

Patient Name : Mr. Subhash Eknath Ghangale

Reg.Date / Time : 08/03/2024 / 12:50:28

Age / Gender : 39 Y / Male

Report Date / Time : 08/03/2024 / 18:10:22

Referred By : Dr. Gail Chaudhari

MR No. : 0849317

SID No. : 40013318

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

HAEMOGLOBIN, RED CELL COUNT & INDICES

HAEMOGLOBIN (Spectrophotometry)	14.2	gm%	13-17
PCV (Electrical Impedance)	40.4	%	40 - 50
MCV (Calculated)	88.4	fL	83-101
MCH (Calculated)	31.0	pg	27.0 - 32.0
MCHC (Calculated)	35.1	g/dl	31.5-34.5
RDW-CV (Calculated)	14	%	11.6-14.0
RDW-SD (Calculated)	51	fL	36 - 46
TOTAL RBC COUNT (Electrical Impedance)	4.57	Million/cmm	4.5-5.5
TOTAL WBC COUNT (Electrical Impedance)	7270	/cumm	4000-10000

DIFFERENTIAL WBC COUNT

NEUTROPHILS (Flow cell)	70.1	%	40-80
LYMPHOCYTES (Flow cell)	20.2	%	20-40
EOSINOPHILS (Flow cell)	0.7	%	1-6
MONOCYTES (Flow cell)	7.7	%	2-10
BASOPHILS (Flow cell)	1.3	%	1-2

ABSOLUTE WBC COUNT

ABSOLUTE NEUTROPHIL COUNT (Calculated)	5090	/cumm	2000-7000
ABSOLUTE LYMPHOCYTE COUNT (Calculated)	1460	/cumm	1000-3000

Contd ...

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HAEMATOLOGY

ABSOLUTE WBC COUNT

ABSOLUTE EOSINOPHIL COUNT (Calculated)	50	/cumm	200-500
ABSOLUTE MONOCYTE COUNT (Calculated)	560	/cumm	200-1000
ABSOLUTE BASOPHIL COUNT (Calculated)	90	/cumm	0-220
PLATELET COUNT (Electrical Impedance)	287000	/cumm	150000-410000
MPV (Calculated)	8.4	fL	6.78-13.46
PDW (Calculated)	11.6	%	11-18
PCT (Calculated)	0.240	%	0.15-0.50

PERIPHERAL BLOOD SMEAR

COMMENTS
(Microscopic)

Normocytic Normochromic RBCs

Sample Collected at : Andheri West

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Dr. Rahul Jain

MD, PATHOLOGY

Consultant Pathologist

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HAEMATOLOGY

EDTA Blood **ABO BLOOD GROUP**

BLOOD GROUP
(Erythrocyte-Magnetized Technology) O

Rh TYPE
(Erythrocyte-Magnetized Technology) POSITIVE

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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	8	mm / 1 hr	0-15
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Notes : The given result is measured at the end of first hour.

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BIOCHEMISTRY

COMPREHENSIVE LIVER PROFILE

SERUM

BILIRUBIN TOTAL (Diazotization)	1.48	mg/dl	0.2 - 1.3
BILIRUBIN DIRECT (Diazotization)	0.21	mg/dl	0.1-0.4
BILIRUBIN INDIRECT (Calculation)	1.27	mg/dl	0.2 - 0.7
ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	21	U/L	<40
ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	21	U/L	<41
ALKALINE PHOSPHATASE (Colorimetric IFCC)	72	U/L	40-129
GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	26	U/L	<70
TOTAL PROTEIN (Colorimetric)	7.20	gm/dl	6.6-8.7
ALBUMIN (Bromocresol Green)	4.60	gm/dl	3.5 - 5.2
GLOBULIN (Calculation)	2.60	gm/dl	2.0-3.5
A/G RATIO (Calculation)	1.8		1-2

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BIOCHEMISTRY

COMPREHENSIVE RENAL PROFILE

SERUM

CREATININE (Jaffe Method)	1.0	mg/dl	0.6 - 1.3
BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	8.0	mg/dl	6 - 20
BUN/CREATININE RATIO (Calculation)	8.0		10 - 20
URIC ACID (Uricase Enzyme)	7.1	mg/dl	3.7 - 7.7
CALCIUM (Bapta Method)	9.1	mg/dl	8.6-10
PHOSPHORUS (Phosphomolybdate)	3.0	mg/dl	2.5-4.5

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BIOCHEMISTRY

LIPID PROFILE

SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	172	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239
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Notes : Elevated concentrations of free fatty acids and denatured proteins may cause falsely elevated HDL cholesterol results.

Abnormal liver function affects lipid metabolism; consequently, HDL and LDL results are of limited diagnostic value. In some patients with abnormal liver function, the HDL cholesterol result may significantly differ from the DCM (designated comparison method) result due to the presence of lipoproteins with abnormal lipid distribution.

Reference: Dati F, Metzmann E. Proteins Laboratory Testing and Clinical Use, Verlag: DiaSys; 1. Auflage (September 2005), page 242-243; ISBN-10: 3000171665.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	194	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499
SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	36	mg/dl	Low:<40 High:>60
SERUM	LDL CHOLESTEROL (Calculation)	97	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	39	mg/dl	15-40
SERUM	CHOL / HDL RATIO	4.8		3-5
SERUM	LDL /HDL RATIO (Calculation)	2.7		0 - 3.5

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BIOCHEMISTRY

FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	101	mg/dl	70 - 110
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Notes : An early-morning increase in blood sugar (glucose) which occurs to some extent in all individuals, more relevant to people with diabetes can be seen (The dawn phenomenon) . Chronic Somogyi rebound is another explanation of phenomena of elevated blood sugars in the morning. Also called the Somogyi effect and posthypoglycemic hyperglycemia, it is a rebounding high blood sugar that is a response to low blood sugar.

References:

<http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BarbaraDavis/Documents/book-understandingdiabetes/ud06.pdf>, Understanding Diabetes.

FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	95	mg/dl	70 - 140
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BIOCHEMISTRY

EDTA WHOLE BLOOD GLYCOSYLATED HAEMOGLOBIN (HbA1C)

HbA1C (High Performance Liquid Chromatography)	5.2	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	103	mg/dl	

Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations. HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. *Diabetologia*, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. *Diabetes Care*, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. *Journal of Diabetes*, 2009, 1:9-17.

Urine URINE GLUCOSE FASTING ABSENT
(Urodip)

Urine URINE GLUCOSE POST PRANDIAL ABSENT
(Urodip)

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IMMUNOLOGY

THYROID PROFILE - TOTAL SERUM

TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.59	ng/ml	0.7-2.04
TOTAL THYROXINE (T4) (ECLIA)	9.46	ug/dl	4.6 - 10.5
THYROID STIMULATING HORMONE (TSH) (ECLIA)	2.103	uIU/ml	0.27 - 4.20

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IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level. The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)

- Low TSH, Low FT4 - Central hypothyroidism.
- Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
- Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter, Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
- Normal TSH, Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism, Medications.
- Normal TSH, High FT4- Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbuminemic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
- High TSH, Low FT4- Primary hypothyroidism.
- High TSH, Normal FT4- Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
- High TSH, High FT4- TSH mediated hyperthyroidism

Note:

1. Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2. Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3. Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:

1. Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2. "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3. Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4. Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

Contd ...

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Healthspring Corporate Office, 5th Floor, East Wing Fortis Building, Charanji Rai Marg, Fort, Mumbai - 400031

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CLINICAL PATHOLOGY

Urine URINE ANALYSIS

PHYSICAL EXAMINATION

VOLUME (Volumetric)	30		
COLOR (Visual Examination)	PALE YELLOW		
APPEARANCE (Visual Examination)	CLEAR		

CHEMICAL EXAMINATION

SP.GRAVITY (Indicator System)	1.015		1.005 - 1.030
REACTION(pH) (Double indicator)	ACIDIC		
PROTEIN (Protein-error-of-Indicators)	ABSENT		
GLUCOSE (GOD-POD)	ABSENT		Absent
KETONES (Legal's Test)	ABSENT		Absent
OCCULT BLOOD (Peroxidase activity)	ABSENT		Absent
BILIRUBIN (Fouchets Test)	ABSENT		Absent
UROBILINOGEN (Ehrlich Reaction)	NORMAL		
NITRITE (Griess Test)	ABSENT		

MICROSCOPIC EXAMINATION

ERYTHROCYTES (Microscopy)	ABSENT	/hpf	0-2
PUS CELLS (Microscopy)	2-3	/hpf	0-5
EPITHELIAL CELLS (Microscopy)	1-2	/hpf	0-5
CASTS (Microscopy)	ABSENT		
CRYSTALS (Microscopy)	ABSENT		
ANY OTHER FINDINGS	NIL		

