

NAME:	Mr. Rohan Bhande	UHID:	
AGE:	33	DATE OF HEALTHCHECK:	9/9/2023
GENDER:	M		

HEIGHT:	1.52	MARITAL STATUS:	M
WEIGHT:	64.3	NO OF CHILDREN:	2
BMI:	27.8		

C/O: Bronchitis on occasion
Asthma, Bleeding

K/C/O: PRESENT MEDICATION: - No

P/M/H: - No

P/S/H: - No

ALLERGY: - Cold

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER: - DM

ALCOHOL:) No

MOTHER: -

TOBACCO/PAN:)

O/E:

LYMPHADENOPATHY:) No

BP: 100/70 PULSE: - 72/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING:) No

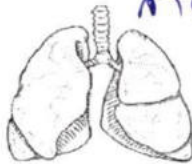
TEMPERATURE: H SCARS:

OEDEMA:

S/E:

P/A:) No

RS:



CVS: Rht

Extremities & Spine: - No

CNS:

Brain, spinal cord, nerves

ENT:) No

Skin:) No

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

Name: Mr Rohit Pandey	Age: 33y	Date of Health check-up: 01/07/2021
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Findings and Recommendation:

Findings:-

Lipid profile
HDL - Chol - 27mg/dl.
were \leftarrow occasional pus cells.
USA - get I fatty liver
Rest reports were

Recommendation:-

Increase water intake

Pradnya

DR. PRADNYA P. DANI
Signature:
(M.B.B.S)
Reg. No. 87941 Consultant -

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 9/9/23

Name: Mr. Rohit Age: 30 Gender: Male / Female

Without Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye 26 Left Eye 26

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	<u>1.0</u>					<u>1.25</u>				
Near										

Correct use.

Colour Vision : _____

Anterior Segment Examination : NO BU

Pupils : _____

Fundus : _____

Intraocular Pressure : 12 mm 13

Diagnosis : _____

Advice : glasses

Re-Check on 1 year (This Prescription needs verification every year)

Dr. 2
(Consultant Ophthalmologist)

DR. RUCHIRA SHARMA
M. S. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

REG. No.: 3262 / 09 / 02

DENTAL CHECKUP

Name: Mr. Rohit Pandey .	MR NO:
Age/Gender : 33 yrs m .	Date: 09/09/23

Medical history: Diabetes Hypertension NRH

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains	✓	✓	✓	✓
Mobility				
Caries (Cavities)				
a) Class 1 (Occlusal)				
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: Scaling & polishing

Orthodontic Advice for Braces: Yes / No

Prosthetic Advice to Replace Missing Teeth: Denture Bridge Implant

Oral Habits: Tobacco Cigarette Others since ___ years

Advice to quit any form of tobacco as it can cause cancer.

Other Findings: _____

Rohit

Name : Mr. Rohit Arunrao Pande Gender : Male Age : 33 Years
UHID : FVAH 8355. Bill No : Lab No : V-967-23
Ref. by : SELF Sample Col.Dt : 09/09/2023 09:25
Barcode No : 8213 Reported On : 09/09/2023 17:10

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

CBC (Complete Blood Count)-WB (EDTA)

Haemoglobin(Colorimetric method)	14.1	g/dl	13 - 18
RBC Count (Impedance)	5.09	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	45.4	%	35 - 55
MCV:(Calculated parameter)	89.2	fl	78 - 98
MCH:(Calculated parameter)	27.8	pg	26 - 34
MCHC:(Calculated parameter)	31.1	gm/dl	30 - 36
RDW-CV:	13.9	%	11.5 - 16.5
Total Leucocyte count(Impedance)	5450	/cumm.	4000 - 10500
Neutrophils:	57	%	40 - 75
Lymphocytes:	34	%	20 - 40
Eosinophils:	05	%	0 - 6
Monocytes:	04	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.96	Lakhs/c.mm	1.5 - 4.5
MPV	9	fl	6.0 - 11.0
Peripheral Smear (Microscopic examination)			
RBCs:	Normochromic, Normocytic		
WBCs:	Normal		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter.		

