

NAME:	MV. Mangesh Sonawale	UHID:	
AGE:	37 years	DATE OF HEALTHCHECK:	28/10/23
GENDER:	Male		

HEIGHT:	174	MARITAL STATUS:	married
WEIGHT:	85.5	NO OF CHILDREN:	
BMI:	28.2		

C/O: No fresh complaints noted

K/C/O: NAD
PRESENT MEDICATION: NAD

P/M/H: NAD

P/S/H: NAD

ALLERGY: None

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING: }
ALCOHOL: }
TOBACCO/PAN: }

FAMILY HISTORY FATHER: } → Pneumonia going on
MOTHER: } HTN

O/E:

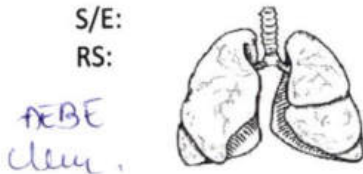
LYMPHADENOPATHY: NAD

BP: 110/90 mmHg PULSE: 80/min
TEMPERATURE: SCARS: NAD

PALLOR/ICTERUS/CYNOSIS/CLUBBING: NAD

OEDEMA: -NAD

S/E:
RS:



P/A:
Soft IWT

CVS: Syst

Extremities & Spine: (-)

ENT:

CNS: consistency

Skin:

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:-

2 mic Acid - 8.5

7 SH - 5-8

Recommendation:-

→ $\frac{p}{q}$

① 7. fume
(no)

p/o

0-01 x 3 months

→ monitor Bf regularly.

Signature:

Consultant -


DR MAYUR GARG
MBBS, MD MEDICINE
REG NO : 2017020378

Name : Mr. Mangesh Sonawane Gender : Male Age : 37 Years
UHID : FVAH 9167. Bill No : Lab No : V-2859-23
Ref. by : SELF Sample Col.Dt : 28/10/2023 09:20
Barcode No : 3084 Reported On : 28/10/2023 20:12

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)

Haemoglobin(Colorimetric method)	14.1	g/dl	13 - 18
RBC Count (Impedance)	4.36	Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	44	%	35 - 55
MCV:(Calculated)	100.9	fl	78 - 98
MCH:(Calculated)	32.3	pg	26 - 34
MCHC:(Calculated)	32	gm/dl	30 - 36
RDW-CV:	16.6	%	11.5 - 16.5
Total Leucocyte count(Impedance)	4010	/cumm.	4000 - 10500
Neutrophils:	65	%	40 - 75
Lymphocytes:	30	%	20 - 40
Eosinophils:	02	%	0 - 6
Monocytes:	03	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	2.3	Lakhs/c.mm	1.5 - 4.5
MPV	9.7	fl	6.0 - 11.0
ESR(Westergren Method)	08	mm/1st hr	0 - 20

Peripheral Smear (Microscopic examination)

RBCs: Macrocytosis(Mild)Anisocytosis(Mild)

WBCs: Normal

Platelets Adequate

Note: Test Run on 5 part cell counter. Manual diff performed.

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

End of Report
Results are to be correlated clinically

Name : Mr. Mangesh Sonawane Gender : Male Age : 37 Years
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TEST

RESULTS

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

ABO Group:

:AB:

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 : **113** mg/dL Normal < 100 mg/dL
Impaired Fasting glucose : 101 to 125 mg/dL
Diabetes Mellitus : >= 126 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)	156	mg/dL	Desirable < 200 Borderline: >200-<240 Undesirable: >240
S. Triglyceride(GPO-POD)	187	mg/dL	Desirable < 150 Borderline: >150-<499 Undesirable: >500
S. VLDL:(Calculated)	37.4	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	<u>27.8</u>	mg/dL	Desirable > 60 Borderline: >40-<59 Undesirable: <40
S. LDL:(calculated)	90.8	mg/dL	Desirable < 130 Borderline: >130-<159 Undesirable: >160
Ratio Cholesterol/HDL	<u>5.6</u>		3.5 - 5
Ratio of LDL/HDL	3.3		2.5 - 3.5

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
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LFT(Liver Function Tests)-Serum			
S.Total Protein (Biuret method)	7.37	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.64	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.73	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.7		0.9 - 2
S.Total Bilirubin (DPD):	1.17	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.44	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):	40	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	71	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	94	U/L	40 - 129
S.GGT(IFCC Kinetic):	50	U/L	11 - 50

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Kidney screening test-Serum			
S.Urea(Urease-GLDH)	15.4	mg/dL	10.0 - 45.0
S. Urea Nitrogen(Calculated)	7.18	mg/dL	5 - 20
S.Creatinine(Jaffe's Kinetic)	0.82	mg/dL	0.50 - 1.3
S.Uric Acid(Uricase-POD)	8.5	mg/dL	3.4 - 7.0

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NABL Accredited Laboratory

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Email: apolloclinicvashi@gmail.com

Apollo Clinic
VASHI

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	15.4 mg/dl	10.0 - 45.0
BUN (Calculated)	7.18 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.82 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	<u>8.76</u>	9:1 - 23:1

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Thyroid (T3,T4,TSH)- Serum

Total T3 (Tri-iodo Thyronine) (ECLIA)	1.34	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	74.36	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	5.80	□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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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
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URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	10	mL	
COLOUR	Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	6.0		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	1 - 2/hpf		0 - 3/hpf
RED BLOOD CELLS	Nil /HPF		Absent
EPITHELIAL CELLS	2 - 3 /hpf		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

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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

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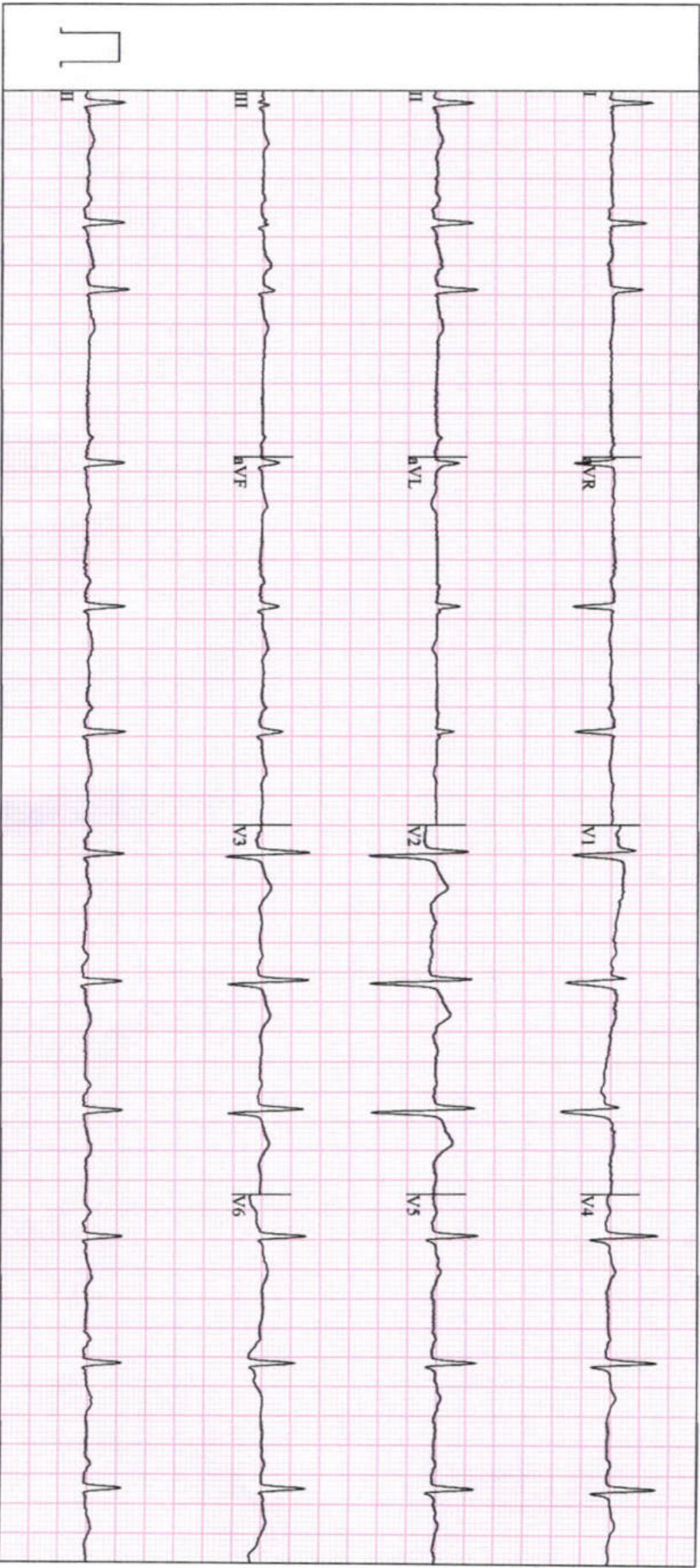
37 Years Male

QRS : 88 ms
QT/QTcBaz : 388 / 419 ms
PR : 166 ms
P : 110 ms
RR/PP : 854 / 857 ms
P/QRS/T : 49 / 26 / 73 degrees

Sinus rhythm with premature atrial complexes
Nonspecific T wave abnormality
Abnormal ECG

Siva Anurupa

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



PATIENT'S NAME	MANGESH SONAWANE	AGE :- 37y/M
UHID NO	9167	28 Oct 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 10.7 x 4.0 cm. **LEFT KIDNEY** measures 11.3 x 3.6 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 –

- **Grade II 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
CONSULTANT SONOLOGIST
Reg: No. 073826