




PARKLINE DIAGNOSTICS PVT. LTD.

L.G. 3, 4 & 5, Bhuvana Towers, S.D. Road, Secunderabad - 500 003 Tel : 040-42038139, 27845852
7995421787, 7093445852 Email : parklinediagnostics@gmail.com www.parklinediagnostics.com



NABL Accredited
Certificate No.:MC-2566

TEST REPORT

Name	: MRS.A CHANDRAKALA	TID/SID	: UMR1669264/ 27797017
Age / Gender	: 36 Years / Female	Registered on	: 22-Jun-2024 / 13:19 PM
Ref.By	: SELF	Collected on	: 22-Jun-2024 / 13:23 PM
Req.No	 BIL4392177	Reported on	: 22-Jun-2024 / 14:24 PM
		Reference	: Medi Wheel

DEPARTMENT OF CLINICAL PATHOLOGY

Complete Urine Examination (CUE), Urine

Investigation	Observed Value	Units	Biological Reference Interval
Colour Method:Physical Examination	Light Yellow		Light Yellow
Appearance Method:Physical Examination	Clear		Clear
Specific gravity Method:Ion concentration/colour indicator	1.005		1.003-1.030
Reaction and pH Method:Double Indicator	6.5		5.0-8.0
Protein Method:Protein Error of pH indicators	Negative		Negative
Glucose Method:Glucose oxidase/Peroxidase	Negative		Negative
Urobilinogen Method:Ehrlich reaction	Negative		0.2-1.0 mg%
Ketones Method:Sodium Nitroprusside	Negative		Negative
Blood Method:Peroxidase	Negative		Negative
Bile Salt Method:Hays Method	Negative		Negative
Bile Pigment Method:Diazo method	Negative		Negative
Microscopic Examination			
Pus cells (leukocytes) Method:Microscopy Of Sediment	1 - 2	/hpf	0-5 /hpf
RBC (erythrocytes) Method:Microscopy Of Sediment	Nil	/hpf	0-2 /hpf
Epithelial cells Method:Microscopy Of Sediment	Nil	/hpf	0-8 /hpf
Crystals Method:Microscopy Of Sediment	Nil	/lpf	Nil /lpf

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Sundays & Holidays : 7.00 am to 1.00 pm

Radiologists Timings (Weekdays) : 7.30 am to 1.30 pm
& 5.45 pm to 7.45 pm
Sundays & Holidays : 7.30 am to 9.30 am




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DEPARTMENT OF CLINICAL PATHOLOGY

Complete Urine Examination (CUE), Urine

Investigation	Observed Value	Units	Biological Reference Interval
Casts	Nil	/lpf	Nil
Method:Microscopy Of Sediment			/lpf
Others	Nil		Nil
Method:Microscopy Of Sediment			

* Sample processed at Parkline

--- End Of Report ---




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TEST REPORT

Name	: MRS.A CHANDRAKALA	TID/SID	: UMR1669264/ 27797169
Age / Gender	: 36 Years / Female	Registered on	: 22-Jun-2024 / 13:19 PM
Ref.By	: SELF	Collected on	: 22-Jun-2024 / 13:23 PM
Req.No	 BIL4392177	Reported on	: 22-Jun-2024 / 17:57 PM
		Reference	: Medi Wheel

DEPARTMENT OF CYTOPATHOLOGY

Pap Smear, Conventional

Clinical Details

NA

Method:Microscopic Examination

Specimen Type

Routine screening

Specimen Adequacy

Satisfactory for evaluation. Transformation zone component not seen.

General Categorization

Smears studied show sheets of superficial and intermediate cells.

Interpretation

Negative for intraepithelial lesion / malignancy.