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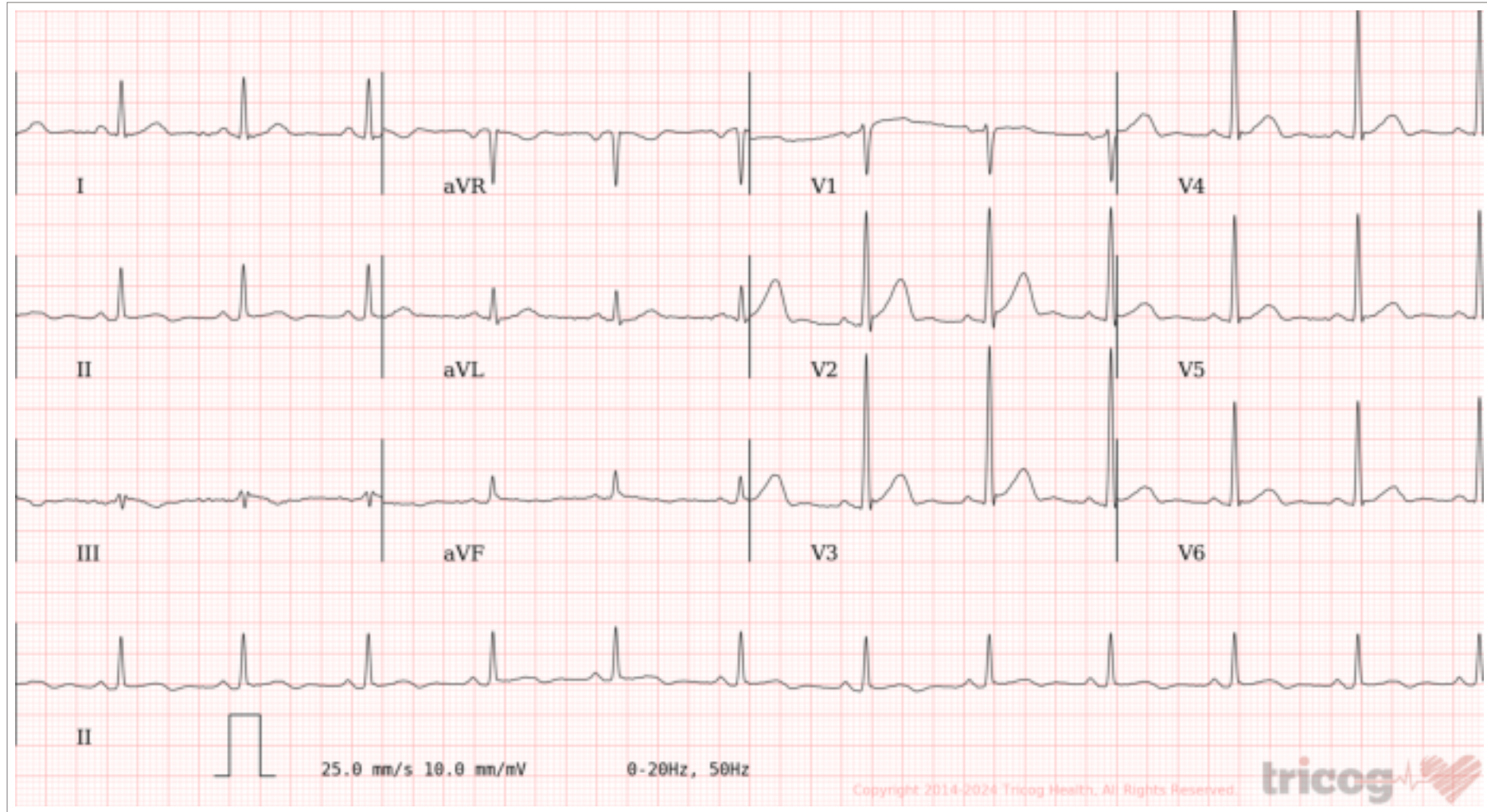
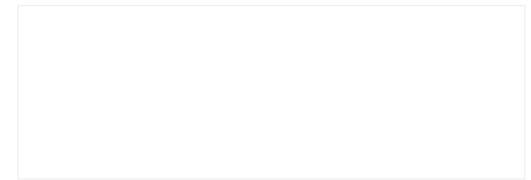
MD,PATHOLOGY

Consultant Pathologist

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Patient ID: 0849317
Patient Name: Subhash Eknath Ghangale

Date and Time: 8th Mar 24 10:44 AM



AR: 74bpm VR: 74bpm QRSD: 80ms QT: 348ms QTcB: 386ms PRI: 148ms P-R-T: 29° 29° NA

ECG Within Normal Limits: Sinus Rhythm. Please correlate clinically.