Alsaba Shaikh
Entered By

Ms Kaveri Gaonkar
Verified By

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Dr. Milind Patwardhan
M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL
ESR(Westergren Method)

Erythrocyte Sedimentation Rate:- 12 mm/1st hr 0 - 20

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TEST

RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group:

:O:

Rh Type:

Positive

Method :

Matrix gel card method (forward and reverse)

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	93	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	124	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Lipid Profile- Serum

S. Cholesterol(Oxidase)	167	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	131	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	26.2	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	<u>27.0</u>	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	113.8	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	<u>6.2</u>		3.5 - 5
Ratio of LDL/HDL	<u>4.2</u>		2.5 - 3.5

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

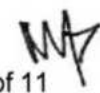
LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	6.60	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.43	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.17	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	2.04		0.9 - 2
S.Total Bilirubin (DPD):	0.63	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.22	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.41	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P): 25		U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P): 32		U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic): 119		U/L	40 - 129
S.GGT(IFCC Kinetic): 30		U/L	11 - 50

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	10.6 mg/dl	10.0 - 45.0
BUN (Calculated)	4.94 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.84 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	5.88	9:1 - 23:1
S.Uric Acid(Uricase Method)	6.0 mg/dl	3.4 - 7.0

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	2.07	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	116.1	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	3.72	□IU/ml	Euthyroid : 0.35 - 5.50 □IU/ml Hyperthyroid : < 0.35 □IU/ml Hypothyroid : > 5.50 □IU/ml

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

1. Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
2. Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
3. Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

1. Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

1. TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
3. Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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M.D(Path)

Page 10 of 11 Chief Pathologist

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

STOOL EXAMINATION

PHYSICAL EXAMINATION

COLOUR	Brownish	
CONSISTENCY	Semi Solid	
MUCUS	Absent	Absent

CHEMICAL EXAMINATION

OCCULT BLOOD (Guaiac method)	Absent	Absent
PH(Litmus paper)	Acidic	Acidic/Alkaline

MICROSCOPIC EXAMINATION

PUS CELLS	Absent	0 - 1
EPITHELIAL CELLS	Absent	Absent
RED BLOOD CELLS	Nil /HPF	Absent
FAT GLOBULES	Absent	Absent
VEGETABLE FIBRES	Present	Present
YEASTS	Absent	Absent
CYST	Absent	Absent
VEGETATIVE FORMS	Absent	Absent
OVA	Absent	Absent

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M.D(Path)
Chief Pathologist

End of Report
Results are to be correlated clinically

PATIENT'S NAME	ROHIT A PANDE	AGE :- 33 Y/M
UHID	8355	DATE :- .09 Sep. 23

X-RAY CHEST PA VIEW

OBSERVATION:

Patient is in positional obliquity.
Bilateral lung fields are clear.
Both hila are normal.
Bilateral cardiophrenic and costophrenic angles are normal.
The trachea is central.
Aorta appears normal.
The mediastinal and cardiac silhouette are normal.
Soft tissues of the chest wall are normal.
Bony thorax is normal.

IMPRESSION:

➤ No significant abnormality seen.



DR. CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg No. 073826

• ANDHERI • COLABA • NASHIK • VASHI

33 Years

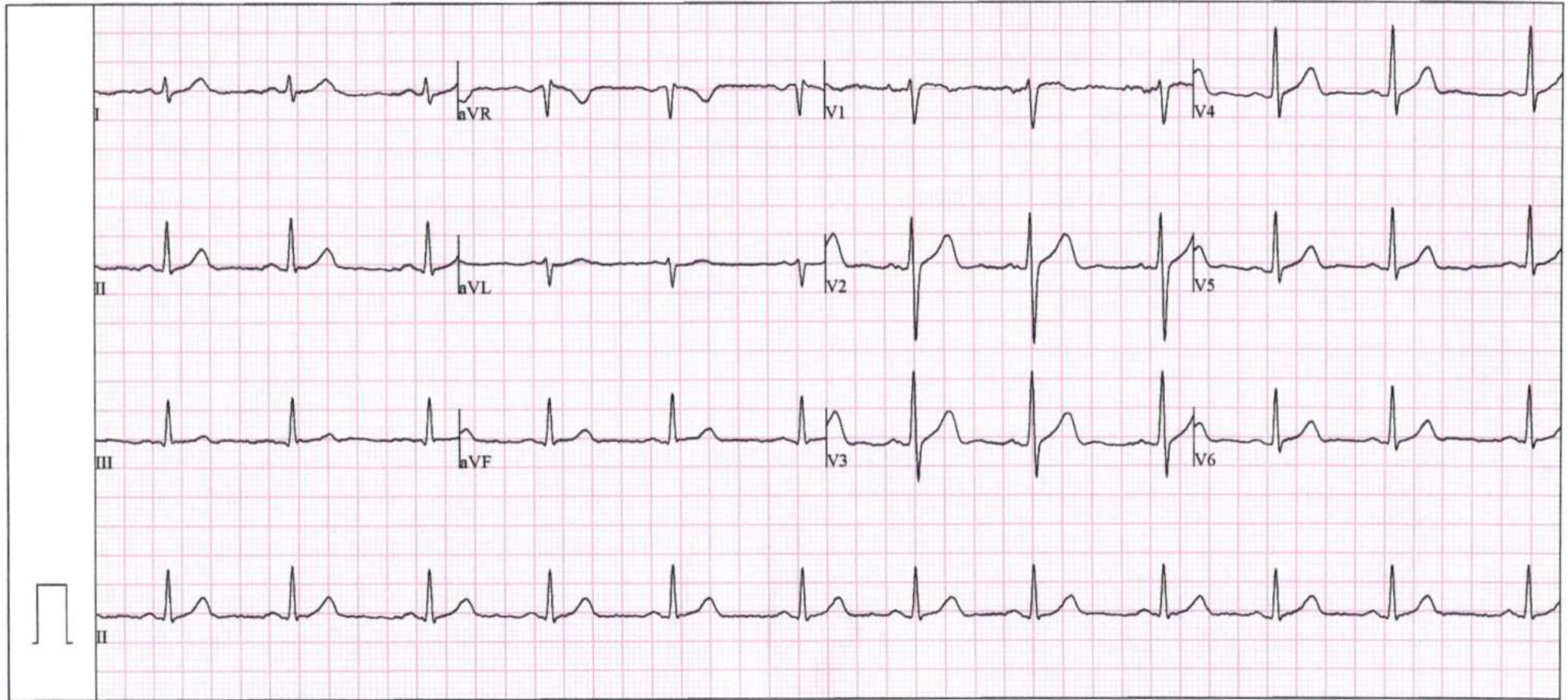
Male

NORMAL ECG

QRS : 78 ms
QT / QTcBaz : 376 / 408 ms
PR : 138 ms
P : 102 ms
RR / PP : 842 / 845 ms
P / QRS / T : 29 / 81 / 50 degrees

Normal sinus rhythm
Normal ECG

Dr. ANIRBAN DASGUPTA
M.B., B.S., D.N.B. Medicine
Diploma Cardiology
MMC -2005/02/0920



Apollo Clinic
The Emerald Plot No-195/B, Sector-12,
Neel Siddhi Towers, Vashi-400703

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: ROHIT, PANDE
Patient ID: 8355
Height:
Weight:

DOB: 31.07.1990
Age: 33yrs
Gender: Male
Race: Asian

Study Date: 09.09.2023
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR.ANIRBAN DASGUPTA
Technician: Anita Gaikwad

Medications:
NIL

Medical History:
NIL

Reason for Exercise Test:
Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:08	0.00	0.00	78	100/80	
	STANDING	00:16	0.00	0.00	76		
	HYPERV.	00:16	0.00	0.00	83		
EXERCISE	WARM-UP	00:07	0.00	0.00	82		
	STAGE 1	03:00	1.70	10.00	126	120/80	
	STAGE 2	03:00	2.50	12.00	157	150/80	
RECOVERY	STAGE 3	00:16	3.40	14.00	173	160/80	
		01:04	0.00	0.00	93	170/80	

The patient exercised according to the BRUCE for 6:16 min:s, achieving a work level of Max. METS: 7.70. The resting heart rate of 78 bpm rose to a maximal heart rate of 179 bpm. This value represents 95 % of the maximal, age-predicted heart rate. The resting blood pressure of 100/80 mmHg, rose to a maximum blood pressure of 170/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions

TMT IS NEGATIVE FOR INDUCIBLE MYOCARDIAL ISCHAEMIA AT THE WORKLOAD ACHIEVED.

Physician-DR.ANIRBAN DASGUPTA

Dr. ANIRBAN DASGUPTA

M.B.B.S., D.N.B. Medicine

Diploma Cardiology

MMC -2003/02/0920

PATIENT'S NAME	ROHIT A PANDE	AGE :- 33y/M
UHID NO	8355	9 Sep 2023

USG WHOLE ABDOMEN

LIVER is normal in size, shape and shows bright echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

SPLEEN is normal in size, and echotexture. No focal lesion seen. SV is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

RIGHT KIDNEY measures 8.7 x 4.1 cm. **LEFT KIDNEY** measures 9.8 x 4.1 cm.

Urinary Bladder is adequately distended; no e/o any obvious wall thickening or mass or calculi seen.

PROSTATE is normal in size, shape & echotexture.
It measures approximately 18 gms.

Visualised bowel loops appear normal. There is no free fluid seen.

IMPRESSION –

- **Grade I fatty liver.**
- **No other significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



DR.CHHAYA S. SANGANI
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