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Ref.By : SELF Collected on : 22-Jun-2024 / 13:23 PM
Req.No  Reported on : 22-Jun-2024 / 14:56 PM
BIL4392177 Reference : Medi Wheel

DEPARTMENT OF HEMATOPATHOLOGY

Blood Grouping ABO And Rh Typing, EDTA Whole Blood

Parameter	Results
Blood Grouping (ABO) Method:Forward and Reverse tube agglutination method	O
Rh Typing (D) Method:Agglutination	POSITIVE -

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DEPARTMENT OF HEMATOPATHOLOGY

Complete Blood Picture (CBP), EDTA Whole Blood

Investigation	Observed Value	Units	Biological Reference Interval
Hemoglobin Method:Spectrophotometry	6.6	g/dL	12.0-15.0 g/dL
Erythrocyte Count(RBC) Method:Electrical Impedence	4.3	mill /cu.mm	3.8-4.8 mill /cu.mm
PCV/HCT Method:Numeric Integration	23	%	36-46 %
MCV Method:Calculated	53	fL	83-101 fL
MCH Method:Calculated	15.0	pg	27-32 pg
MCHC Method:Calculated	28.1	gm/dL	31.5-34.5 gm/dL
RDW (CV) Method:Calculated	18.3	%	11.6-14.0 %
Total WBC Count Method:Impedence flowcytometry/Light scattering	3.8	10 ³ /μL	4-10 10 ³ /μL
Differential Count			
Neutrophils Method:Flowcytometry/Microscopy	57	%	40-80 %
Lymphocytes Method:Flowcytometry/Microscopy	35	%	20-40 %
Monocytes Method:Flowcytometry/Microscopy	5	%	2-10 %
Eosinophils Method:Flowcytometry/Microscopy	3	%	1-6 %
Basophils Method:Flowcytometry/Microscopy	0	%	0-2 %
Absolute Neutrophil Count	2.17	10 ³ /μL	2.0-7.0 10 ³ /μL
Absolute Lymphocyte Count	1.3	10 ³ /μL	1.0-3.0 10 ³ /μL

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DEPARTMENT OF HEMATOPATHOLOGY

Complete Blood Picture (CBP), EDTA Whole Blood

Investigation	Observed Value	Units	Biological Reference Interval
Absolute Monocyte Count	0.19	10 ³ /μL	0.20-1.0 10 ³ /μL
Absolute Eosinophils Count	0.11	10 ³ /μL	0.02-0.5 10 ³ /μL
Absolute Basophil Count	0	10 ³ /μL	0.02-0.1 10 ³ /μL
Method:Calculated			
Platelet Count	230	10 ³ /μL	150-410 10 ³ /μL
Method:Electrical Impedence			

Peripheral Smear

RBC

Method:Microscopy

Microcytic and Hypochromic, Anisocytosis+

WBC

Method:Microscopy

Leucocytopenia+. No abnormal cells seen.

Platelets

Method:Microscopy

Discrete and adequate. Normal in morphology

Note

Advised Serum iron studies, Hb electrophoresis

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DEPARTMENT OF HEMATOPATHOLOGY

Erythrocyte Sedimentation Rate (ESR), Sodium Citrate Whole Blood

Investigation	Observed Value	Units	Biological Reference Intervals
ESR 1st Hour Method:Westergren	15	mm/hour	0-20 mm/hour

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Ref.By : SELF Collected on : 22-Jun-2024 / 13:23 PM
Req.No  Reported on : 22-Jun-2024 / 16:06 PM
BIL4392177 Reference : Medi Wheel

DEPARTMENT OF CLINICAL CHEMISTRY I

Blood Urea Nitrogen (BUN), Serum

Investigation	Observed Value	Units	Biological Reference Interval
Blood Urea Nitrogen.	7.9	mg/dL	7-23 mg/dL
Method:Calculated			

Interpretation: Urea is a waste product formed in the liver when protein is metabolized. Urea is released by the liver into the blood and is carried to the kidneys, where it is filtered out of the blood and released into the urine. Since this is a continuous process, there is usually a small but stable amount of urea nitrogen in the blood. However, when the kidneys cannot filter wastes out of the blood due to disease or damage, then the level of urea in the blood will rise. The blood urea nitrogen (BUN) evaluates kidney function in a wide range of circumstances, to diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status as well.