AUTHORIZED BY



Dr. Charit
MD, DM: Cardiology

63382

REPORTED BY



Dr. Nisar Ahammad K

KMC 122453



R

SUBHASH GHANGALE 39YRS

08/03/2024

HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 86bpm

B.P. 120/80

PRETEST

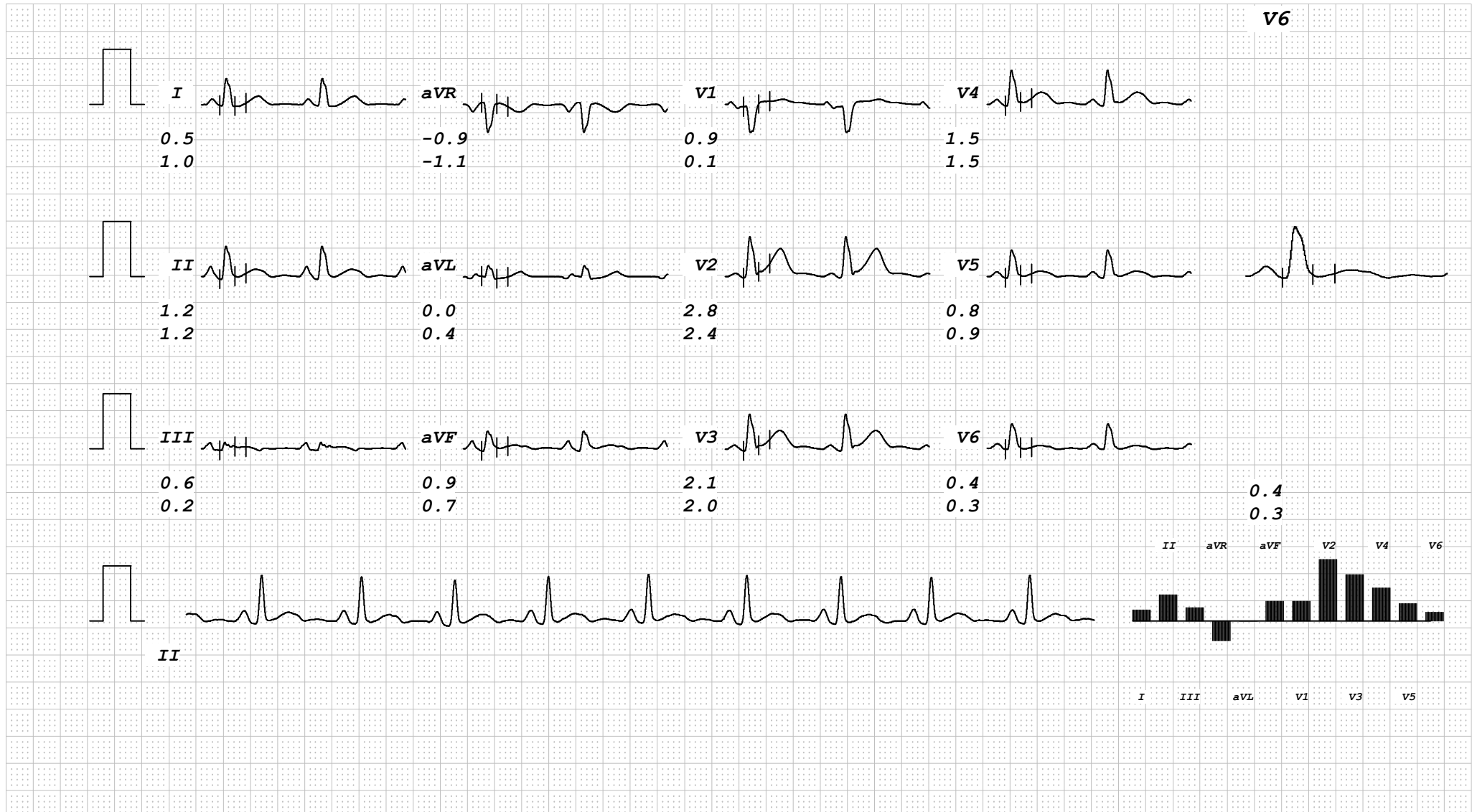
SUPINE

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 85bpm

B.P. 120/80

PRETEST

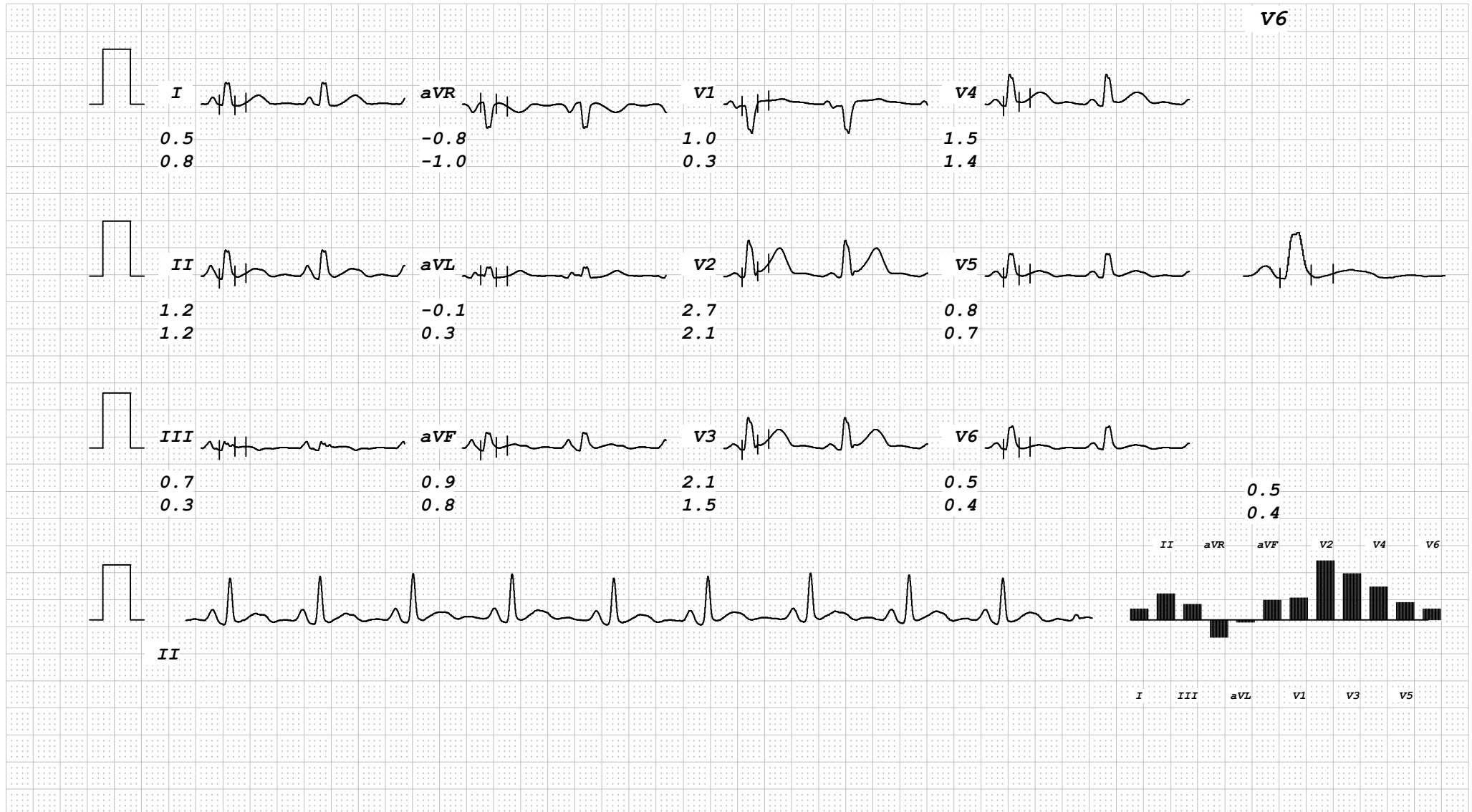
STANDING

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 87bpm

B.P. 120/80

PRETEST

HYPERVENT

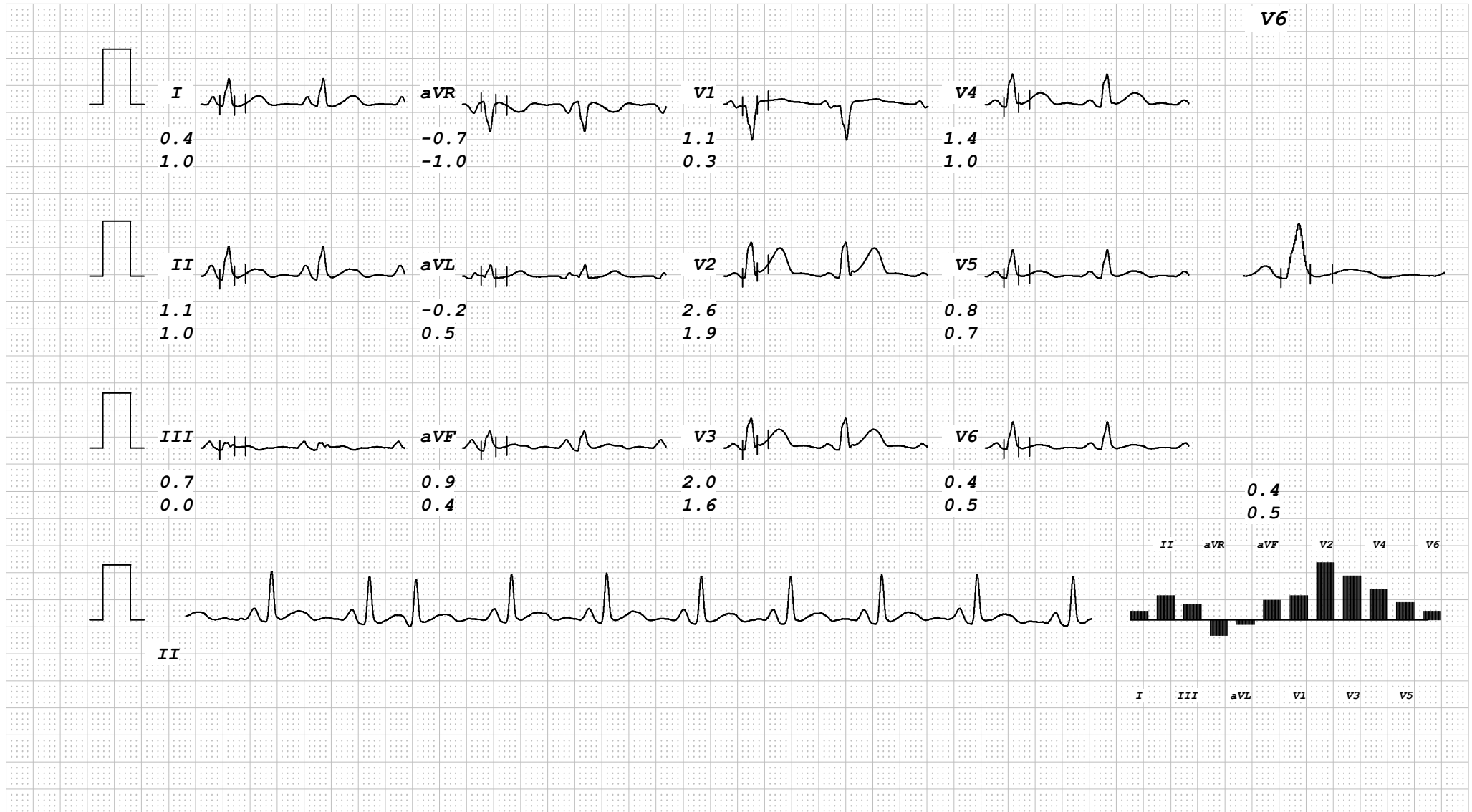
PHASE TIME 0:09

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 87bpm

B.P. 120/80

PRETEST

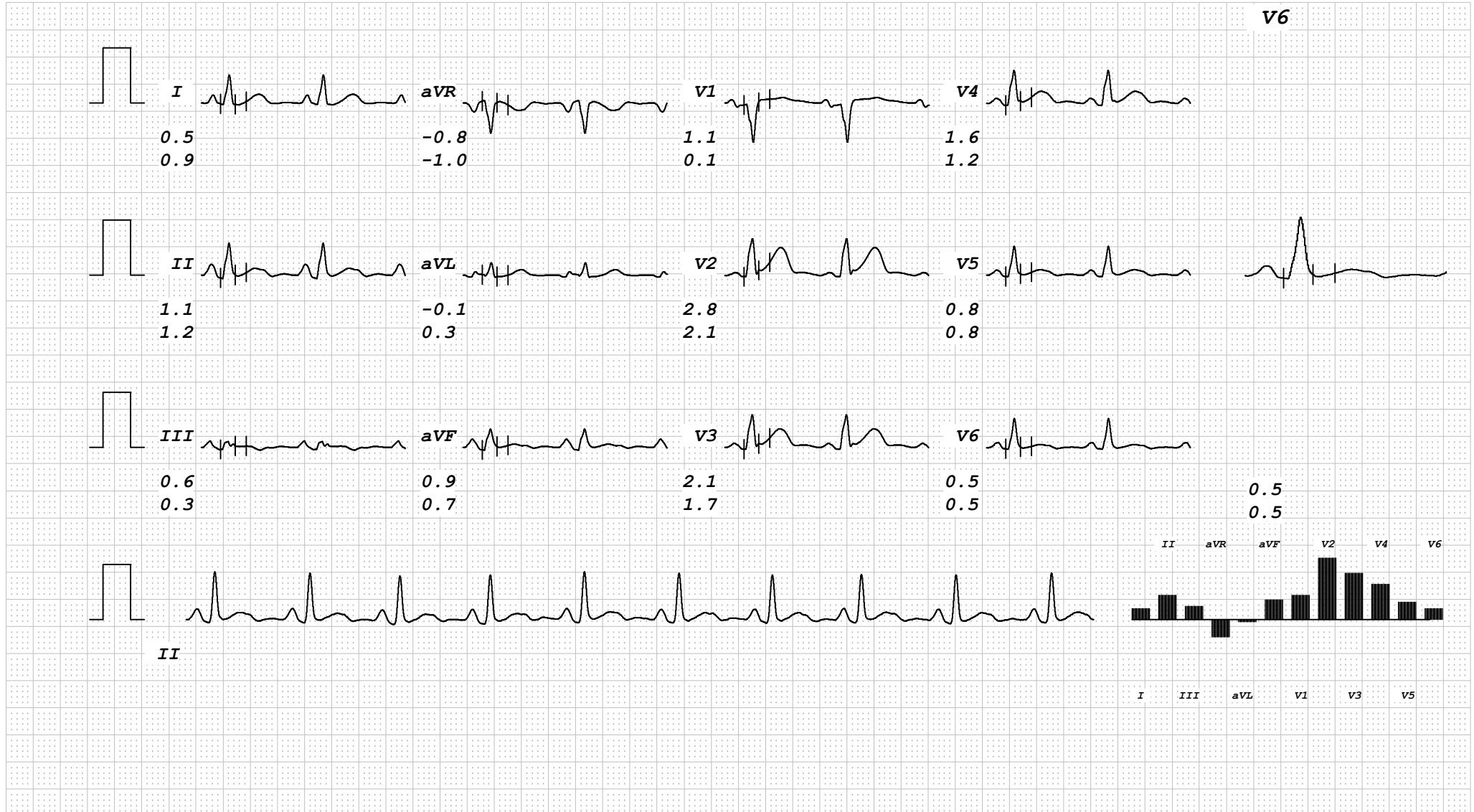
VALSALVA

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 109bpm

