

TEST REPORT

Reg. No. : 411100161 **Reg. Date :** 09-Nov-2024 09:08 **Ref.No :** **Approved On :** 09-Nov-2024 11:30
Name : Mrs. VARSHABEN RAJENDRAKUMAR PUJARA **Collected On :** 09-Nov-2024 09:51
Age : 53 Years **Gender:** Female **Pass. No. :** **Dispatch At :**
Ref. By : APOLLO **Tele No. :**
Location :

Test	Results	Unit	Bio. Ref. Interval
Complete Blood Count			
Hemoglobin(SLS method)	12.7	g/dL	12.0 - 15.0
RBC Count(Ele.Impedence)	4.40	X 10 ¹² /L	3.8 - 4.8
Hematocrit (calculated)	38.4	%	36 - 46
MCV (Calculated)	87.3	fL	83 - 101
MCH (Calculated)	28.9	pg	27 - 32
MCHC (Calculated)	33.1	g/dL	31.5 - 34.5
RDW-SD(calculated)	43.00	fL	36 - 46
Total WBC count	8900	/μL	4000 - 10000
DIFFERENTIAL WBC COUNT			
	[%]	EXPECTED VALUES	[Abs] EXPECTED VALUES
Neutrophils	58	38 - 70	5162 /cmm 1800 - 7700
Lymphocytes	33	21 - 49	2937 /cmm 1000 - 3900
Eosinophils	03	0 - 7	267 /cmm 20 - 500
Monocytes	06	3 - 11	534 /cmm 200 - 800
Basophils	00	0 - 1	0 /cmm 0 - 100
NLR (Neutrophil: Lymphocyte Ratio)	1.76	Ratio	1.1 - 3.5
Platelet Count (Manual)	H 440000	/cmm	150000 - 410000
PCT	0.40	ng/mL	< 0.5
MPV	9.00	fL	6.5 - 12.0
Peripheral Smear			
RBCs	Normocytic normochromic.		
WBCs	Normal morphology		
Platelets	Adequate on Smear		
Malarial Parasites	Not Detected		

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Test done from collected sample.



Page 1 of 13

Approved by: Dr. Keyur Patel

M.B.B.S,D.C.P(Patho)
G- 22475

Approved On: 09-Nov-2024 11:30

Generated On : 09-Nov-2024 15:10

For Appointment : 7567 000 750

www.conceptdiagnostics.com

conceptdiaghealthcare@gmail.com

1st Floor, Sahajand Palace, Near Gopi Restaurant, Anandnagar Cross Road, Prahladnagar, Ahmedabad-15.


 SPECIALITY LABORATORY LTD.
 PRAHLADNAGAR BRANCH

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ESR 04 mm/hr
17-50 Yrs : <12,
51-60 Yrs : <19,
61-70 Yrs : <20,
>70 Yrs: <30

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TEST REPORT

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Name : Mrs. VARSHABEN RAJENDRAKUMAR PUJARA			Collected On : 09-Nov-2024 09:51
Age : 53 Years	Gender: Female	Pass. No. :	Dispatch At :
Ref. By : APOLLO			Tele No. :
Location :			

Test Name	Results	Units	Bio. Ref. Interval
BLOODGROUP & RH			
<u>Specimen: EDTA and Serum; Method: Gel card system</u>			
Blood Group "ABO" <i>Agglutination</i>	"A"		
Blood Group "Rh" <i>Agglutination</i>	Positive		
EDTA Whole Blood			

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Name : Mrs. VARSHABEN RAJENDRAKUMAR PUJARA			Collected On : 09-Nov-2024 13:29
Age : 53 Years	Gender: Female	Pass. No. :	Dispatch At :
Ref. By : APOLLO			Tele No. :
Location :			

Test Name	Results	Units	Bio. Ref. Interval
POST PRANDIAL PLASMA GLUCOSE			
Specimen: Fluoride plasma			
Post Prandial Plasma Glucose <i>Hexokinase</i>	L 102.83	mg/dL	Normal: <=139 Prediabetes : 140-199 Diabetes: >=200
Flouride Plasma			