Reference: Tietz Fundamentals of Clinical Chemistry and Molecular Diagnostics

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Req.No	 BIL4392177	Reported on	: 22-Jun-2024 / 16:06 PM
		Reference	: Medi Wheel

DEPARTMENT OF CLINICAL CHEMISTRY I

Creatinine, Serum

Investigation	Observed Value	Units	Biological Reference Interval
Creatinine.	0.55	mg/dL	0.50-1.20 mg/dL
Method:Alkaline Picrate			

Interpretation: Creatinine is a nitrogenous waste product produced by muscles from creatinine. Creatinine is majorly filtered from the blood by the kidneys and released into the urine, so serum creatinine levels are usually a good indicator of kidney function. Serum creatinine is more specific and more sensitive indicator of renal function as compared to BUN because it is produced from muscle at a constant rate and its level in blood is not affected by protein catabolism or other exogenous products. It is also not reabsorbed and very little is secreted by tubules making it a reliable marker. Serum creatinine levels are increased in pre renal, renal and post renal azotemia, active acromegaly and gigantism. Decreased serum creatinine levels are seen in pregnancy and increasing age.

Reference : Wallach's Interpretation of Diagnostics Tests, 9th Edition

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TEST REPORT

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Ref.By : SELF Collected on : 22-Jun-2024 / 13:23 PM
Req.No  Reported on : 22-Jun-2024 / 16:06 PM
BIL4392177 Reference : Medi Wheel

DEPARTMENT OF CLINICAL CHEMISTRY I

Glucose Fasting (FBS), Sodium Fluoride Plasma

Investigation	Observed Value	Units	Biological Reference Interval
Glucose Fasting Method:GOD - PAP	98	mg/dL	Normal: <100 Impaired FG: 100-125 Diabetic : \geq 126 mg/dL

Reference : American Diabetes Association 2023

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Req.No  Reported on : 22-Jun-2024 / 16:06 PM
BIL4392177 Reference : Medi Wheel

DEPARTMENT OF CLINICAL CHEMISTRY I

Glucose Post Prandial (PPBS), Sodium Fluoride Plasma

Investigation	Observed Value	Units	Biological Reference Interval
Glucose Post Prandial Method:GOD - PAP	109	mg/dL	Normal : 90 - 140 Impaired Glucose Tolerance: 141-199 Diabetic : \geq 200 mg/dL

Reference : American Diabetes Association 2023

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Req.No  Reported on : 22-Jun-2024 / 16:35 PM
BIL4392177 Reference : Medi Wheel

DEPARTMENT OF CLINICAL CHEMISTRY I

Glycosylated Hemoglobin (HbA1C), EDTA Whole Blood

Investigation	Observed Value	Units	Biological Reference Interval
Glycosylated Haemoglobin Method:High Performance Liquid Chromatography(HPLC)	4.9	%	< 5.7% : Normal 5.7% - 6.4% : Prediabetes > 6.4% Diabetes
Mean Plasma Glucose (MPG) Estimate Method:Derived from HBA1c	94	mg/dL	Excellent Control : 90 to 120 Good Control : 121 to 150 Average Control : 151 to 180 Panic Value : > 211 mg/dL

Note:Mean Plasma Glucose is calculated from HBA1c value and it indicates Average Blood Sugar level over the past three months.

INTERPRETATION :

- Glycated hemoglobin (glycohemoglobin / HbA1c) is a form of hemoglobin (Hb) that is chemically linked to a sugar.
- A1c is measured primarily to determine the three-month average blood sugar level and can be used as a diagnostic test for diabetes mellitus and as an assessment test for glycemic control in people with diabetes.
- In diabetes, higher amounts of glycated hemoglobin, indicating poorer control of blood glucose levels, have been associated with cardiovascular disease, nephropathy, neuropathy, and retinopathy.
- American diabetes Association (ADA) recommends an A1C goal for many non pregnant adults of < 7% (without significant hypoglycemia). On the basis of provider judgment and patient preference, achievement of lower A1C levels than the goal of 7% may be acceptable, and even beneficial, if it can be achieved safely without significant hypoglycemia or other adverse effects of treatment. Less stringent A1C goals (such as < 8%) may be appropriate for patients with severe hypoglycemia, extensive co morbid conditions etc, or where the harms of treatment are greater than the benefits.
- Glycemic goals for some older adults might reasonably be relaxed as part of individualized care, but hyperglycemia leading to symptoms or risk of acute hyperglycemia complications should be avoided in all patients.