B.P. 130/90

Bruce

Stage 1

TOTAL TIME 2:55

PHASE TIME 2:55

ST @ 10mm/mV

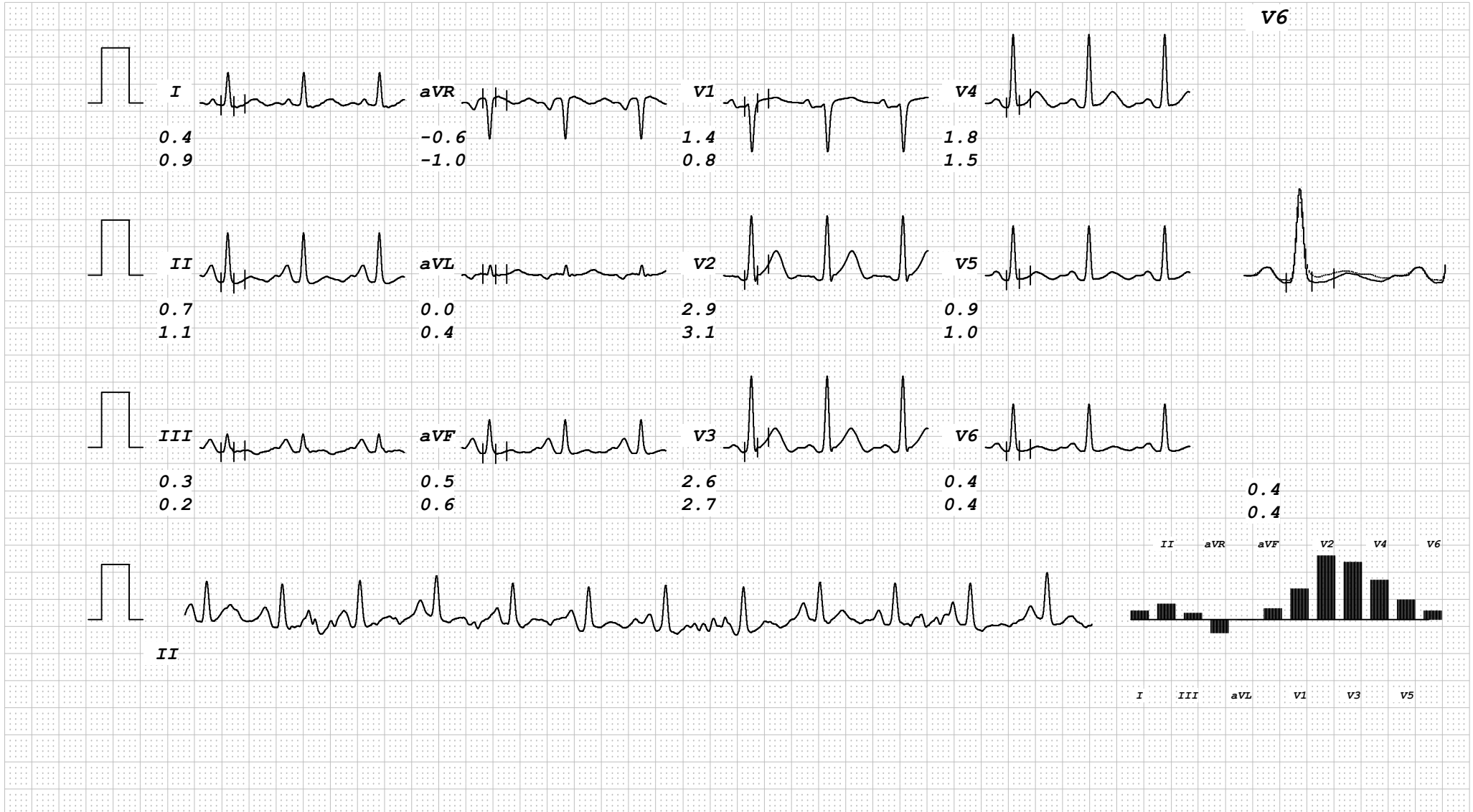
80ms PostJ

Speed 2.7 km/hr

SLOPE 10 %

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 131bpm

B.P. 140/90

Bruce

Stage 2

TOTAL TIME 5:55

PHASE TIME 2:55

ST @ 10mm/mV

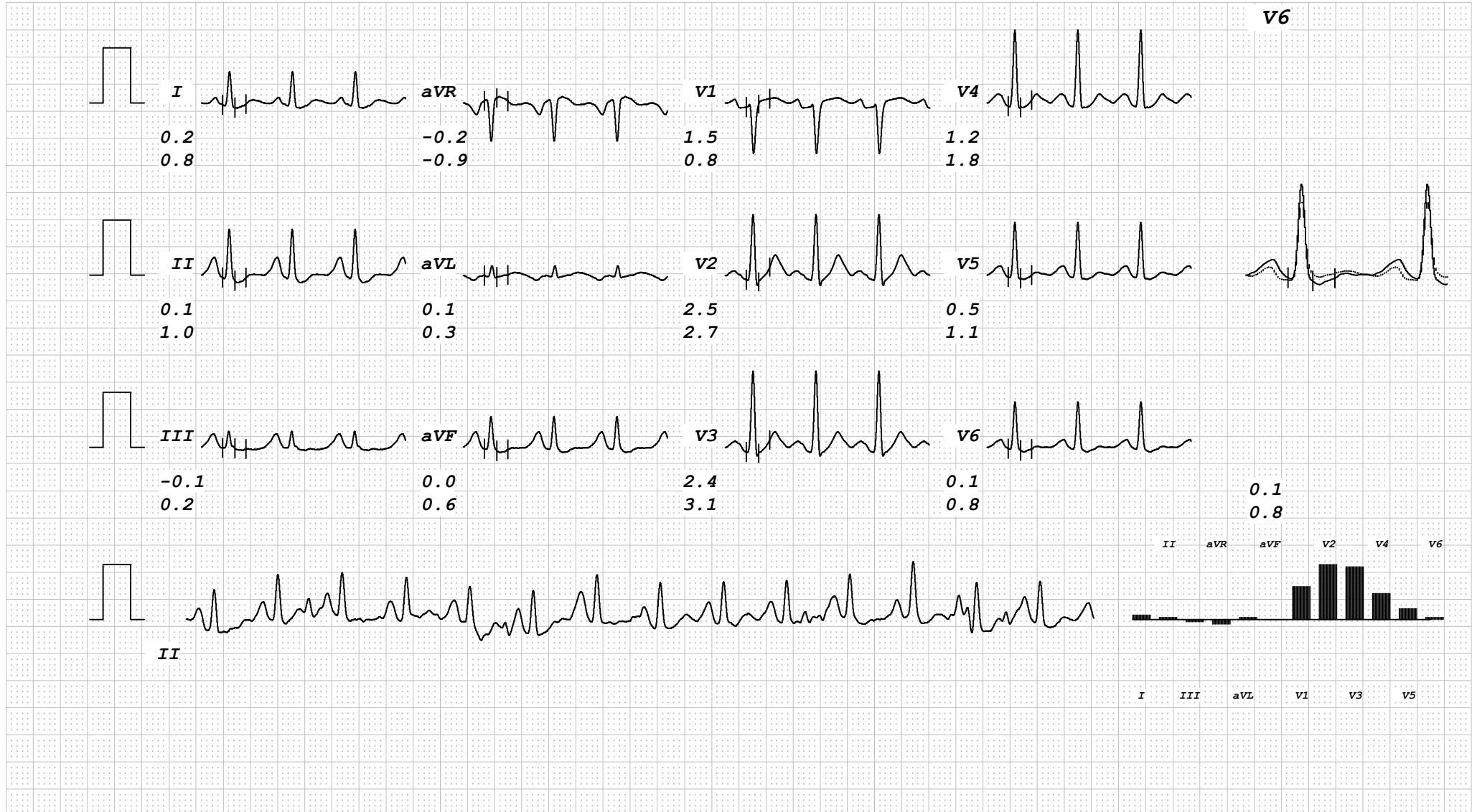
80ms PostJ

Speed 4 km/hr

SLOPE 12 %

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 153bpm

B.P. 150/100

Bruce

PK-EXERCISE

TOTAL TIME 8:07

PHASE TIME 2:07

ST @ 10mm/mV

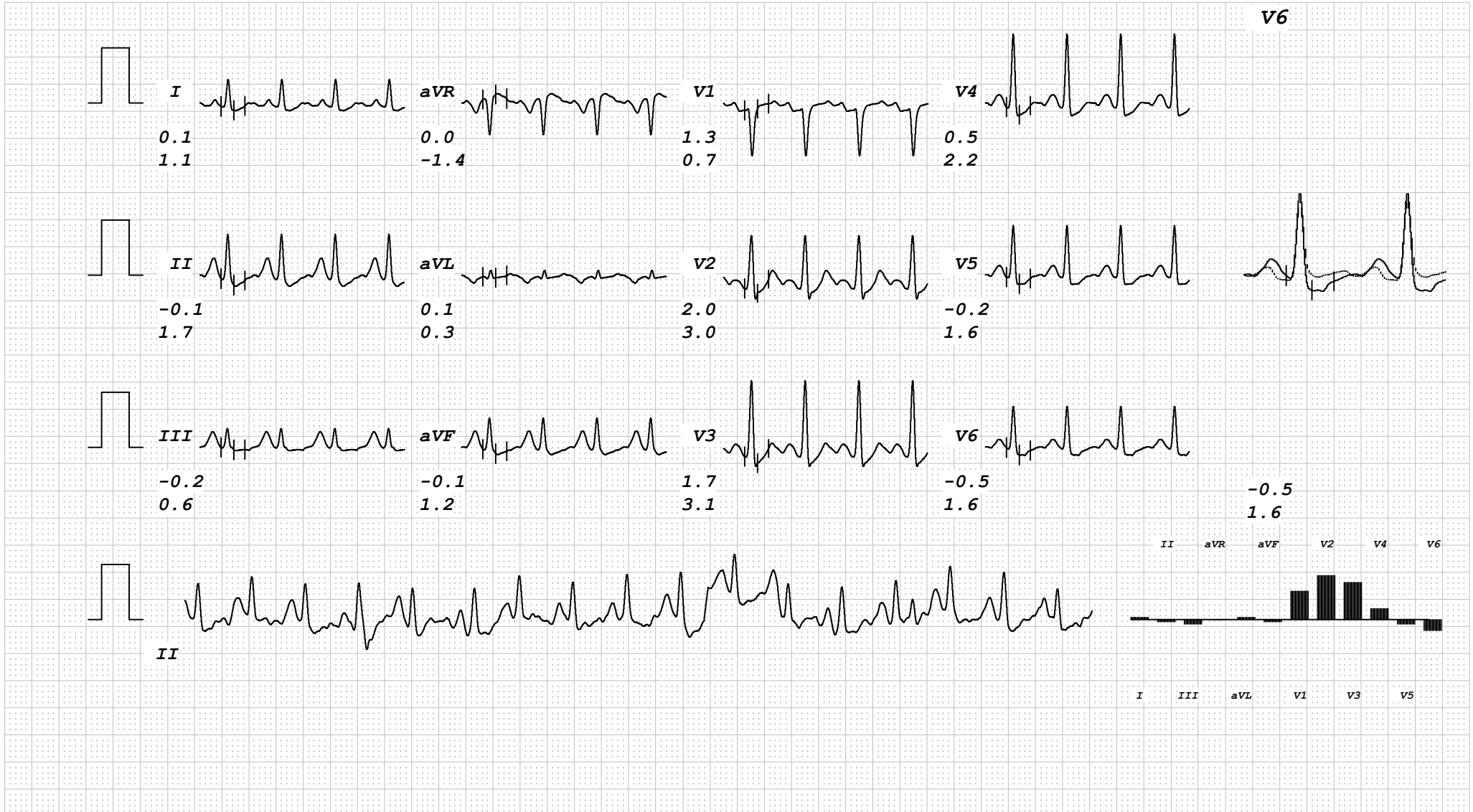
80ms PostJ

Speed 5.4 km/hr

SLOPE 14 %

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 125bpm

B.P. 150/100

Bruce

RECOVERY

TOTAL TIME 9:10

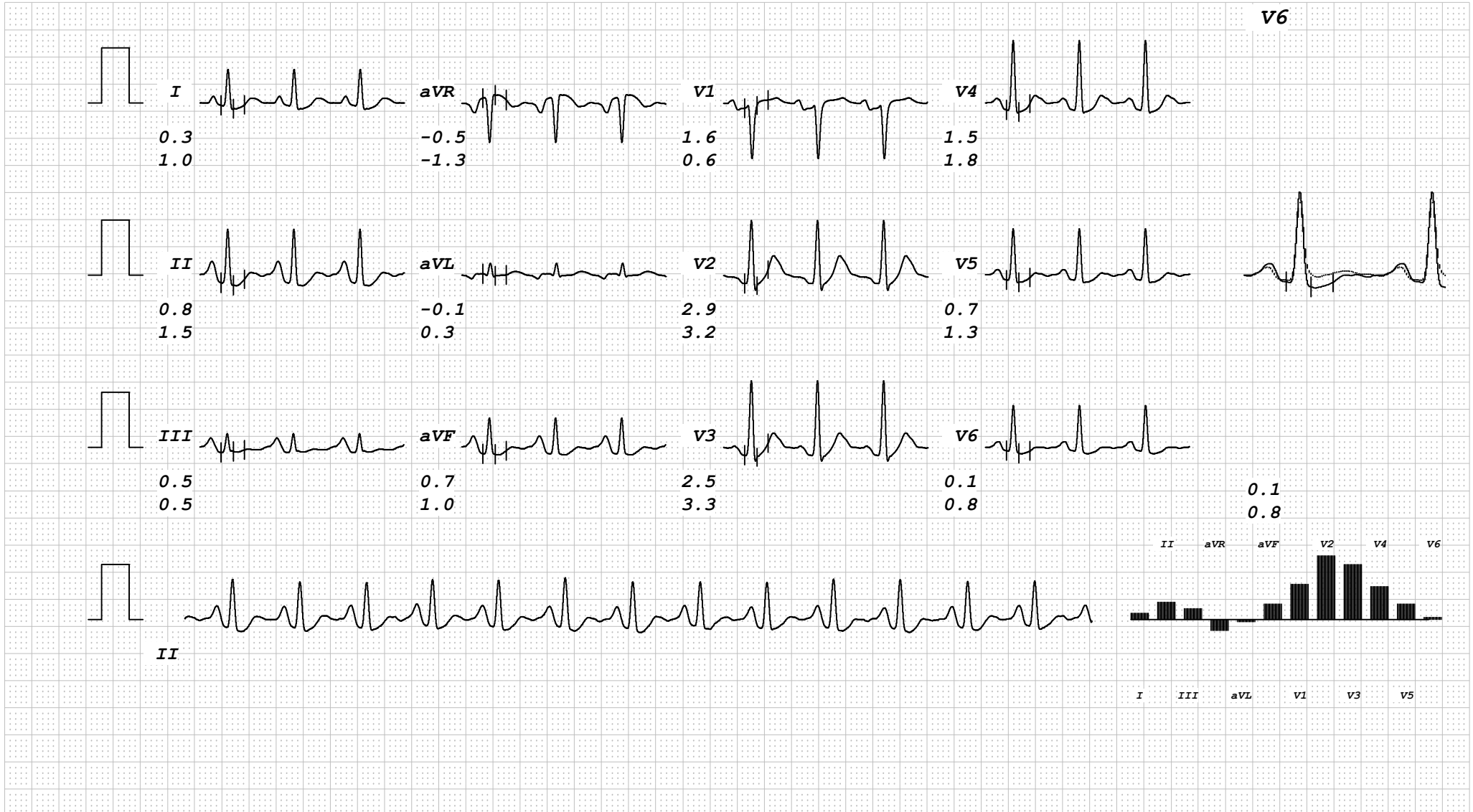
PHASE TIME 0:55