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Location :

Test Name	Results	Units	Bio. Ref. Interval
RANDOM PLASMA GLUCOSE			
Specimen: Fluoride plasma			
Random Plasma Glucose <i>Hexokinase</i> Flouride Plasma	108.08	mg/dL	>= 200 Suggestive of Diabetes

Remarks:

If the patient Random Plasma Glucose value is >=200 mg/dL , Advice Oral Glucose Tolerance test(OGTT)for Further Evaluation.

Criteria for the diagnosis of diabetes

1. HbA1c >= 6.5 *

Or

2. Fasting plasma glucose >126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.

Or

3. Two hour plasma glucose >= 200mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucose dissolved in water.

Or

4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose >= 200 mg/dL. *In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing.American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34;S11.

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Location :

Test Name	Results	Units	Bio. Ref. Interval
-----------	---------	-------	--------------------

GGT	15.40	U/L	6 - 42
-----	-------	-----	--------

L-Y-Glutamyl-3 Carboxy-4-Nitroanilide, Enzymetic Colorimetric

Serum

Uses:

- Diagnosing and monitoring hepatobiliary disease.
- To ascertain whether the elevated ALP levels are due to skeletal disease or due to presence of hepatobiliary disease.
- A screening test for occult alcoholism.

Increased in:

- Intra hepatic biliary obstruction.
- Post hepatic biliary obstruction
- Alcoholic cirrhosis
- Drugs such as phenytoin and phenobarbital.
- Infectious hepatitis (modest elevation)
- Primary/ Secondary neoplasms of liver.

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Ref. By : APOLLO **Tele No.** :
Location :

Test Name	Results	Units	Bio. Ref. Interval
LIPID PROFILE			
CHOLESTEROL	255.00	mg/dL	Desirable <=200 Borderline high risk 200 - 240 High Risk >240
Triglyceride <i>Enzymatic Colorimetric Method</i>	137.00	mg/dL	<150 : Normal, 150-199 : Border Line High, 200-499 : High, >=500 : Very High
Very Low Density Lipoprotein(VLDL) <i>Calculated</i>	27	mg/dL	0 - 30
Low-Density Lipoprotein (LDL) <i>Calculated Method</i>	H 183.42	mg/dL	< 100 : Optimal, 100-129 : Near Optimal/above optimal, 130-159 : Borderline High, 160-189 : High, >=190 : Very High
High-Density Lipoprotein(HDL)	44.58	mg/dL	<40 >60
CHOL/HDL RATIO <i>Calculated</i>	H 5.72		0.0 - 3.5
LDL/HDL RATIO <i>Calculated</i>	H 4.11		1.0 - 3.4
TOTAL LIPID <i>Calculated</i>	744.00	mg/dL	400 - 1000
Serum			

As a routine test to determine if your cholesterol level is normal or falls into a borderline-, intermediate- or high-risk category.
 To monitor your cholesterol level if you had abnormal results on a previous test or if you have other risk factors for heart disease.
 To monitor your body's response to treatment, such as cholesterol medications or lifestyle changes.
 To help diagnose other medical conditions, such as liver disease.
 Note : biological reference intervals are according to the national cholesterol education program (NCEP) guidelines.

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Ref. By : APOLLO			Tele No. :
Location :			

Test Name	Results	Units	Bio. Ref. Interval
<u>LIVER FUNCTION TEST</u>			
TOTAL PROTEIN	6.82	g/dL	6.6 - 8.8
ALBUMIN	4.33	g/dL	3.5 - 5.2
GLOBULIN <i>Calculated</i>	2.49	g/dL	2.4 - 3.5
ALB/GLB <i>Calculated</i>	1.74		1.2 - 2.2
SGOT	15.80	U/L	<31
SGPT	17.20	U/L	<31
Alkaline Phosphatase <i>ENZYMATIC COLORIMETRIC IFCC, PNP, AMP BUFFER</i>	96.20	U/L	40 - 130
TOTAL BILIRUBIN	0.81	mg/dL	0.1 - 1.2
DIRECT BILIRUBIN	0.07	mg/dL	<0.2
INDIRECT BILIRUBIN <i>Calculated</i>	0.74	mg/dL	0.0 - 1.00
Serum			