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DEPARTMENT OF CLINICAL CHEMISTRY I

Lipid Profile, Serum

Investigation	Observed Value	Units	Biological Reference Interval
Total Cholesterol Method:CHOD-PAP	145	mg/dL	Desirable Level: < 200 Borderline : 200 - 239 High : > 240 mg/dL
HDL Cholesterol Method:Direct Clearance	46	mg/dL	<40:Major risk factor for heart disease 40-59:The higher,the better >=60:Considered protective against heart disease mg/dL
LDL Cholesterol Method:Calculated	89	mg/dL	< 100 mg/dL
VLDL Cholesterol Method:Calculated	10	mg/dL	10-55 mg/dL
Triglycerides Method:GPO-POD	53	mg/dL	Normal:<150 Borderline:150-199 High:200-499 Very High:>=500 mg/dL
Chol/HDL Ratio Method:Calculated	3.15		Normal : <4 Low risk : 4 - 6 High risk : >6
LDL Cholesterol/HDL Ratio Method:Calculated	1.93		Ideal : < 2 Good : 2 - 5 Bad : > 5

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DEPARTMENT OF CLINICAL CHEMISTRY I

Liver Function Test (LFT), Serum

Investigation	Observed Value	Units	Biological Reference Interval
Total Bilirubin. Method:Diazo with sulphanilic acid	1.00	mg/dL	0.3-1.2 mg/dL
Direct Bilirubin. Method:Diazo with sulphanilic acid	0.31	mg/dL	0.00-0.40 mg/dL
Indirect Bilirubin. Method:Calculated	0.69	mg/dL	0.2-0.8 mg/dL
Alanine Aminotransferase ,(ALT/SGPT) Method:IFCC without P5P	12	U/L	10-40 U/L
Aspartate Aminotransferase,(AST/SGOT) Method:IFCC without P5P	18	U/L	10-40 U/L
ALP (Alkaline Phosphatase). Method:AMP-IFCC	94	U/L	30-115 U/L
PROTEINS			
Total Protein. Method:Biuret	7.42	g/dL	6.0-8.0 g/dL
Albumin. Method:Bromocresol Green (BCG)	4.39	g/dL	3.5-4.8 g/dL
Globulin. Method:Calculated	3.03	g/dL	2.3-3.5 g/dL
A/GRatio. Method:Calculated	1.45		0.8-2.0
Gamma GT. Method:IFCC-Enzymatic	22	U/L	7.0-50.0 U/L

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DEPARTMENT OF CLINICAL CHEMISTRY I

Thyroid Profile (T3,T4,TSH), Serum

Investigation	Observed Value	Units	Biological Reference Interval
Triiodothyronine Total (T3) Method:Enhanced chemiluminescence	1.34	ng/mL	0.970-1.69 ng/mL
Thyroxine Total (T4) Method:Enhanced chemiluminescence	11.8	µg/dL	5.53-11.0 µg/dL
Thyroid Stimulating Hormone (TSH) Method:Enhanced chemiluminescence	1.86	µIU/mL	0.400-4.049 µIU/mL

Note: Change in method and reference range
NOTE:

TSH - Reference ranges during pregnancy:*

1st Trimester : 0.10 - 2.50

2nd Trimester : 0.20 - 3.00

3dr Trimester : 0.30 - 3.00

*As per the Guidelines of American Thyroid Association for the diagnosis and management of thyroid disease during pregnancy and post partum.

1.Primary Hyperthyroidism is accompanied by elevated T3 & T4 values along with depressed TSH level.

2.Primary Hypothyroidism is accompanied by depressed T3 & T4 levels and elevated TSH levels.

3.Normal T4 levels accompanied by high T3 levels are seen in patients with T3 Thyrotoxicosis.

4.Slightly elevated T3 levels may be found in pregnancy and estrogen therapy, while depressed levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propranolol and propylthiouracil.

5.Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result form TSH secreting pituitary tumors(secondary).

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DEPARTMENT OF CLINICAL CHEMISTRY I

Uric Acid, Serum

Investigation	Observed Value	Units	Biological Reference Interval
Uric Acid.	3.13	mg/dL	1.9-7.5 mg/dL
Method:Uricase			

Interpretation: It is the major product of purine catabolism. Hyperuricemia can result due to increased formation or decreased excretion of uric acid which can be due to several causes like metabolic disorders, psoriasis, tissue hypoxia, pre-eclampsia, alcohol, lead poisoning, acute or chronic kidney disease, etc. Hypouricemia may be seen in severe hepato cellular disease and defective renal tubular reabsorption of uric acid.