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 112bpm

B.P. 140/80

Bruce

RECOVERY

TOTAL TIME 10:10

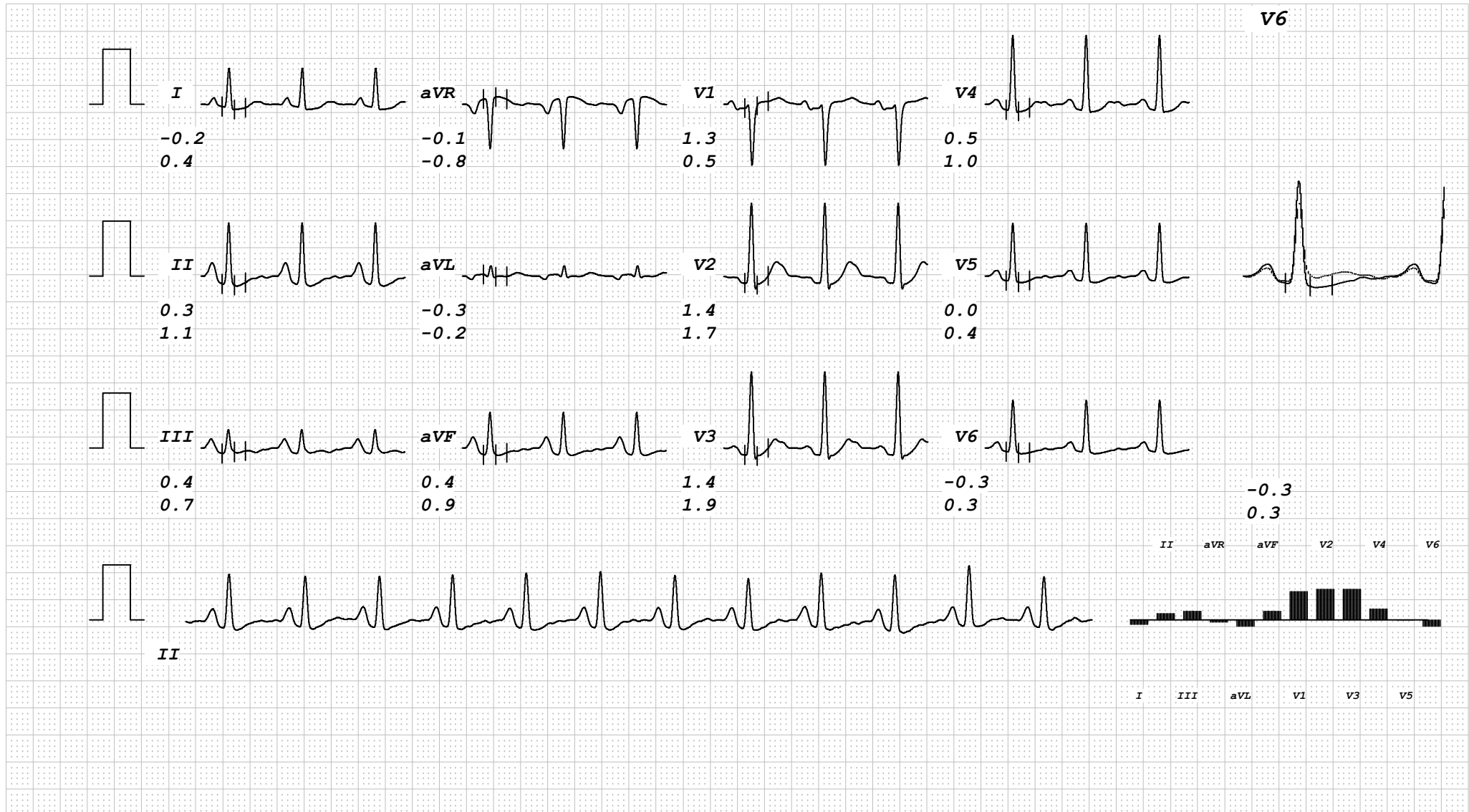
PHASE TIME 1:55

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 106bpm

B.P. 140/80

Bruce

RECOVERY

TOTAL TIME 11:10

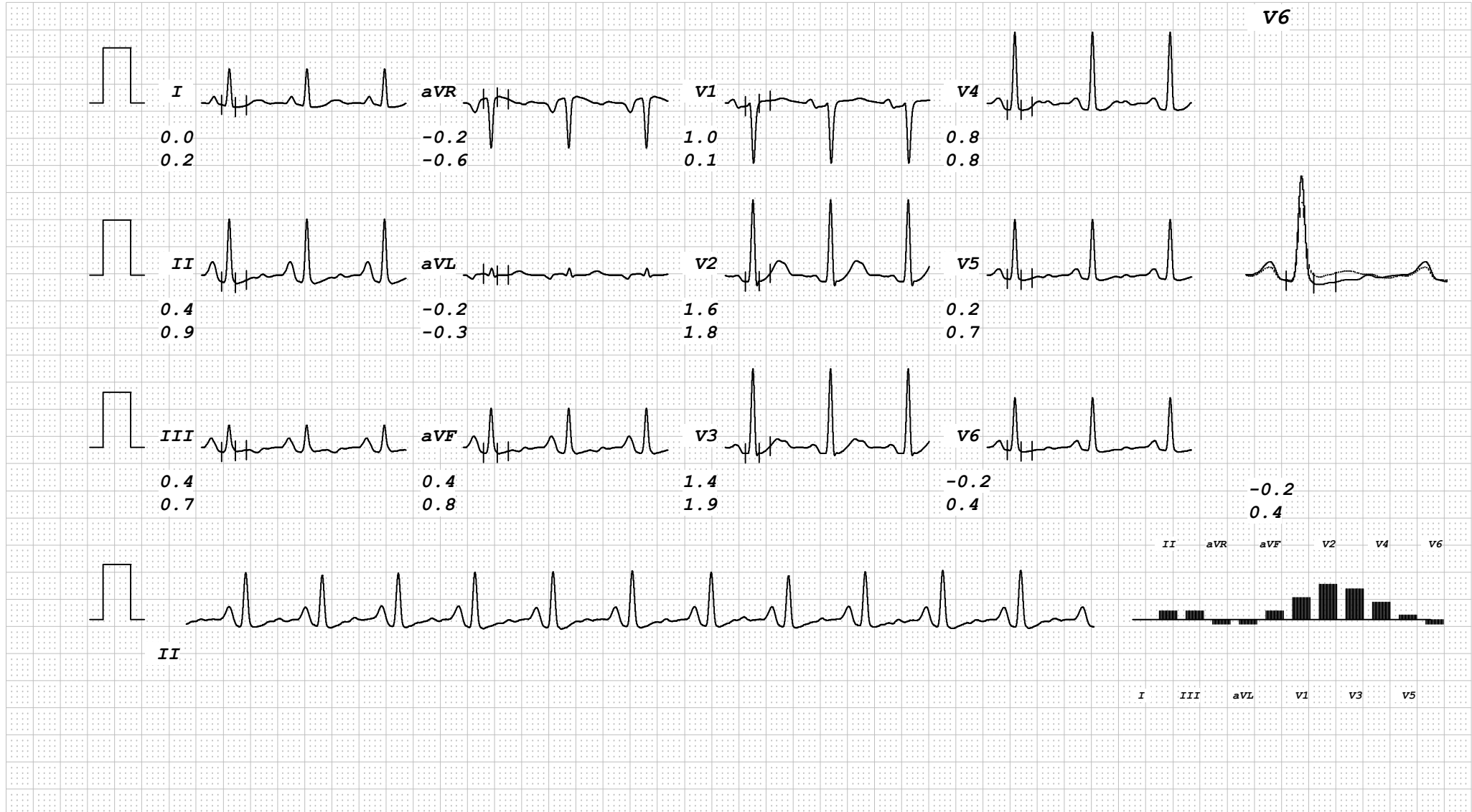
PHASE TIME 2:55

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 101bpm

B.P. 140/80

Bruce

RECOVERY

TOTAL TIME 12:10

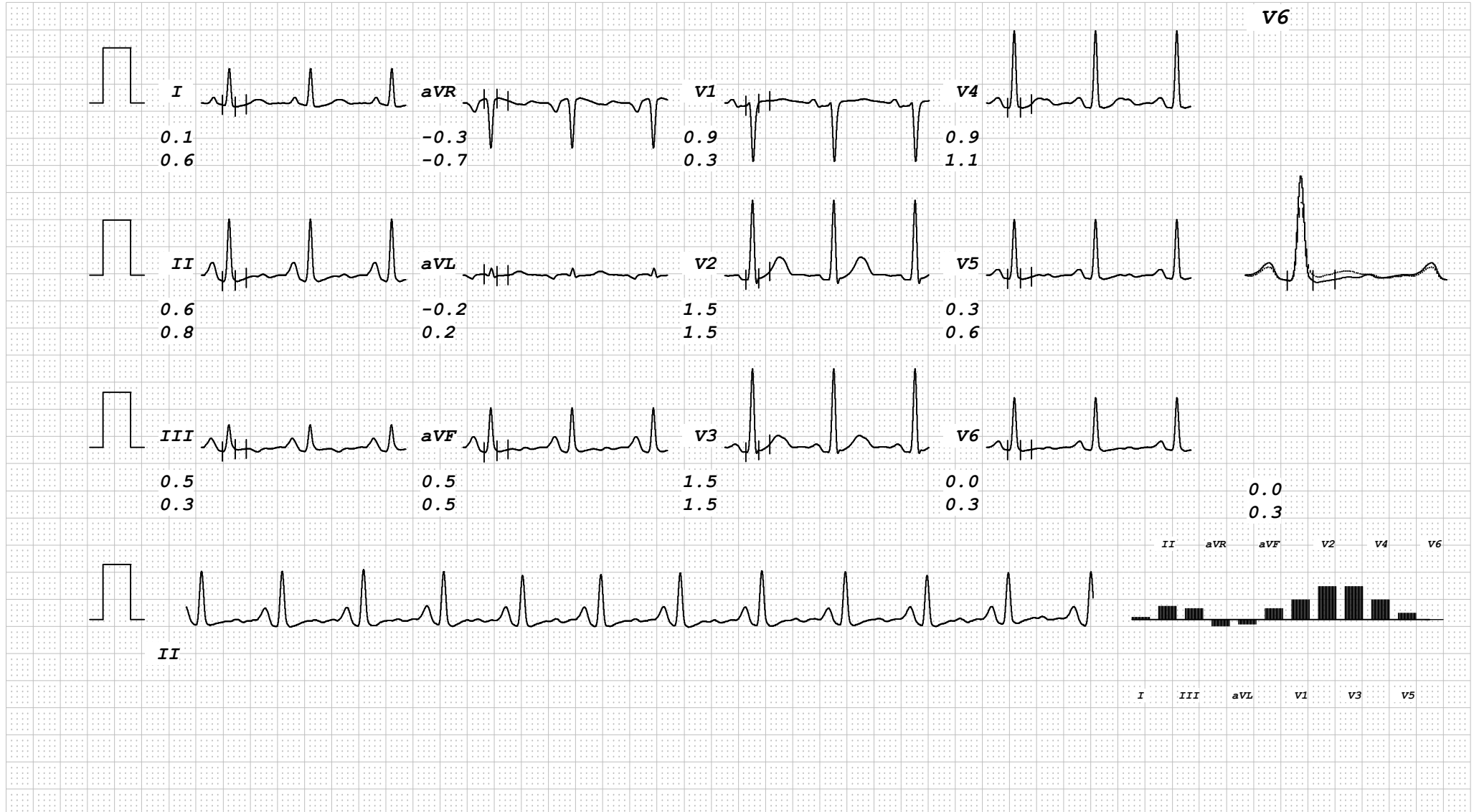
PHASE TIME 3:55

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

SUBHASH GHANGALE

I.D. 493

Age 39/M

Date 08/03/2024

RATE 101bpm

B.P. 120/80

Bruce

RECOVERY

TOTAL TIME 13:10

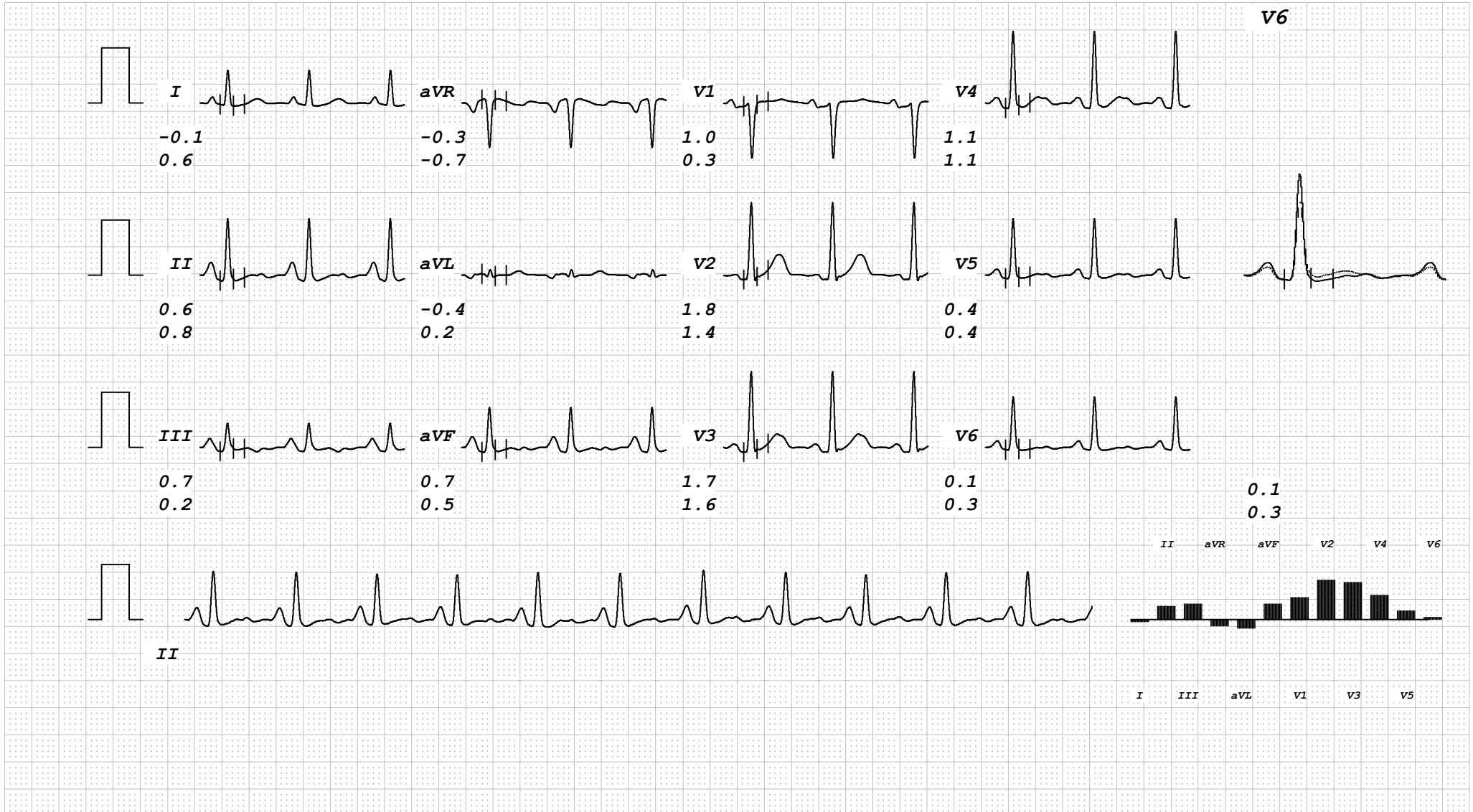
PHASE TIME 4:55

ST @ 10mm/mV

80ms PostJ

