

NAME:	Mr. Bhawanee Kumar H.	UHID:	
AGE:	40	DATE OF HEALTHCHECK:	20-1-2024
GENDER:	M		

HEIGHT:	161	MARITAL STATUS:	M.
WEIGHT:	81.3	NO OF CHILDREN:	2
BMI:	31.4		

C/O: Lt. Eye infection & injury.

K/C/O: PRESENT MEDICATION: - Calcium + Vit D

P/M/H: -

P/S/H: - Lt Eye Sp.

ALLERGY: -

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER: - DM

ALCOHOL: - Occ.

MOTHER: - DM.

TOBACCO/PAN:

O/E:

LYMPHADENOPATHY:

BP: 120/80 PULSE: - 98/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING: - None

TEMPERATURE: - SCARS:

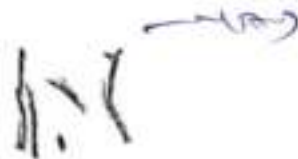
OEDEMA:

S/E:

RS:



P/A:



CVS: - Normal

Extremities & Spine: - No knee pain, No Dys.

ENT: - None

CNS: - Conscious, oriented

Skin: - None

Vision:

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

Name:	Age:	Date of Health check-up:
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Findings and Recommendation:

Findings:- COC - Hb (less)

left supants warr

Recommendation:-

Sug HB Electrophenia

DR. PRADNYA P. DANI
(M.B.B.S)
Reg. No. 87541

Pradny

Signature:
Consultant -

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 25.1.24

Name: Prashant Kumar H. Age: 40 Gender: Male/Female

Without Correction :

Distance: Right Eye 6/9 Left Eye FC worse.

Near : Right Eye N.G Left Eye —

With Correction :

Distance: Right Eye 6/6 Left Eye — N.I

Near : Right Eye N.G Left Eye —

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	/	-0.50	90	/	6/6	Plano				
Near	—————									

Colour Vision: (Normal)

Anterior Segment Examination: (RE) CNV (LE) PCION (+)

Pupils: H/O trauma in child hood

Fundus: _____

Intraocular Pressure: _____

Diagnosis: _____

Advice: (Can do desk work)

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

Dr. **DR. SHETHNIK PRASHANT**
 (Consultant Ophthalmologist)
 M.B.B.S. D.M.S.
 Regn. No 2008/10/30/10

DENTAL CHECKUP

Name: Bharath Kumar	MR NO:
Age/Gender : 40/M	Date: 25/1/24

Medical history: Diabetes Hypertension _____

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: _____

Adv.
 XRay = 8/8.
 Filling = 8/8. - 1200 X 2.

• ANDHERI • COLABA • NASHIK • VASHI



Name : Mr. Bharath Kumar H Gender : Male Age : 40 Years
UHID : FVAH 10374. Bill No : Lab No : V-3329-23
Ref. by : SELF Sample Col.Dt : 25/01/2024 09:10
Barcode No : 5599 Reported On : 25/01/2024 18:34

TEST

RESULTS

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

ABO Group: :O:
Rh Type: **Positive**
Method : Matrix gel card method (forward and reverse)

Pooja Surve
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Ms Kaveri Gaonkar
Verified By



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

End of Report
Results are to be correlated clinically

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	90	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 :	103	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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Page 3 of 3
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LIPID PROFILE - Serum

S. Cholesterol(Oxidase)	138	mg/dL	Desirable < 200 Borderline: >200-<240 Undesirable: >240
S. Triglyceride(GPO-POD)	81	mg/dL	Desirable < 150 Borderline: >150-<499 Undesirable: >500
S. VLDL:(Calculated)	16.2	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	36.7	mg/dL	Desirable > 60 Borderline: >40-<59 Undesirable: <40
S. LDL:(calculated)	85.1	mg/dL	Desirable < 130 Borderline: >130-<159 Undesirable: >160
Ratio Cholesterol/HDL	3.8		3.5 - 5
Ratio of LDL/HDL	2.3		2.5 - 3.5