Reference : Wallach's Interpretation of Diagnostics Tests, 9th Edition

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L.G. 3, 4 & 5, Bhuvana Towers, S.D. Road, Secunderabad - 500 003 Tel : 040-42038139, 27845852
7995421787, 7093445852 Email : parklinediagnostics@gmail.com www.parklinediagnostics.com

TEST REPORT

Name	: MRS.A CHANDRAKALA	TID/SID	: UMR1669264/ 27797021
Age / Gender	: 36 Years / Female	Registered on	: 22-Jun-2024 / 13:19 PM
Ref.By	: SELF	Collected on	: 22-Jun-2024 / 13:23 PM
Req.No	 BIL4392177	Reported on	: 22-Jun-2024 / 16:06 PM
		Reference	: Medi Wheel

DEPARTMENT OF CLINICAL CHEMISTRY I

Bun/Creatinine Ratio, Serum

--

BUN/Creatinine Ratio **14.3** 10:1-20:1
Method:Calculated

Reference:

A Manual of Laboratory Diagnostic Tests. Edition 7, Lippincott Williams and Wilkins, By Frances Talaska Fischbach, RN, BSN, MSN, and Marshall Barnett Dunning 111, BS, MS, Ph.D.

* Sample processed at Parkline

--- End Of Report ---




Dr.Jyothi Kiranmai
Regd. No: 52272
MD PATHOLOGY



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TEST REPORT

Name : **MRS.A CHANDRAKALA** TID/SID : UMR1669264/ 27797017-F
Age / Gender : 36 Years / Female Registered on : 22-Jun-2024 / 13:19 PM
Ref.By : SELF Collected on : 22-Jun-2024 / 13:23 PM
Req.No  Reported on : 22-Jun-2024 / 16:06 PM
BIL4392177 Reference : Medi Wheel

DEPARTMENT OF CLINICAL CHEMISTRY I

Glucose Urine Fasting

Investigation	Observed Value
Urine Glucose Fasting Method:Reagent strip/Reflectance photometry	Nil NIL

* Sample processed at Parkline

--- End Of Report ---



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TEST REPORT

Name	: MRS.A CHANDRAKALA	TID/SID	: UMR1669264/ 27797017
Age / Gender	: 36 Years / Female	Registered on	: 22-Jun-2024 / 13:19 PM
Ref.By	: SELF	Collected on	: 22-Jun-2024 / 13:23 PM
Req.No	 BIL4392177	Reported on	: 22-Jun-2024 / 16:25 PM
		Reference	: Medi Wheel

DEPARTMENT OF HEALTH CHECKUP

Glucose Urine Post Prandial

--

Urine Glucose Post Prandial	Nil	NIL
Method:Reagent strip/Reflectance photometry		

* Sample processed at Parkline



--- End Of Report ---

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NABL Accredited
Certificate No.MC-2566

MEDICAL EXAMINATION REPORT

Name	Mrs. A. Chandrakala	Date : 22/6/2024
Company	Medi Wheel.	Reg. No. : 4392177
Contact No.	9642438781	Sex <input type="checkbox"/> F <input type="checkbox"/> Age : <input type="checkbox"/> 36
Type	Pre-Emp	Emp. No.:
	Overseas	Height 150cm
	Annual	Weight 56 kg
Remarks	Microcytic hypochromic Anemia with Hb = 6.6 g/dl Present Advice to improve Hb level Repeat CBP after 4-6 weeks Rest all physical and lab parameters within normal limits.	
Fitness Status	Medically Fit / Unfit	Physician's Signature Regn. No. 11351

Distant Vision : Near Vision :

Right Eye: 6/12 - 1.50 sph 6/6

Right Eye: NC

With glasses / Without glasses

With glasses / Without glasses

left Eye: 6/12 - 1.50 sph 6/6

left Eye: NC

with glasses / without glasses

with glasses / without glasses

Colour Vision : BE normal

Ophthalmologist's Signature

DR. KATTA
M.B.B.S., D.O., F.R.
Regd. 1981 (AMCI)

Right Ear

Left Ear

Hearing :

Rinee's Test ;

Weber Test :

Discharge :