LINKED MEDIAN

Mag. X 2



HEALTHSPRING OSHIWARA

ANDHERI WEST

MUMBAI

SUBHASH GHANGALE
 ID : 493
 DATE : 08/03/2024
 AGE/SEX : 39 /M
 HT/WT : 175 / 70
 REF.BY :

TREADMILL TEST REPORT
 PROTOCOL : Bruce
 HISTORY : NIL
 INDICATION :
 MEDICATION : NIL

PHASE	TOTAL TIME	STAGE TIME	SPEED Km/Hr	GRADE %	H.R. bpm	B.P. mmHg	RPP x100	ST LEVEL (MM)			METS
								II	V1	V5	
SUPINE					86	120 / 80	103	1.2	0.9	0.8	
STANDING					85	120 / 80	102	1.2	1	0.8	
HYPERVENT		0:9			87	120 / 80	104	1.1	1.1	0.8	
VALSALVA					87	120 / 80	104	1.1	1.1	0.8	
Stage 1	2:55	2:55	2.7	10	109	130 / 90	141	0.7	1.4	0.9	4.67
Stage 2	5:55	2:55	4	12	131	140 / 90	183	0.1	1.5	0.5	7.04
PK-EXERCISE	8:7	2:7	5.4	14	153	150 / 100	229	-0.1	1.3	-0.2	9.15
RECOVERY	9:10	0:55			125	150 / 100	187	0.8	1.6	0.7	