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	6.70	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.43	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.27	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.95		0.9 - 2
S.Total Bilirubin (DPD):	1.11	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.38	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.73	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	22	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	24	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	65	U/L	40 - 129
S.GGT(IFCC Kinetic):	21	U/L	11 - 50

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
BIOCHEMISTRY		
S.Urea(Urease Method)	21.6 mg/dl	10.0 - 45.0
BUN (Calculated)	10.08 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.96 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	10.5	9:1 - 23:1
S.Uric Acid(Uricase Method)	6.2 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)	2.09	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	109.6	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	2.7	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), Nephrosis 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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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)


REACTION(PH)	7.0		4.6 - 8.0
SPECIFIC GRAVITY	1.015		1.005 - 1.030
URINE ALBUMIN	Absent		Absent
URINE SUGAR(Qualitative)	Absent		Absent
KETONES	Absent		Absent
BILE SALTS	Absent		Absent
BILE PIGMENTS	Absent		Absent
UROBILINOGEN	Normal(< 1 mg/dl)		Normal
OCCULT BLOOD	Absent		Absent
Nitrites	Absent		Absent

MICROSCOPIC EXAMINATION

PUS CELLS	Occasional		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	Occasional		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

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 Dr. Milind Patwardhan
 M.D(Path)
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

STOOL EXAMINATION

PHYSICAL EXAMINATION

COLOUR Brown
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

Anushka Chavan
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Verified By



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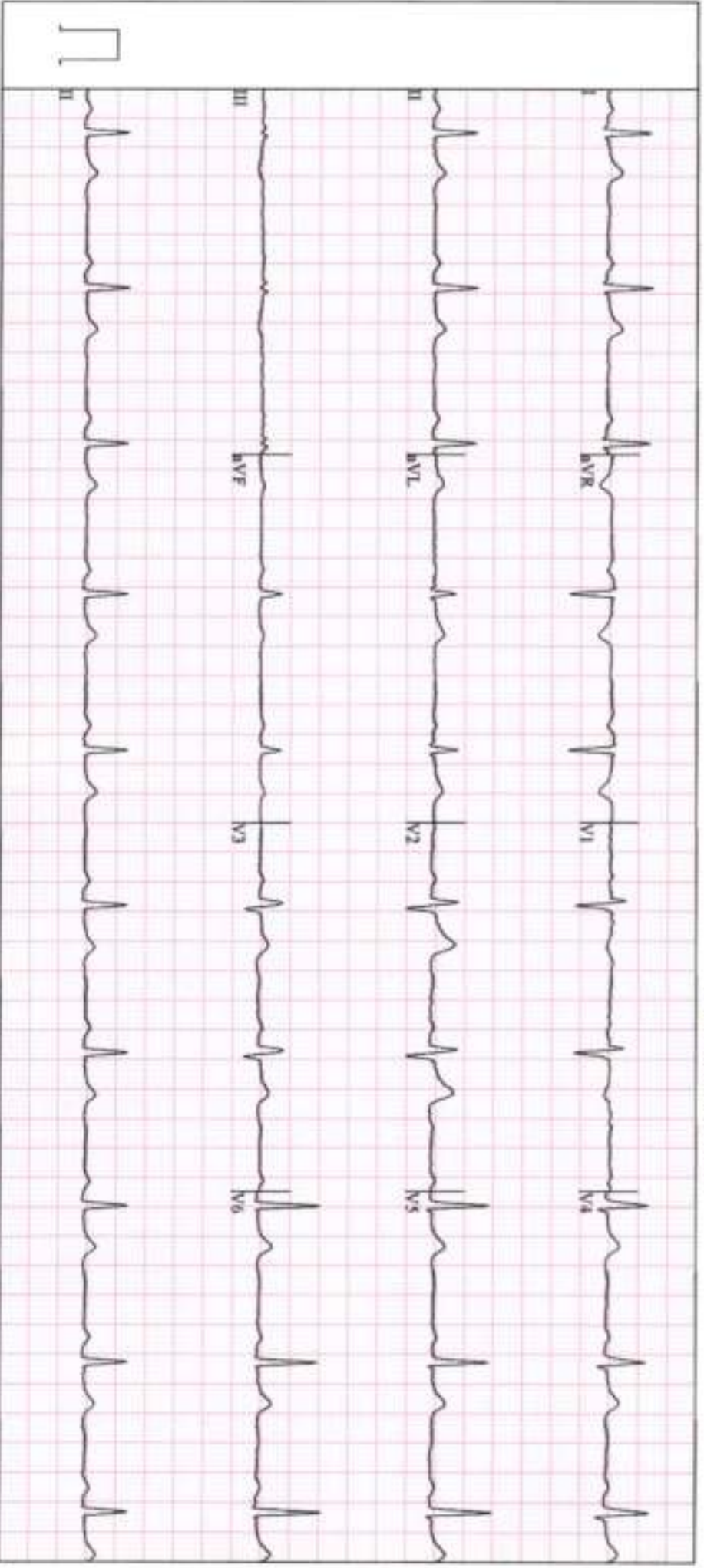
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QRS : 88 ms
QT / QTcBaz : 410 / 402 ms
PR : 184 ms
P : 110 ms
RR / PP : 1040 / 1034 ms
P / QRS / T : 35 / 31 / 10 degrees

Sinus bradycardia
Otherwise normal ECG

Dr. S. S. Radhycada

DR. ANIRBAN DASGUPTA
M. B. B. S., D. N. B. Medicine
Diploma Cardiology
MMC - 2005/02/09920



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

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: BHARATH KUMAR, H
Patient ID: 10374
Height:
Weight:

DOB: 16.11.1983
Age: 40yrs
Gender: Male
Race: Asian

Study Date: 25.01.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR. ANIRBAN DASGUPTA
Technician: SWAPNALI LAKHIMALE

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	00:22	0.00	0.00	75	120/80	
	STANDING	00:07	0.00	0.00	76		
	HYPERV.	00:15	0.00	0.00	81		
	WARM-UP	00:15	0.50	0.00	80		
	EXERCISE	STAGE 1	03:00	1.70	10.00	120	130/80
	STAGE 2	03:00	2.50	12.00	157	140/90	
	STAGE 3	02:11	3.40	14.00	179	160/90	
RECOVERY		01:22	0.00	0.00	137	170/90	

The patient exercised according to the BRUCE for 8:10 min:s, achieving a work level of Max. METS: 10.40. The resting heart rate of 81 bpm rose to a maximal heart rate of 179 bpm. This value represents 99% of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 170/90 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

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

PATIENT'S NAME	BHARATH KUMAR H	AGE :- 40 y/M
UHID NO	10374	25 Jan 2024

DIGITAL RADIOGRAPH OF CHEST (PA VIEW)

The lung fields are clear.

Heart and aorta appears normal.

Both hila appear normal.

Both costo-phrenic angles are clear.

Visualized bony thorax appears normal.

IMPRESSION: NO SIGNIFICANT ABNORMALITY IS DETECTED.

Clinico-haematological correlation is recommended.

Thanking you for the referral,
With regards,



DR. SIDDHI PATIL
Cons. Radiologist

PATIENT'S NAME	BHARATH KUMAR H	40YRS /M
UHID NO	10374	25 jan 2024

USG WHOLE ABDOMEN

LIVER is normal in size, shape and 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 10.7 x 4.8 cm. **LEFT KIDNEY** measures 10.7 x 4.7 cm.

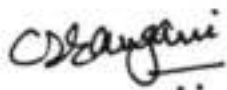
Urinary Bladder is adequately distended; no e/o any obvious wall thickening or mass or calculi seen.

PROSTATE is normal in size, shape & echotexture.

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

IMPRESSION -

- No significant abnormality detected.



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CONSULTANT SONOLOGIST
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