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TEST REPORT

Reg. No. : 411100161 **Reg. Date :** 09-Nov-2024 09:08 **Ref.No :** **Approved On :** 09-Nov-2024 12:47
Name : Mrs. VARSHABEN RAJENDRAKUMAR PUJARA **Collected On :** 09-Nov-2024 09:51
Age : 53 Years **Gender:** Female **Pass. No. :** **Dispatch At :**
Ref. By : APOLLO **Tele No. :**
Location :

Test Name	Results	Units	Bio. Ref. Interval
THYROID FUNCTION TEST			
T3 (triiodothyronine), Total <small>CMIA</small>	0.93	ng/mL	0.40 - 1.81
T4 (Thyroxine), Total <small>CMIA</small>	6.16	µg/dL	5.5 - 11.0
TSH (Thyroid stimulating hormone) <small>CMIA</small>	1.960	µIU/mL	0.35 - 4.94

Sample Type: Serum

Comments:

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4. Quantification of TSH is significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

TSH levels During Pregnancy :

- First Trimester : 0.1 to 2.5 µIU/mL
- Second Trimester : 0.2 to 3.0 µIU/mL
- Third trimester : 0.3 to 3.0 µIU/mL

Reference : Carl A.Burtis,Edward R.Ashwood,David E.Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Edition. Philadelphia: WB Saunders,2012:2170

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Approved by: Dr. Razvin Somani

M.D. Pathology
Reg. No. G-51211

Approved On: 09-Nov-2024 12:47

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Age : 53 Years	Gender: Female	Pass. No. :	Dispatch At :
Ref. By : APOLLO			Tele No. :
Location :			

Test Name	Results	Units	Bio. Ref. Interval
<u>URINE ROUTINE EXAMINATION</u>			
<u>Physical Examination</u>			
Colour	Pale Yellow		
Clarity	Clear		
<u>CHEMICAL EXAMINATION (by strip test)</u>			
pH	6.0		4.6 - 8.0
Sp. Gravity	1.020		1.002 - 1.030
Protein	Absent		Absent
Glucose	Absent		Absent
Ketone	Absent		Absent
Bilirubin	Absent		Nil
Nitrite	Absent		Nil
Leucocytes	Nil		Nil
Blood	Nil		Absent
<u>MICROSCOPIC EXAMINATION</u>			
Leucocytes (Pus Cells)	1-2		0 - 5/hpf
Erythrocytes (RBC)	Nil		0 - 5/hpf
Casts	Nil	/hpf	Absent
Crystals	Nil		Absent
Epithelial Cells	Occasional		Nil
Monilia	Absent		Nil
T. Vaginalis	Absent		Nil
Bacteria	Absent		Absent
Urine			

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Age : 53 Years	Gender: Female	Pass. No. :	Dispatch At :
Ref. By : APOLLO			Tele No. :
Location :			

Test Name	Results	Units	Bio. Ref. Interval
Creatinine	0.66	mg/dL	0.51 - 1.5

Serum

Creatinine is the most common test to assess kidney function. Creatinine levels are converted to reflect kidney function by factoring in age and gender to produce the eGFR (estimated Glomerular Filtration Rate). As the kidney function diminishes, the creatinine level increases; the eGFR will decrease. Creatinine is formed from the metabolism of creatine and phosphocreatine, both of which are principally found in muscle. Thus the amount of creatinine produced is, in large part, dependent upon the individual's muscle mass and tends not to fluctuate much from day-to-day. Creatinine is not protein bound and is freely filtered by glomeruli. All of the filtered creatinine is excreted in the urine.