RECOVERY	9:10	0:55			125	150 / 100	187	0.8	1.6	0.7	
RECOVERY	10:10	1:55			112	140 / 80	156	0.3	1.3	0	
RECOVERY	10:10	1:55			112	140 / 80	156	0.3	1.3	0	
RECOVERY	11:10	2:55			106	140 / 80	148	0.4	1	0.2	
RECOVERY	11:10	2:55			106	140 / 80	148	0.4	1	0.2	
RECOVERY	12:10	3:55			101	140 / 80	141	0.6	0.9	0.3	
RECOVERY	12:10	3:55			101	140 / 80	141	0.6	0.9	0.3	
RECOVERY	13:10	4:55			101	120 / 80	121	0.6	1	0.4	
RECOVERY	13:10	4:55			101	120 / 80	121	0.6	1	0.4	

EXERCISE DURATION : 8:7 MAX WORK LOAD : 9.15 METS
 MAX HEART RATE : 153 bpm 84 % of target heart rate 181 bpm
 MAX BLOOD PRESSURE : 150 / 100 mm Hg
 REASON OF TERMINATION : Achieved THR,
 BP RESPONSE :
 ARRYTHMIA :
 H.R. RESPONSE :
IMPRESSIONS :

Technician :

Patient Name: SUBHASH GHANGALE

M/ 39 Yrs.

Ref. by:

Date: 8/3/2024

SONOGRAPHY OF ABDOMEN AND PELVIS

TECHNIQUE: Real time, B mode, gray scale sonography of the abdominal and pelvic organs was performed with convex transducer.

LIVER: The liver is normal in size, shape and has smooth margins. The hepatic parenchyma shows normal homogeneous echotexture without solid or cystic mass lesion or calcification. No evidence of intrahepatic biliary radical dilatation.

PORTAL VEIN: It measures normal in diameter.

GALL BLADDER: The gall bladder is well distended. There is no evidence of calculus, wall thickening or pericholecystic collection.

COMMON BILE DUCT: The visualised common bile duct is normal in caliber. No evidence of calculus is seen in the common bile duct. Terminal common bile duct is obscured due to bowel gas artifacts.

PANCREAS: The head and body of pancreas is normal in size, shape, contours and echo texture. Rest of the pancreas is obscured due to bowel gas artifacts.

SPLEEN: The spleen is normal in size and shape. Its echotexture is homogeneous.

KIDNEYS:

Right kidney	Left kidney
9.4 x 3.7 cm	9.8 x 4.1 cm

The kidneys are normal in size and have smooth renal margins. Cortical echotexture is normal. The central echo complex does not show evidence of hydronephrosis. No evidence of hydroureter or calculi, bilaterally.

URINARY BLADDER: The urinary bladder is well distended. It shows uniformly thin walls and sharp mucosa. No evidence of calculus is seen. No evidence of mass or diverticulum is noted.

PROSTATE: It measures about 3.7 x 3.2 x 2.8 cms; with a weight of 17 gm. The prostate gland shows well defined and smooth margins. The prostatic echotexture is normal and homogeneous.

There is no ascites. There is no obvious evidence of significant lymphadenopathy.

IMPRESSION:

- **No abnormality detected.**

Thanks for the reference.

With regards,



DR. Nitish Kotwal

CONSULTANT RADIOLOGIST

(MBBS, DMRD RADIOLOGY)

Investigations have their limitations. Solitary pathological/Radiological and other investigations never confirm the final diagnosis. They only help in diagnosing the disease in correlation to clinical symptoms and other related tests. Please interpret accordingly.





PATIENT'S NAME - Subhash Chhangale DATE -
AGE/GENDER - male / 13 yrs
DOCTOR'S NAME - Dr Gait 8/5/2024
VISION SCREENING

	RE	RE	LE	LE
	Glasses	UNAIDED	Glasses	UNAIDED
DISTANT		6/6		6/6
NEAR		N8		N8
COLOUR	normal			
Recommendations				

VITALS

Pulse - 75	B.P- 120/80	SpO2 98
Height 175	Weight - 70	BMI-
Waist - 89	Hip - 100	Waist/Hip Ratio- .
Chest - 94	Inspiration-	Expiration-

CENTRE NAME - Ashiwara

SIGN & STAMP-



Im: - made over nose tip



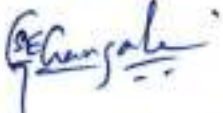
Date: 08/03/2024

To,
The Healthspring,
Andheri (Oshiwara),

Sir,
Re: Not to do stool testing.

I, the undersigned, do not want to do my stool testing during annual health-check-up at healthspring.

Thanks.


(Subhash Eknath Ghangale).



Certificate No.: MC-3199
NABL Accredited
ISO: 15189



FROST AND SULLIVAN AWARD
OF BEST PRIMARY CARE
PRACTICE IN SOUTH EAST ASIA 2017

BUSINESS MODEL
INNOVATION AWARDS
BEST BUILDING OF A BRAND



Name : SUBHASH GHANGALE	Age : 39YRS
Gender : MALE	Date : 08/03/2024

X-RAY CHEST PA VIEW

X-ray of the chest in P.A. projection reveals that the bony thorax is normal.

Lung fields and pleural spaces are clear on both sides.

The silhouettes of the heart and aorta are normal in size and configuration.

Both domes of the diaphragm are normal in position, contour and outline.

IMPRESSION: NO EVIDENCE OF ANY DISEASE IS SEEN IN THE CHEST.

Dr. Nitish Kotwal
MBBS, DMRD (Bom)
Consultant Radiologist And Sonologist..
Online reporting done hence no signature



भारत सरकार

Government of India



Issue Date: 23/04/2012

सुभाष एकनाथ घंगाले

Subhash Eknath Ghangale

जन्म तारीख / DOB: 01/02/1985

पुरुष / MALE



8696 1040 9910

मेरा आधार, मेरी पहचान

PrtScr
SysRq

Scroll
Lock

Pause
Break

GPS Map Camera



Google

Mumbai, Maharashtra, India

Shri Krishna Complex, KL Walawalkar Marg, Corner of new link road and fun cinemas lane, Veera Desai Industrial Estate, Andheri West, Mumbai, Maharashtra 400053, India
Lat 19.13546°

Long 72.832412°


08/03/24 08:58 AM GMT +05:30

Delete

End

Page



 GPS Map Camera

Mumbai, Maharashtra, India

Shri Krishna Complex, KL Walawalkar Marg, Corner of new link road and fun cinemas lane, Veera Desai Industrial Estate, Andheri West, Mumbai, Maharashtra 400053, India
Lat 19.13546°

Long 72.832412°

08/03/24 08:58 AM GMT +05:30

 Google

HEALTHSPRING

TREADMILL STRESS TEST REPORT

DATE: 08/03/2024

NAME:	SUBHASH GHANGALE	AGE:(years)	39	SEX:	M
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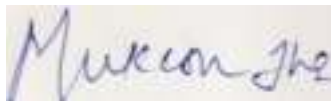
PROTOCOL USED	BRUCE PROTOCOL		
ANGINA SCALE (0 – None, 1 – Non-Limiting, 2 – Limiting)	0	MAXIMUM ST DEPRESSION (mm)	0
WORKLOAD: MAXIMUM METS ACHIEVED (METS)	9.15	DOUBLE PRODUCT	22950 mm Hg/Min
DUKES SCORE (High Risk Score \leq -11, Low Risk Score \geq 5)	8		

CONCLUSION:

NORMAL INOTROPIC & CHRONOTROPIC RESPONSE
BASELINE ECG SHOWS NO SIGNIFICANT ST-T CHANGES
NO SYMPTOMS AND ARRHYTHMIAS WERE SEEN DURING THE EXERCISE AND RECOVERY
NO SIGNIFICANT ST-T CHANGES WERE SEEN DURING THE EXERCISE AND RECOVERY
GOOD EFFORT TOLERANCE AND FUNCTIONAL CAPACITY
TARGET HEART RATE ACHIEVED
THE STRESS TEST IS **NEGATIVE** FOR INDUCIBLE ISCHEMIA AT THE GIVEN WORKLOAD

IMPRESSION:

THE STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA AT THE GIVEN WORKLOAD
ADVISED- CLINICAL CORRELATION



DR. MUKESH JHA
MD (MEDICINE), DM (CARDIOLOGY)
REG NO- 2010/09/2935

NOTE-

A NEGATIVE STRESS TEST DOES NOT CONCLUSIVELY RULE OUT CORONARY ARTERY DISEASE. A POSITIVE STRESS TEST IS NOT CONCLUSIVE EVIDENCE OF CORONARY ARTERY DISEASE. THERE IS A POSSIBILITY OF THE TEST BEING FALSE POSITIVE OR FALSE NEGATIVE DUE TO OTHER ASSOCIATED MEDICAL CONDITIONS. THESE REPORTS ARE FOR DOCTORS & PHYSICIANS AND NOT FOR MEDICO-LEGAL PURPOSES. KINDLY CO-RELATE THE REPORT WITH CLINICAL CONDITIONS.

THIS TMT/ ECG IS REPORTED ONLINE WITHOUT INTERACTING WITH PATIENTS AND THE RESULT SHOULD BE CLINICALLY CO-RELATED AND INDEPENDENTLY REVIEWED BY THE PATIENT'S CONSULTANT DOCTOR. THE PATIENT WAS NOT SEEN BY THE DOCTOR PERSONALLY AND THE ABOVE REPORT HAS BEEN REVIEWED BY THE DOCTOR BASED ON THE TMT/ECG RESULT AS PROVIDED TO THE DOCTOR.