SYSTEMIC EXAMINATION

Pulse : 70 bpm

B.P. : 110/70 with

Lungs :

- A. Shape of Chest B/c symmetrical
- B. Breath Sounds regular
- C. Adventitious Sounds NO

Heart :

- A. Sounds S1, S2 ⊕
- B. Murmurs NO

Nervous System

Abdomen :

- A. Liver NPD
- B. Spleen NPD
- C. Piles NO
- D. Any Lump NO

- A. Higher Function :
- B. Cranial Nerves :
- C. Sensory System :
- D. Motor System :
- E. Jerks :

Normal

General :

- A. Hernia NO
- B. Hydrocele NO
- C. Varicocele NO

Breast :

Rt. Normal Lt. Normal

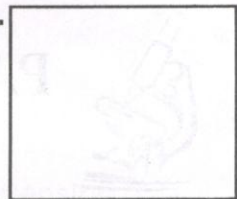
COMPREHENSIVE MEDICAL EXAMINATION REPORT

NAME A. Chandakala

AGE 36

MARITAL STATUS married CHILDREN : M F

IDENTIFICATION (IF ANY) A mole on right hand



PAST HISTORY

Any family H/o : High Blood Pressure, Heart Disease, Tuberculosis, Diabetes, Asthma, Cancer

mother father mother + father

Any personal H/o Major illness like : Typhoid.....No.....Jaundice.....No.....Etc.

Any H/o STD.....No.....Skin infection.....No.....

H/o Blood Transfusion.....No.....Recent Vaccination.....Covax.....

H/o Epilepsy.....No.....Giddiness.....No.....

H/o Surgery.....LCG - 2019.....Fracture in the past.....No.....
2021

Any Personal H/O.

High Blood Pressure, Heart Disease Tuberculosis, Diabetes, Asthma, Cancer

Drug Abuse, Drug Allergy, Micturition, Bowels, Alcohol, Smoking, Sleep, MC, Wt. Loss/Wt. Gain

Present illness / Medication

None Thyroid medication
Thyroxine 50mg

GENERAL EXAMINATION

Conjunctiva : <u>Normal</u>	Bone, Joints : <u>Normal</u>
Skin : <u>Normal</u>	Nutritional Status : <u>well nourished</u>
Ears : <u>Normal</u>	Lymph Nodes : <u>Normal</u>
Nose : <u>Normal</u>	Edema Feet : <u>No</u>
Throat & Oral Cavity : <u>Normal</u>	Varicose Veins : <u>No</u>

CANDIDATE'S DECLARATION

I hereby solemnly declare that I am not suffering from Asthma, Hypertension, Diabetes, Occult Psychological disorders or any other ailment which can be suppressed without my voluntary declaration.

Date :

A. Chandrakala

Signature

Place :

Note : General Physical Examination and Investigation included in the health check-up Have certain limitations and may not be able to detect all latent and asymptomatic diseases. Any new symptoms developing after the health check-up or persisting thereafter should be brought to the attention of the treating physician.

Name : Chandrabala. Sex : F Age : 36

Date :

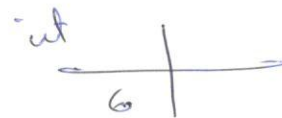
OPD No :

ca⁺ sn⁺



Dc int



Composite restⁿ done



Oral prophylaxis done


Smilesss 
 MULTI SPECIALITY DENTAL CLINIC
Smile Confidently... Not Confidentially....
 B.D.S, IMPLANTOLOGIST (USA)
 1-3-1, Rajamudaliar Street, Kalasiguda,
 Secunderabad, Cell : 8977910590,

Sowmya



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Mr Chandakala 36y

O/E - NOT anemic

Chl-2 $\leq \frac{6}{4}$

BP 110/70

M.H. - Regular
Normal flow

cks }
RS } NAD

Breasts

Both breasts Normal
No Lumps.

Nipple, areola normal

K. R. Roshan

Dr. USHA MBBS, DGO.
Obstetrician & Gynaecologist
Regd. No. 9885



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TEST REPORT

Name : Mrs . A CHANDRAKALA
Age/Gender : 36 Years/Female
Ref By : Self
Reg.No : BIL4392177

TID : UMR1669264
Registered On : 22-Jun-2024 01:19 PM
Reported On :
Reference : Medi Wheel

DEPARTMENT OF ULTRASOUND Ultrasound Whole Abdomen

LIVER : Normal in size and echotexture. No focal lesions.
No IHBD /CBD dilatation. Portal vein is normal.