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Ref. By : APOLLO			Tele No. :
Location :			

Test Name	Results	Units	Bio. Ref. Interval
Urea	37.0	mg/dL	<= 65 YEARS AGE: <50 mg/dL; >65 YEARS AGE: <71 mg/dL

UREASE/GLDH

Serum

Useful screening test for evaluation of kidney function. Urea is the final degradation product of protein and amino acid metabolism. In protein catabolism, the proteins are broken down to amino acids and deaminated. The ammonia formed in this process is synthesized to urea in the liver. This is the most important catabolic pathway for eliminating excess nitrogen in the human body. Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis), and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors). The determination of serum BUN currently is the most widely used screening test for the evaluation of kidney function. The test is frequently requested along with the serum creatinine test since simultaneous determination of these 2 compounds appears to aid in the differential diagnosis of prerenal, renal and postrenal hyperuremia.

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Location :			

Test Name	Results	Units	Bio. Ref. Interval
<u>ELECTROLYTES</u>			
Sodium (Na+) <small>Method:ISE</small>	141.2	mmol/L	136 - 145
Potassium (K+) <small>Method:ISE</small>	4.2	mmol/L	3.5 - 5.1
Chloride(Cl-) <small>Method:ISE</small>	103.2	mmol/L	98 - 107
Serum			

Comments

The electrolyte panel is ordered to identify electrolyte, fluid, or pH imbalance. Electrolyte concentrations are evaluated to assist in investigating conditions that cause electrolyte imbalances such as dehydration, kidney disease, lung diseases, or heart conditions. Repeat testing of the electrolyte or its components may be used to monitor the patient's response to treatment of any condition that may be causing the electrolyte, fluid or pH imbalance.

Report To Follow: LBC PAP SMEAR (Cytology) ----- End Of Report -----

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Varukaben Rajendrakumar Pujara .

Q'm not in fasting Mode .

Varukaben .

in fasting mode

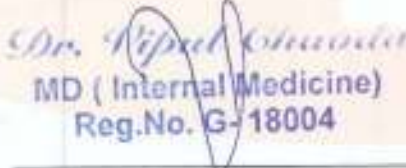
09/11/24 .





MER- MEDICAL EXAMINATION REPORT

Date of Examination	09/17/2024		
NAME	Vanshika Rajendrakumar Pujara		
AGE	51	Gender	Female
HEIGHT(cm)	148	WEIGHT (kg)	58
B.P.	134/86/82		
X RAY	NORMAL		
ECG	NORMAL		
Present Ailments	N/A		
Details of Past ailments (If Any)	N/A		
Comments / Advice : She /He is Physically Fit	PHYSICALLY FIT		
EYE CHECKUP	Far Vision - 6/9 without glasses Near Vision - N12 without glasses Colour Vision - Normal		


 Dr. Nipal Choudhary
 MD (Internal Medicine)
 Reg.No. G-18004

Signature with Stamp of Medical Examiner

Vasshaben.
Slup

9/11/24

OH:

3 FTND

LD: 25yr

Abd TL 26 yrs back

Mh LMP: Menopausal x 3-4 yrs

Pamh: Regular

fath pain | ~~abd~~ ? Sx for GERD

PIA - Sch

PIs - Sx headach
Pap test taken

PIV - MD

Abd

Pap Pap

- HIV report





NAME	VARSHABEN R PUJARA		
AGE/ SEX	51yrs / F	DATE	09/11/2024
REF. BY	HEALTH CHECKUP	DONE BY	Dr. Parth Thakkar

2D ECHO CARDIOGRAPHY & COLOR DOPPLER STUDY

FINDINGS:-

- Normal LV systolic function, LVEF=60%.
- No RWMA at rest.
- LV and LA are of normal size.
- RA & RV are of normal size.
- Normal LV Compliance.
- Intact IAS & IVS.
- All Valves are structurally Normal.
- Mild MR, Trivial AR, No PR.
- Mild TR, No PAH, RVSP-30mmHg.
- No clot or vegetation.
- No evidence of pericardial effusion.
- IVC is normal in size with preserved respiratory variation.



MEASUREMENTS:-

LVIDD	38 (mm)	LA	28 (mm)
LVIDS	27 (mm)	AO	22 (mm)
LVEF	60%	AV cusp	
IVSD / LVPWD	10/10(mm)	EPSS	

DOPPLER STUDY:-

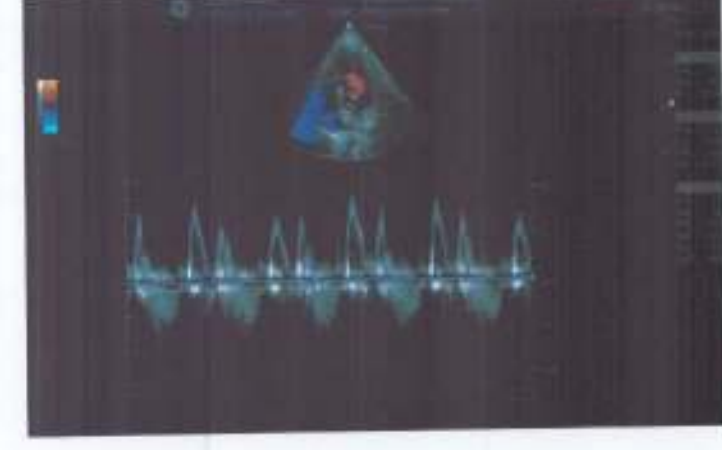
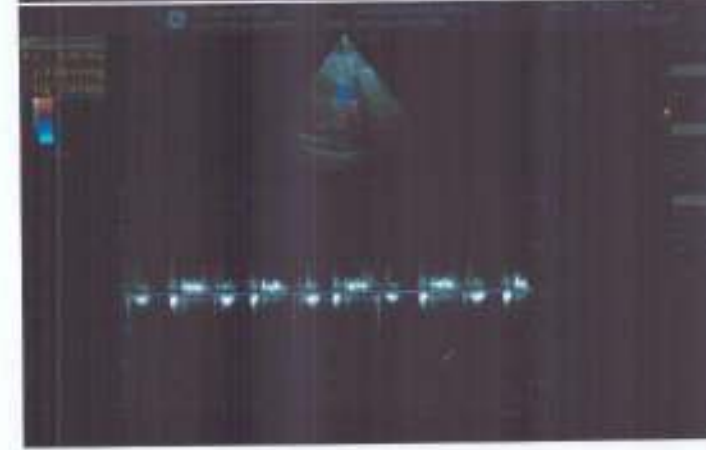
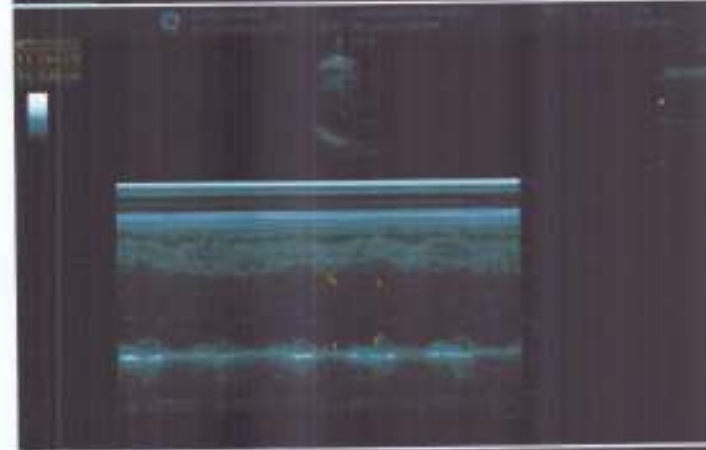
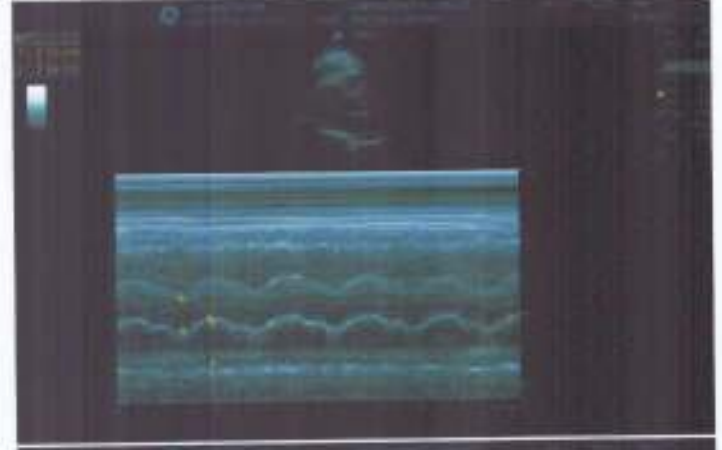
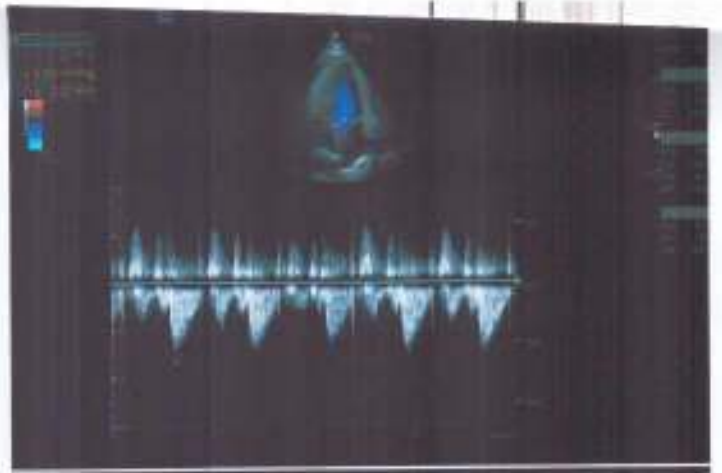
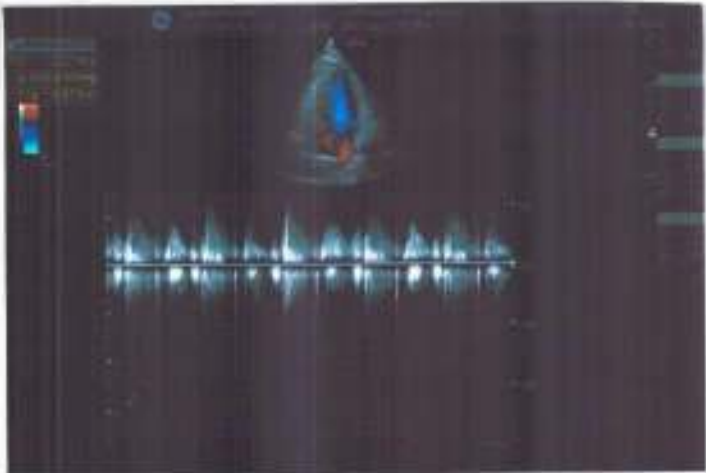
Valve	Velocity (M/sec)	Max gradient (MmHg)	Mean gradient (Mm Hg)	Valve area Cm ²
Aortic	1.32			
Mitral	E: 0.9 A: 0.7			
Pulmonary	0.76			
Tricuspid	2.2	20		

CONCLUSION:-

- Normal LV systolic function, LVEF=60%.
- No RWMA at rest.
- Normal LV Compliance.
- All Valves are structurally Normal.
- Mild MR, Trivial AR, No PR.
- Mild TR, No PAH, RVSP-30mmHg.
- IVC is normal in size with preserved respiratory variation.

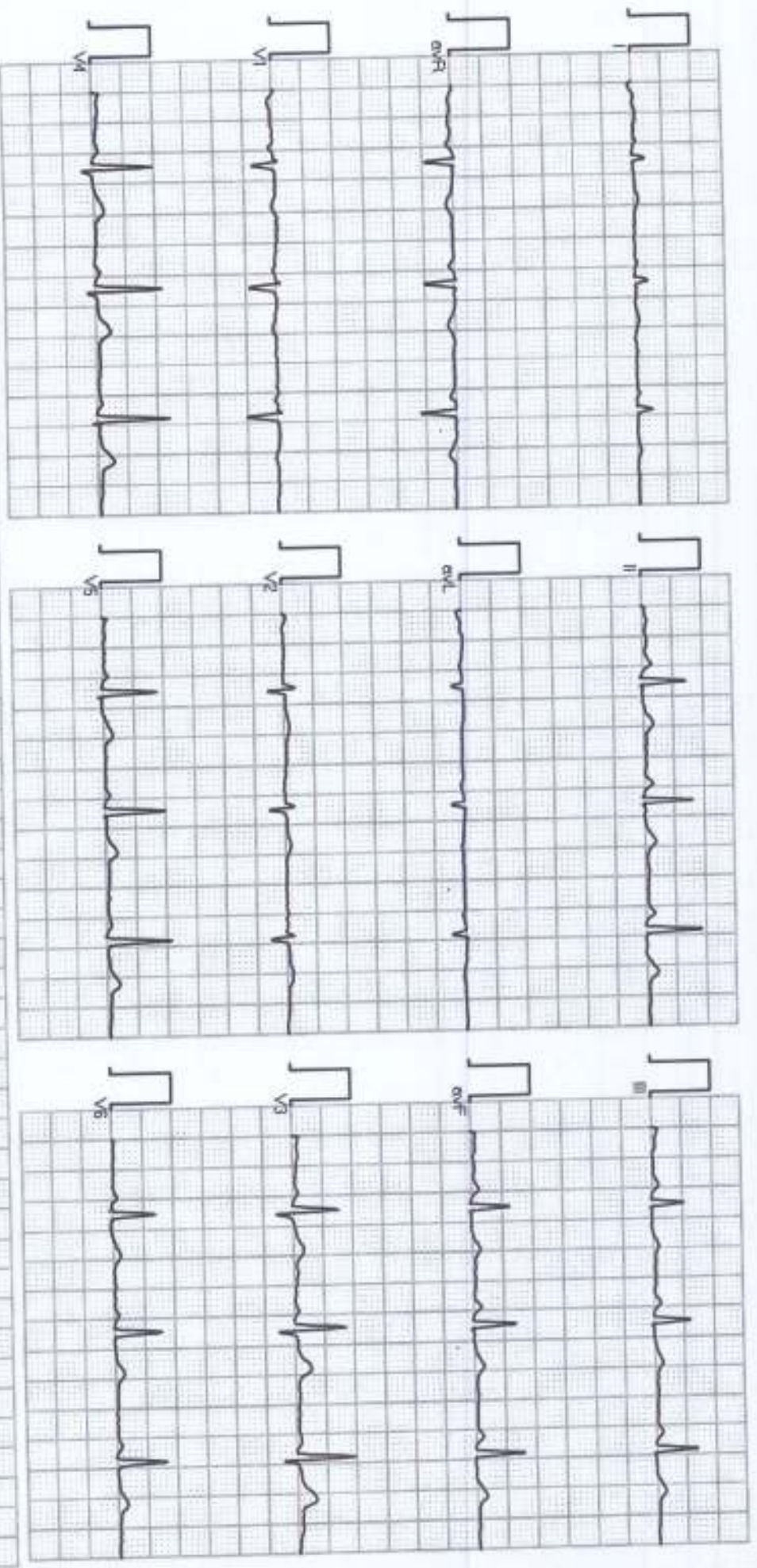
DR. PARTH THAKKAR
MD (Med.) DrNB (Cardiology)
Interventional cardiologist
G - 33

Dr. Parth Thakkar
MD (Med.), DrNB (Cardiology)
Interventional Cardiologist



CONCEPT DIAGNOSTIC

3100 / VARSHABEN R PUJARA / 51 Yrs / F / 148Cms. / 58Kgs / Non Smoker
Heart Rate : 69 bpm / Tested On : 09-Nov-24 13:51:16 / HF 0.05 Hz - LF 35 Hz / Notch 50 Hz / Sh 1.00 Cm/mV / Sw 25 mm/s



Vent Rate: 69 bpm
 PR Interval: 128 ms
 QRS Duration: 66 ms
 QT/QTc Int: 394/410 ms
 P-QRS-T axis: 77.00° 75.00° 72.00°



Axis NSR/WNL

DR. PARTH THAKKAR
 MD (Med) DNB (Cardiology)
 Interventional cardiologist

G - 32045

Reported By: DR PARTH THAKKAR

NAME :	VARSHABEN PUJARA	AGE/SEX:	51Y/F
REF. BY:	HEALTH CHECK UP	DATE :	9-Nov-24

X-RAY CHEST - PA VIEW

- Both lung fields are clear.
- No evidence of consolidation or Koch's lesion seen.
- Both CP angles are clear.
- Heart size is within normal limit.
- Both dome of diaphragm appear normal.
- Bony thorax under vision appears normal.

Dr. Tejas Patel
 Diplomate N. B.
 G-33659



Dr. TEJAS PATEL
DNB RADIODIAGNOSIS



NAME :	VARSHABEN PUJARA	AGE/SEX:	51 Y/F
REF. BY:	HEALTH CHECK UP	DATE :	9-Nov-24

USG ABDOMEN & PELVIS

LIVER: normal in size & shows increased echogenicity. No evidence of dilated IHBR. No evidence of focal or diffuse lesion. CBD & Portal vein normal.

GALL-BLADDER: normal, No evidence of Gall Bladder calculi.

PANCREAS: normal in size & echotexture, No e/o peri-pancreatic fluid collection.

SPLEEN: normal in size & shows normal echogenicity.

KIDNEYS: Both kidneys appear normal in size & echotexture.
Right kidney measures x mm. Left kidney measures x mm.
Multiple variable sized non-obstructive right renal calyceal calculi (3-7mm). Few small non obstructive left renal calyceal calculi (3-4mm).
No evidence of hydronephrosis on either side.

URINARY BLADDER: shows minimal distension & normal wall thickness. No evidence of calculus or mass lesion.

UTERUS: poorly seen, grossly normal. No e/o adnexal mass seen on either side.

USG WITH HIGH FREQUENCY SOFT TISSUE PROBE:

Visualized bowel loops appears normal in caliber. No evidence of focal or diffuse wall thickening. No collection in RIF. No e/o Ascites. No e/o significant lymphadenopathy.

IMPRESSION:

- Grade-I fatty liver.
- Bilateral non obstructive renal calyceal calculi (3-7mm).

Dr. TEJAS PATEL

DNB RADIODIAGNOSIS

Dr. Tejas Patel

Diplomate N. B.

G-33659





NAME :	VARSHABEN PUJARA	DATE :	9-Nov-24
AGE/SEX:	51 Y/F	REG.NO :	00
REFERRED BY: HEALTH CHECK UP			

SONOGRAPHY OF BILATERAL BREASTS:

Normal mixed fatty and fibroglandular breast parenchyma is seen bilaterally.

There is no obvious evidence of a focal spiculated mass lesion, architectural distortion, focal asymmetry or clusters of microcalcifications seen to suggest presence of a malignancy.

No evidence of any dilated ducts seen on either side.

No evidence of any significant axillary adenopathy is seen.

IMPRESSION

- Normal sonomammography of both breasts. (BIRADS I)

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DR. TEJAS PATEL
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NOTE: Investigations are never conclusive but should be co-related along with relevant clinical examination and other investigations to achieve final diagnosis. Not for medico-legal use.

