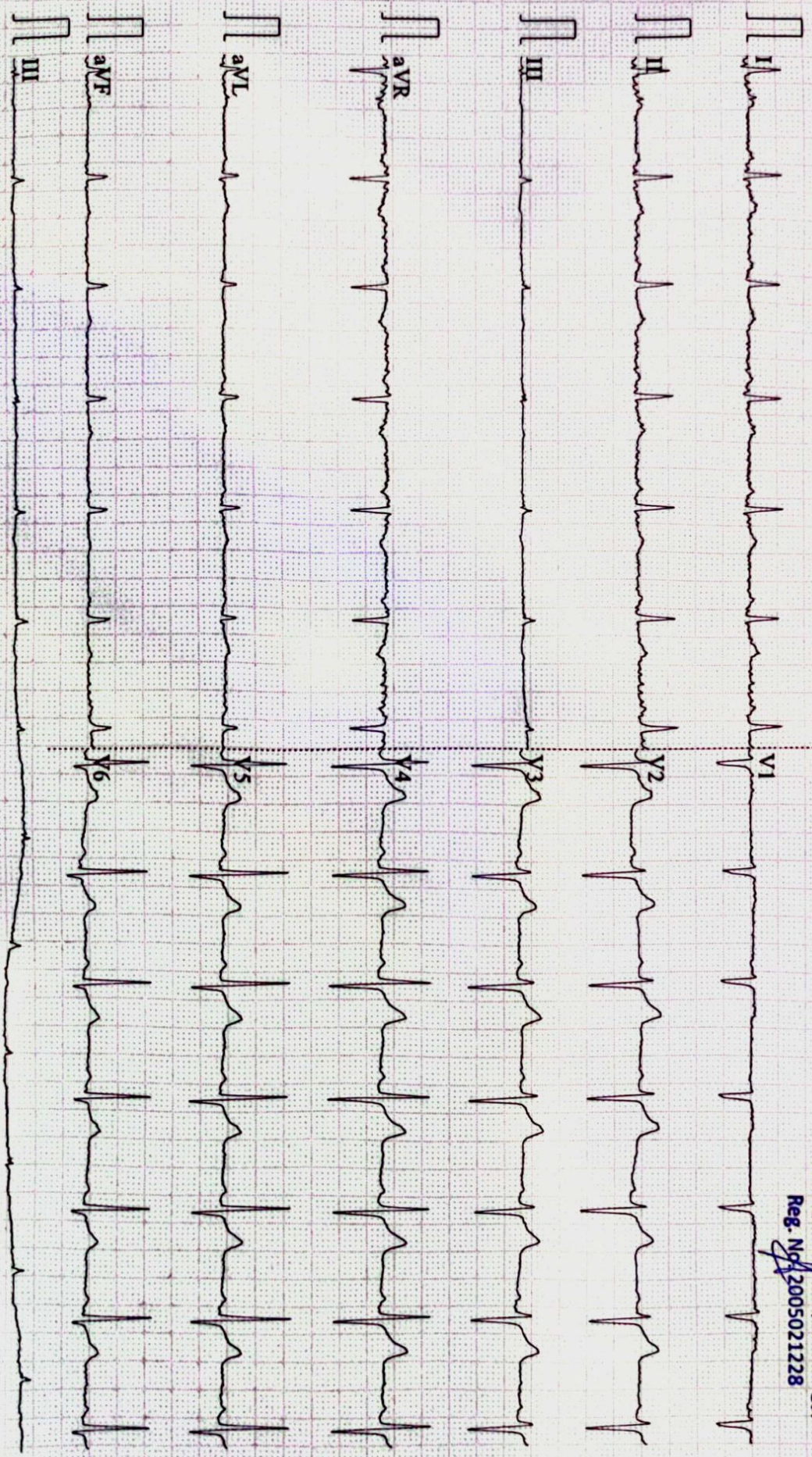
Diagnosis Information:

Sinus Rhythm
Normal ECG

NSH
NO SPECIFIC ST-T CHANGES
NO ACTIVE INTERVENTION REQUIRED
RIGHT HAND

Report Confirmed by:

Dr. Anant Ramkishanrao Munde
MBBS, DNB, DM (Cardiology)
Reg. No. 2005021228



0.25-35Hz AC50 25mm/s 10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivivayak Hospital



Sonography Colour Doppler 3D / 4D USG	
Name - Mr. Parag Sontakke	Age - 40 Y/M
Ref by Dr.- Siddhivinayak Hospital	Date- 26/08/2023

USG ABDOMEN & PELVIS

Clinical details:- Routine

The Liver is normal in size and shows raised echogenicity. There is no obvious abnormal focal lesion seen. There is no IHBR dilatation seen in both the lobes of the liver.

The CBD and the Portal vein appear normal.

The Gall bladder is well distended & appears normal. No calculi or filling defects are seen. No evidence of Pericholecystic collection. The wall thickness is normal.

Right Kidney measures 11.5 x 5.5 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.

Left Kidney measures 10.8 x 5.2 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.

The Pancreas is normal in size & shows homogenous echopattern. It shows no focal lesion.

The Spleen is normal in size (10.6 cm) with homogenous echotexture.

The urinary bladder is partially distended and appears normal. There is no evidence of any obvious calculi or any mass lesion seen. Both Uretero-vesical junctions appear clear. No abnormal intraluminal lesion noted.

Prostate appears normal in size measures 24 cc. The echotexture pattern is normal. there is no obvious focal lesion seen.

No free fluid or obvious lymphadenopathy is seen in abdomen and pelvis.

IMPRESSION:

- Fatty liver

Adv.: Clinical and lab correlation.


DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis. Second opinion is always advisable.





Name - Mr. Parag Sontakke	Age 40 Y/M
Ref by Dr.- Siddhivinayak Hospital	Date - 26/08/2023

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





ECHOCARDIOGRAM

NAME	MR. PARAG SONTAKKE
AGE/SEX	40 YRS/M
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DOCTOR	DR. ANANT MUNDE, DNB, DM (CARDIOLOGY)
DATE OF EXAMINATION	26/08/2023

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	CHAMBERS: LEFT ATRIUM: Normal LEFT VENTRICLE: Moderate concentric LV hypertrophy <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
GREAT VESSELS: <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	SEPTAE: <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact
CORONARIES: Proximal coronaries normal CORONARY SINUS: Normal PULMONARY VEINS: Normal	VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	22 mm	Left atrium	34 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	40.6 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	25.3 mm	RVEF	%
Ascending aorta	mm	IVSd	15.3 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	13.3 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	68 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	13.2 mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

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	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.34	1.19
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm ²)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)				
REGURGITATION		TRJV= m/s PASP= mmHg		
E/A	E<A			
E/E'				

FINAL IMPRESSION: HYPERTENSIVE HEART DISEASE

- No RWMA
- Normal LV systolic function (LVEF: 68%)
- Moderate concentric LV hypertrophy
- Good RV systolic function
- Grade I diastolic dysfunction
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE: Control HTN

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

INTERVENTIONAL CARDIOLOGIST

Dr. Anant Ramkishanrao Munde

MBBS, DNB, DM (Cardiology)

Reg. No. 2005021228

OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

PARAG SONTTAK

AGE

40

DATE -

26.08.2023

Specs : Without Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/6	6/6
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS



S-1, Vedant Complex, Vartak Nagar, Thane (W) 400 606

E : ohs.svh@gmail.com W : www.siddhivinayakhospitals.org T. : 022 - 2588 3531 M. : 9769545533





MC-4661

Name : Mr. PARAG SONTAKKE Collected On : 26-Aug-2023 9:08 AM
 Lab ID. : 164912 Received On : 26-Aug-2023 9:18 AM
 Age/Sex : 40 Years /Male Reported On : 28-Aug-2023 12:42 PM
 Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL

***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	215.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	33.0	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease: >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	198.6	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	40	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	142	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	4.30		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	6.52		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

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

Checked By
SHAISTA Q

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





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**COMPLETE BLOOD COUNT**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	15.1	gm/dl	13 - 18
HEMATOCRIT (PCV)	45.3	%	42 - 52
RBC COUNT	5.17	$\times 10^6/\mu\text{L}$	4.70 - 6.50
MCV	88	fl	80 - 96
MCH	29.2	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	13.8	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	8450	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	49	%	40 - 80
LYMPHOCYTES	40	%	20 - 40
EOSINOPHILS	05	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	309000	/cumm	150000 - 450000
MPV	9.7	fl	6.5 - 11.5
PDW	15.9	%	9.0 - 17.0
PCT	0.300	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

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

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HEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	32	mm/1hr.	0 - 20

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

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**URINE ROUTINE EXAMINATION**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
VOLUME	30 ml		
COLOUR	Pale Yellow		
APPEARANCE	Slightly Hazy		
CHEMICAL EXAMINATION			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.015		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Absent		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	Absent		
PUS CELLS	2-3	/ HPF	0 - 5
EPITHELIAL	1-2	/ HPF	0 - 5

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MC-4661

Dr. Smita Ranveer's
Radiance
CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

Name : Mr. PARAG SONTAKKE Collected On : 26-Aug-2023 9:08 AM
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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CASTS	Absent		
CRYSTALS	Calcium Oxalate(Few)		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		
REMARK	Result relates to sample tested. Kindly correlate with clinical findings. Result relates to sample tested, Kindly correlate with clinical findings. ----- END OF REPORT -----		

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Age/Sex	: 40 Years /Male	Reported On	: 28-Aug-2023 12:42 PM
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: FINAL



IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>TFT (THYROID FUNCTION TEST)</u>			
SPACE		Space	-
SPECIMEN	Serum		
T3	118.9	ng/dl	84.63 - 201.8
T4	10.03	µg/dl	5.13 - 14.06
TSH	0.429	µIU/ml	0.270 - 4.20
T3 (Triido Thyronine hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating hormone)	
AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

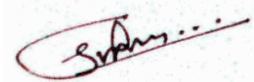
INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

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

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MC-4661

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GROUP</u>			
SPECIMEN	WHOLE BLOOD		
* ABO GROUP	'O'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
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***BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	24.7	mg/dL	19 - 45
BLOOD UREA NITROGEN (Calculated)	11.54	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.83	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	6.7	mg/dL	3.5 - 7.2
S. SODIUM (ISE Direct Method)	138.8	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.71	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	104.7	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.72	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	10.0	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.85	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.32	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.53	g/dl	1.9 - 3.5
A/G RATIO (Calculated)	1.71		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

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

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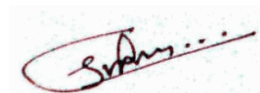
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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Normocytic Normochromic
WBC	Total leucocyte count is normal on smear.
	Neutrophils:51 %
	Lymphocytes:39 %
	Monocytes:06 %
	Eosinophils:04 %
	Basophils:00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No parasite seen.
Result relates to sample tested, Kindly correlate with clinical findings.	
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**LIVER FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.61	mg/dL	0.0 - 2.0
DIRECT BILLIRUBIN (Method-Diazo)	0.25	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.36	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	10.6	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	21.2	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	74.0	U/L	53 - 128
S. PROTIEN (Method-Biuret)	6.85	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.32	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.53	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.71		0 - 2

METHOD - EM200 Fully Automatic

Result relates to sample tested, Kindly correlate with clinical findings.

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BIOCHEMISTRY

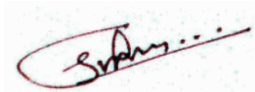
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	41.0	U/L	13 - 109
<u>GLYCOCELATED HEMOGLOBIN (HBA1C)</u>			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	8.7	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	203.0	mg/dL	NON - DIABETIC : <=5.6 PRE - DIABETIC : 5.7 - 6.4 DIABETIC : >6.5

METHOD Particle Enhanced Immunoturbidimetry
 HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood. It indicates average blood sugar level over past three months.

Result relates to sample tested, Kindly correlate with clinical findings.

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