SPLEEN : Normal in size and echotexture. No focal lesion seen.

GALL BLADDER : Well distended. No sludge / gall stones / sol.
Gall bladder - Wall thickness is normal.
No pericholecystic oedema.

PANCREAS : Normal in size and echotexture.No calcification / sol.
Pancreatic duct is normal. No peripancreatic fluid collection.

RIGHT KIDNEY : 9.8 x 4.0 cms.
Normal in size and echotexture.
Cortical thickness is normal.
No evidence of calculi. Lower pole cortical cyst 1.92 cms.
Pelvi calyceal system is normal.

LEFT KIDNEY : 9.9 x 4.2 cms.
Normal in size and echotexture.
Cortical thickness is normal.
No evidence of calculi / sol.
Pelvi calyceal system is normal.

URINARY BLADDER : Well distended.Normal in contour.
Wall thickness is normal. No calculus / sol.


UTERUS : Anteverted measuring 6.9 x 3.4 x 4.2 cms - Normal in size and echotexture.
No space occupying lesion is seen.
Cervix is normal in size and echopattern.

ENDOMETRIUM : 4.0 mm -Normal.

OVARIES : Right ovary : 3.4 x 2.0 cms and Left ovary : 3.2 x 1.9 cms.
Both ovaries normal in size and echotexture.
No adnexal mass seen.
No fluid in POD.

IMPRESSION : Normal Study.
Clinical correlation.

*** End Of Report ***


Dr. PRAJAKTA SUKHADEVE
DNB RADIOLOGY
Reg. No. 88493



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TEST REPORT

Name : Mrs . A CHANDRAKALA
Age/Gender : 36 Years/Female
Ref By : Self
Reg.No : BIL4392177

TID : UMR1669264
Registered On : 22-Jun-2024 01:19 PM
Reported On :
Reference : Medi Wheel

X-RAY CHEST PA VIEW

Lung fields are clear.

Cardia is normal.

Hila are normal.


C P angles are free.

Bony cage is normal.

Soft tissues are normal.

IMPRESSION : NORMAL CHEST X-RAY

*** End Of Report ***


Dr. PRAJAKTA SUKHADEVE
DNB RADIOLOGY
Reg. No. 68493

PATIENT SUMMARY REPORT

PARKLINE DIAGNOSTICS PVT.LTD

ID : 439
NAME : **MS A CHANDRA KALA**
AGE / SEX : 36 / FEMALE

HEIGHT (cm) : 150
WEIGHT (kg) : 56
PROTOCOL : BRUCE

REF. BY : MEDI WHEEL UNION BANK
DONE BY : DR PRASHANT P
TECHNICIAN : G.M.SURESH

CASE HISTORY :

MEDICATION :

OBJECT OF TEST : Routine Check Up.
RISK FACTOR : None.
ACTIVITY : Very Active.
OTHER INVESTIGATION : ECG
REASON FOR TERMINATION : THR ACHIEVED
EXERCISE TOLERANCE : Moderate (< 10 METS).
EXERCISE INDUCED ARRHYTHMIAS : No.
HAEMO RESPONSE : Normal.
CHRONO RESPONSE : Normal.
FINAL IMPRESSION :
EXTRA COMMENTS :

TMT is Negative

Dr. P. PRASHANT MARUTI
DM., Cardiology
Consultant Interventional Cardiologist
Reg. No. TSMC/FMR/25860

Confirmed By : _____

Signature

ID: 43421A
MRS.A CHANDRAKALA
Female 36Years

HR : 78 bpm
P : 114 ms
PR : 156 ms
QRS : 79 ms
QT/QTc : 375/428 ms
P/QRS/T : 30/50/43 °
RV5/SV1 : 1.324/0.463 mV

Diagnosis Information:
Sinus Rhythm
Poor R Wave Progression(V3)

mm

[Signature]

Dr. P. PRASHANT MARUTI
DM., Cardiology
Consultant Interventional Cardiologist
Reg. No. TSMC/FMR/25860

Report Confirmed by:

