



HEALTH CHECK UP SUMMARY

Name :		
Age :		UHID : WHRJ.0000663459
Sex :		Mr. AHMAD SHEKH
UHID :		Age : 33 Yrs/Male
Exam. Date :		Dr. SHYAM KARIA

To be Filled in by the patient

Has anyone in your family suffered from the following ailments ? if yes, please specify the time period

FAMILY HISTORY

Hypertension :	NO/YES	<i>Mother</i>	Asthma :	NO/YES	<i>no</i>
Heart disease :	NO/YES		Cancer :	NO/YES	
Diabetes :	NO/YES		Skin Disease :	NO/YES	
Epilepsy :	NO/YES	<i>no</i>	Mental Disease :	NO/YES	
Renal Disease :	NO/YES		Peptic ulcer :	NO/YES	
Stroke :	NO/YES				
Arthritis / Gout :	NO/YES				

Have you ever suffered from any of these ailments :

PERSONAL & MEDICAL HISTORY

Heart Disease :	NO/YES	<i>no</i>	Hypertension :	NO/YES	<i>no</i>
Asthma :	NO/YES		Cancer :	NO/YES	
Diabetes :	NO/YES		Malaria :	NO/YES	
Renal Disease :	NO/YES		Skin Disease :	NO/YES	
Epilepsy :	NO/YES		Arthritis / Gout :	NO/YES	
Stroke :	NO/YES		Peptic Ulcer :	NO/YES	
Mental Disorder :	NO/YES		Chronic Dysentery :	NO/YES	
Eosinophilia :	NO/YES		Major illness :	NO/YES	
Vertigo :	NO/YES		Hospitalization :	NO/YES	
Jaundice :	NO/YES		Tuberculosis :	NO/YES	
Smoking :	NO/YES		Medication :	NO/YES	
Chewing Tobacco :	NO/YES				
Pan / Betel nut :	NO/YES				
Alcohol intake :	NO/YES				
Allergies :	NO/YES				
Operations :	NO/YES				

If yes - please name them

Is there any specific issue/concern you may want to discuss with the doctor ?

relax Constipation

Male

PR interval 150 ms
QRS duration 78 ms
QT/QTc 384/375 ms
P-R-T axes 41 58 57

Otherwise normal ECG



UHID : WHF1.0000663459

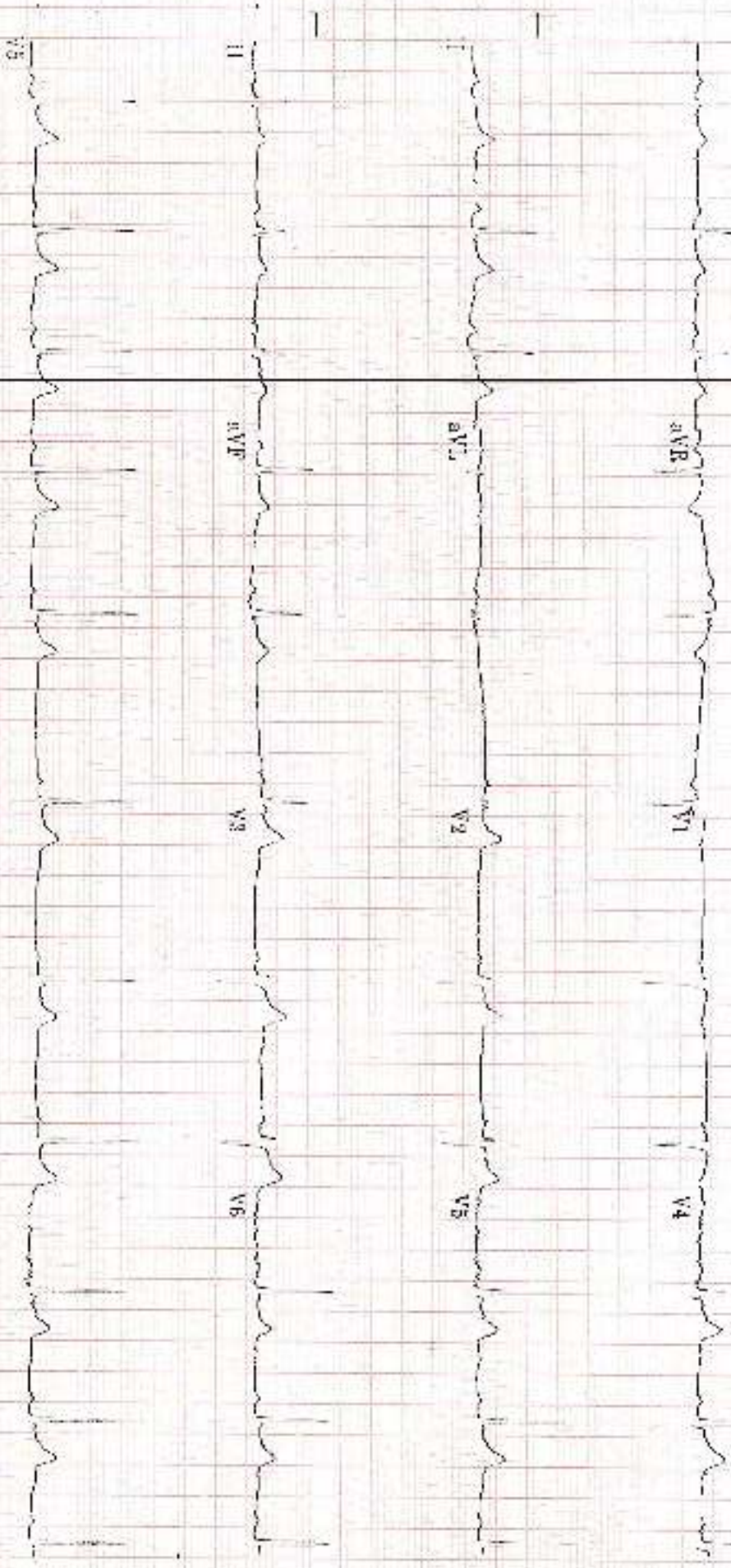
Mr. AHMAD SHEKH

Age : 33 Yrs/Male

Dr. SHYAM KARIA

Uncalibrated

12-LEAD ECG



25.0 mm/s 10.0 mm/mV

4 by 2.0e + 1 s/s

MACS5 009C

II 129L V293

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHEKH	Bill No.	: OCR6/25/0003189
Age/Sex	: 33 Years/Male	Sample Collection	: 09/11/2024 10:59 AM
UHID	: WHRJ.0000653450	Receiving Date Time	: 09/11/2024 10:59 AM
Primary Consultant	: DR. SHYAM KARIA	Report Date	: 09/11/2024 10:59 AM
Order Date	: 09/11/2024 10:14 AM	Approval Date Time	: 09/11/2024 11:03 AM
Order No.	: 40385	Specimen	: EDTA Whole Blood
Visit Code	: OP6.0211158	Bed No.	

HEMATOLOGY

PARAMETER	METHOD	RESULT	UNIT	B.R.I	Final Report
Complete Blood Count (With ESR)- EDTA Blood					
Haemoglobin	SLS Photometric Method	13.7	g/dL		13.5-18.0
Haematocrit	RBC Histogram	43.2	%		42-52
RBC Count	Impedance	5.30	10 ⁶ /μL		4.7-6.0
MCV	Calculated	81.4	fL		78-100
MCH	Calculated	25.8	pg		27-31
MCHC	Calculated	31.7	g/dL		30-35
RDW-CV	Calculated	14.1	%		11.5-14.0
WBC Total Count TLC	Flow cytometry / Microscopy	7.07	10 ³ /μL		4.0-10.5
Platelet Count	Impedance	242	10 ³ /μL		150-450
WBC Differential Count (DLC)					
Neutrophils	Flow cytometry / Microscopy	55.2	%		40-80
Lymphocytes	Flow cytometry / Microscopy	21.5	%		20-40
Eosinophils	Flow cytometry / Microscopy	10.8	%		2-6
Monocytes	Flow cytometry / Microscopy	11.8	%		2-10
Basophils	Flow cytometry / Microscopy	0.7	%		0-2
Blood ESR - 1 Hour	Westergren	06	mm/hr		0-20

-- END OF REPORT --

VARSHA DHOLARIYA
Verified By

Dr. PRAVIN GOJIYA

M.D., (PATHOLOGY)

Units, Reference and Result not provided. This Report Relates to Sample received by Laboratory
* NOT A SUGGESTION FOR RESISTANCE TREATMENT



DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHFKH	Bill No.	: OCR6/25/0003189
Age/Sex	: 33 Years/Male	Sample Collection	: 09/11/2024 10:59 AM
UHID	: WHR1.0000663459	Receiving Date Time	: 09/11/2024 10:59 AM
Primary Consultant	: DR. SHYAM KARIA	Report Date	: 09/11/2024 10:59 AM
Order Date	: 09/11/2024 10:14 AM	Approval Date Time	: 09/11/2024 11:03 AM
Order No.	: 40385	Specimen	: EDTA Whole Blood
Visit Code	: OP6.0211158	Bed No.	:

LABORATORY MEDICINE

PARAMETER	METHOD	RESULT	UNIT	Final Report
LIPOGRAM				
Total Cholesterol	CHOD-PAP	166.06	mg/dL	Desirable: <200 Borderline: 200-239 High: >240
HDL Cholesterol - Direct	Direct Method	40.1	mg/dL	Low: <40.0 High: >60.0
Chol/HDL Ratio	Calculated	4.14		3.5-5.0
Triglycerides	GOP-PAP	65.5	mg/dL	Normal: <150 Borderline: 150-199 High: 200-499 Very High: >500
LDL-Cholesterol -Direct	Homogeneous Enzymatic Colorimetric Assay	125.3	mg/dL	Optimal: <100 Near Optimal: 100-130 Borderline: 130-159 High: 160-190 Very High: >190
LDL/HDL Ratio	Calculated	3.12		2.5-3.5
VLDL Cholesterol	Calculated	13.1	mg/dL	Normal: <30 Optimal: <130
Non - HDL Cholesterol	Calculated	138.4	mg/dL	Desirable: 130-159 Borderline: 159-189 High: 189-220 Very high: >220

As per NCEP guideline, 12 hr fasting is required for Lipid profile testing. Otherwise TG, VLDL and Non HDL cholesterol results might be variably high, depending upon amount and type of food consumed.

Reference: National Cholesterol Education Program (NCEP) Adult treatment Panel III Report.

-- END OF REPORT --

NIDHI PUROHIT
Verified By


Dr. PRAVIN GOJIYA

Printed production of Report is permitted. The Report is valid for sample received by Laboratory.
* B.K. : BIOLOGICAL RESPONSE SYSTEMS

M.D. (PATHOLOGY)



DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHEKH	Bill No.	: OCR6/25/0003189
Age/Sex	: 33 Years/Male	Sample Collection	: 09/11/2024 10:59 AM
UHID	: WHRU.0000663459	Receiving Date Time	: 09/11/2024 10:59 AM
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* NOT FOR CLINICAL REFERENCE PURPOSES

M.D., [PATHOLOGY]



DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHEKH	Bill No.	: OCR6/25/0003189
Age/Sex	: 43 Years/Male	Sample Collection	: 09/11/2024 10:59 AM
UHID	: WHRJ.0000663459	Receiving Date Time	: 09/11/2024 10:59 AM
Primary Consultant	: DR. SHYAM KARIA	Report Date	: 09/11/2024 10:59 AM
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Order No.	: 40385	Specimen	: EDTA Whole Blood
Visit Code	: OP6.0211158	Bed No.	:

BIOCHEMISTRY

Final Report

PARAMETER	METHOD	RESULT	UNIT	B.R.I
Alkaline Phosphatase - Serum				
Alkaline Phosphatase	PNP AMP Kinetic	100.8	U/L	40 - 130
Bilirubin- Serum				
Serum Total Bilirubin	Diazo	0.22	mg/dl	0.1 - 1.2
Serum Direct Bilirubin	Diazo	0.11	mg/dL	0.1-0.3
Serum Indirect Bilirubin	Calculated	0.11	mg/dl	
Blood Urea Nitrogen-Serum				
Blood Urea Nitrogen	Calculated	12.54	mg/dL	Infant/child: 5-18 (18-60 years): 6-20 (60-90 years): 8-23
Urea- Serum	Urease-GLDH	27.1	mg/dL	16.6 - 48.5
Creatinine- Serum				
Serum Creatinine	Jaffe's Kinetic	0.85	mg/dL	Newborn: 0.3-1.0 Infant: 0.2-0.4 Child: 0.3-0.7 Adolescent: 0.5-1.0 Adult: <1.2
Gamma GT- Serum				
Gamma GT (NON ACCREDITED)	G glutamyl-p-nitroanilide	31.3	U/L	10 - 71
Plasma Glucose- Fasting				
Plasma Glucose - Fasting	Hexokinase	92.57	mg/dL	60 - 100

Interpretation:

American Diabetes Association (ADA) criteria for diagnosis of Diabetes Mellitus:

Normal: Less than 100 mg/dL

Impaired Tolerance: 100 - 125 mg/dL

Diabetes Mellitus: More than 126 mg/dL

Note:

Two abnormal results, on more than one occasion are required for diagnosis of DM.

- Other causes of transient glucose intolerance must be ruled out before diagnosis of DM.

- For Fasting blood sugar test, blood sample should be given after an 8 hour fast.

- An individual may have higher FBS level in comparison to PPBS level due to following reasons: Glycaemic index and response to food consumed, changes in body composition, high insulin sensitivity, exaggerated response to insulin, alimentary hypoglycemia, renal glycosuria, effect of hypoglycaemics/insulin treatment, anxious individual with disturbed sleep, dawn phenomenon and somogyi effect.



DEPARTMENT OF LABORATORY MEDICINE

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UHID	: WHRJ.0000663/59	Receiving Date Time	: 09/11/2024 10:59 AM
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BIOCHEMISTRY

PARAMETER	METHOD	RESULT	UNIT	B.R.I	Final Report
S.G.O.T (AST)- Serum					
S.G.O.T (AST)	UV Kinetic	22	U/L	0 - 40	
S.G.P.T (ALT)	UV Kinetic	39.1	U/L	0 - 41	
Total Protein- Serum					
Total Protein	Biuret	7.17	g/dL	Term: 4.6-7.1 7-19 year: 6.3-8.6 Adult: 5.5-8.0	
Albumin	BCG	4.76	g/dL	Term: 2.5-3.4 7-19 year: 3.7-5.6 Adult: 3.5-5.5	
Globulin	Calculated	2.41	g/dL	2 - 3.5	
Albumin/Globulin Ratio	Calculated	1.97		0.9 - 2	
Uric Acid- Serum					
Uric Acid	Enzymatic	5.9	mg/dl	2.5 - 8.0	
Blood Urea Nitrogen	Calculated	12.54	mg/dL	Infant/child: 5-18 (18-60 years): 6-20 (60-90 years): 8-23 Newborn: 0.3-1.0	
Creatinine	Jaffe's Kinetic	0.85	mg/dL	Infant: 0.2-0.4 Child: 0.3-0.7 Adolescent: 0.5-1.0 Adult: <1.2	
Blood Urea Nitrogen/Creatinine Ratio	Calculated	14.75		< 20	

--- END OF REPORT ---

NIDHI PUROHIT
Verified By

Dr. PRAVIN GOJIYA

M.D., (PATHOLOGY)

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* I.D.D. : BIOLOGICAL CHEMISTRY REFERENCE



DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHEKH	Bill No.	: OCRE/25/0003189
Age/Sex	: 33 Years/Male	Sample Collection	: 09/11/2024 10:59 AM
UHID	: WHRJ.0000663459	Receiving Date Time	: 09/11/2024 10:59 AM
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HEMATOLOGY

PARAMETER	METHOD	RESULT	UNIT	B.R.I	Final Report
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BB-Blood Group RH Factor Serum and EDTA Blood

Blood Group	Column Agglutination Technology (CAT)	B			
Rh Factor		POSITIVE			

(NON ACCREDITED)

- Method : Blood grouping done by Gel card(Forward and Reverse) and/or Slide Agglutination(Forward) method with Anti-A(IgM), Anti-B(IgM) and Anti-D(IgM-IgG).

- Anti-D(IgG+IgM) does not detect DU(Weak Ag) variant in routine test. All Negative samples should be further tested at Blood Bank by DU Test for final confirmation.

- Subtyping of antigen can not be known by routine BGRh test. All A and AB blood groups should be further investigated at Blood Bank for further subtyping of Antigen(A1 or A2).

- For all Blood samples, it is presumed that the sample belongs to Patient named on it or on Requisition form. Results are released as per the sample received.

-- END OF REPORT --

KAVITA RATHOD
Verified By



Dr. PRAVIN GOJIYA

M.D.,(PATHOLOGY)

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K1 - BIOLOGICAL REFERENCE IN LINA.



DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHEKH	Bill No.	: OCRG/25/0003189
Age/Sex	: 33 Years/Male	Sample Collection	: 09/11/2024 10:59 AM
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BIOCHEMISTRY

PARAMETER	METHOD	RESULT	UNIT	B.R.I	Final Report
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Glycosylated Haemoglobin- EDTA Blood

Glycosylated Haemoglobin	HPLC	5.5	%		Non-diabetic: <5.7
Estimated Mean glucose (NON ACCREDITED)	Calculated	111.14	mg/dL		

Test Performed by HPLC method (BioRad - D10)

Interpretation:

American Diabetes Association (ADA) criteria for diagnosis of Diabetes Mellitus:
 Prediabetes: 5.7 – 6.4
 Diabetes Mellitus: More than 6.5

Note:

- Two abnormal results, on more than one occasion are required for diagnosis of DM.
- Other causes of transient glucose intolerance must be ruled out before diagnosis of DM.
- HbA1C is used for monitoring diabetic control. It reflects the estimated average (Mean) glucose. Trends in HbA1C are better indicator of diabetic control than a solitary test.
- In known diabetic patients, following values can be considered as a tool for monitoring the glycaemic control: Excellent control – less than 7 %, Good control – 7 to 8 %, Action suggested – More than 8 %.

Interference and Limitation:

- All hemoglobin variants which are glycosylated at B-chain N-terminus and which have antibody recognizable region identical to that of HbA1C are determined by this assay.
- Abnormal Hb might affect the half life of RBCs or the in vivo glycation rates. Care must be taken when interpreting any HbA1C result from patient with Hb variants/High Hb-F. For Homozygous/Heterozygous Hemoglobinopathies, alternative method should be used.
- Any cause of shortened erythrocyte survival (Hemolytic anemia or other hemolytic disease), Recent significant or chronic blood loss will reduce exposure of RBCs to glucose with consequent decrease in HbA1C.
- Test result obtained by different testing procedure should not be compared directly. Values may not be comparable with different methodologies and even different laboratories using same methodology. (Ref.: Wallach, 8th Edition)

--- END OF REPORT ---

NIDHI PUROHIT

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Dr. PRAVIN GOJIYA

M.D., (PATHOLOGY)

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 * R.A. : BIOLOGICAL REACTION TERMINAL



DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHEKH	Bill No.	: OCR6/25/0003189
Age/Sex	: 33 Years/Male	Sample Collection	: 09/11/2024 10:59 AM
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Order No.	: 40385	Specimen	: EDTA Whole Blood
Visit Code	: OP6.0211158	Bed No.	:

IMMUNOLOGY

PARAMETER	METHOD	RESULT	UNIT	Final Report
T3 T4 TSH- Serum				
Total T3	Electrochemiluminescence immunoassay	1.32	ng/mL	0.8 – 2
Total T4	Electrochemiluminescence immunoassay	7.61	µg/dL	5.1 – 14.1
				Term: 1.3-19.0 3 days: 1.1-17 10 weeks: 0.6-10.0 14 months: 0.4-7.0 5 years: 0.4-6.0 14 years: 0.3-5.0 ADULT: 0.27-4.2 Pregnancy: 1st Trimester: 0.1-2.5 2nd Trimester: 0.2-3.0 3rd Trimester: 0.3-3.0
TSH	Electrochemiluminescence immunoassay	1.44	µIU/ml	

INTERPRETATION: TSH is formed in anterior pituitary and is subject to a circadian secretion, so result may show considerable physiologic and seasonal variation.

High TSH : Primary hypothyroidism (untreated or inadequately treated), Hashimoto thyroiditis, Iodine deficiency goiter, External neck irradiation, Post thyroidectomy, Pituitary thyrotroph adenoma etc.

Drugs : Iodine containing agent like amlodaron / iopanoic acid / iopodate, Amphetamines, Dopamine antagonist like metoclopramide / domperidone / chlorpromazine / haloperidol, Lithium etc. can increase TSH level.

Low TSH : Toxic multinodular goiter, Autonomously functioning thyroid adenoma, Graves disease, Thyroiditis, Extrathyroidal thyroid hormone source, Factitious, Secondary hypothyroidism (Pituitary / hypothalamic tumor or infiltrates) etc.

Drugs : Glucocorticoids, dopamine, dopamine agonist like bromocriptine, L-dopa, Apomorphine, Pyridoxine, Over replacement of thyroid hormone in hypothyroidism etc can decrease TSH level.

TSH result may be transiently altered because of some non thyroidal acute illness (NTI). To evaluate thyroid status of hospitalized ill patient, clinical correlation / repeat testing may be needed.

Interference : RA factor, Heterophile antibodies, Human anti-mouse antibodies, High biotin level, Icterus, hemolysis, lipemia etc. may produce spurious results.

Individual test result should not be considered conclusive, Test result should be used with detailed medical history, clinical examination and other findings for final diagnosis.

--- END OF REPORT ---

NIDHI PUROHIT
Verified By

Dr. PRAVIN GOJIYA



DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: MR. AHMAD SHEKH	Bill No.	: OCR6/25/0003189
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Order No.	: 40385	Specimen	: EDTA Whole Blood
Visit Code	: OP6.0211158	Bed No.	:

CLINICAL PATHOLOGY

PARAMETER	METHOD	RESULT	UNIT	B.R.I	Final Report
Urine Routine					
Physical Examination					
Colour	Visual	Pale Yellow			
Volume	Macroscopic View	20	ml		
Appearance	Macroscopic View	Clear			Clear
Urine for pH	Strip Method	6.0			5.0 - 8.0
Specific Gravity	Strip Method	1.025			1.005 - 1.030
Chemical Examination					
Urine Protein	Protein Error of Indicator Method	Absent			Absent
Urine Sugar	Glucose Oxidase Method	Absent			Absent
Urine Ketones	Sodium Nitroprusside Method	Absent			Absent
Urine Blood	Peroxidase like Activity	Absent			Absent
Bile Salts/Bile Pigment	Fouchet's Reaction	Absent			Absent
Urobilinogen.	Ehrlich's Reaction	Normal			Normal
Microscopic Examination					
Pus Cells	Microscopy	Occasional	/hpf		< 3
Red Blood Cells	Microscopy	Absent	/hpf		Absent
Epithelial Cells	Microscopy	0-1	/hpf		< 5
Casts	Microscopy	Absent			Absent
Crystals	Microscopy	Absent			Absent
Amorphous Deposit	Microscopy	Absent			Absent

-- END OF REPORT --

VARSHA DHOLARIYA
Verified By


Dr. PRAVIN GOJIYA

Dr. PRAVIN GOJIYA

M.D. (PATHOLOGY)

For the Evaluation of Requested Parameters, Refer to Sample Received by Laboratory
* CLP - MEDICAL REFERENCE MATERIAL

Dr. Harshal Baldha
M.S. (Ophth.), FRF, DO
Consultant Ophthalmologist



UHID : WHRJ.0000663459
Mr. AHMAD SHEKH
Age : 33 Yrs/Male
Dr. SHYAM KARIA

Provisional Diagnosis:

UHID : 9/11/26

T-Afebrile/Febrile _____ °C
P- _____/min R- _____/min
B.P- _____/_____ mmHg
Drug Allergy- Yes/No _____
Pain- Yes/No _____
Fall-Risk Yes/No _____

no REC

Subj :

Obj :

Vn :

BE 6/6s bil - 6/6s

Tn :

RE (C)

Als :

Normal UR (C)

P/s :

SE WDR

Follow up date - _____

Malnourished/Under/Nourished/Well Nourished
Nutritional Assessment Required:- Yes/ No

Wockhardt Hospitals Ltd.

Unit : N M Virani Wockhardt Hospital
Kalwad Road, Rajkot - 360 007 Tel : 0281 689 4444
Email : enquire@wockhardthospitals.com Web : www.wockhardthospitals.com
CIN : U85100MH1991PLC063098

WHL/OP/RAJ-01

DEPARTMENT OF RADIO DIAGNOSTICS

Patient Name : MR. AHMAD SHEKH
Age/Sex : 33 Yrs / Male
UHID : WHRJ.0000563459
Reporting Date : 09/11/2024 10:19 AM
Ref No. : UGR/25/0003199
Order Date : 09/11/2024 10:14 AM
Referred by :
Order No. : 18256

USG ABDOMEN WITH PELVIS

Real time sonography of the abdomen and pelvis was performed using the 3.5 MHz transducer.

Findings:

The liver is normal in size and echotexture. No focal lesion is seen.

The portal vein appear normal in course and calibre.
The gall bladder is normal in size with a normal wall thickness and there are no calculi noted within.
CBD appears normal in course and caliber.
Intrahepatic biliary tree is normal.

The pancreas is normal in size and echotexture.
The spleen is normal in size and echotexture.

Both kidneys are normal in size, position and echogenicity. Cortical thickness and corticomedullary differentiation are normal. No hydronephrosis or calculi noted.
Right kidney measures 94x 38 mm
Left kidney measures 100x 52 mm

There is no evidence of obvious ascites.
The urinary bladder is normal. No vesical calculi noted.
The prostate is normal in size and homogenous in echotexture.

COMMENTS:

- No significant abnormality detected.

Dr. Ashish Kamdar

Senior Consultant Radiologist.

The CT, MRI/USG/ X RAY investigation has technical limitations as well as inaccuracies. It should always be viewed with histopathological correlation and other investigations.

Verified By: JESSY ABRAHAM

Authorized By:

Page 1 of 2

N M Virani Wockhardt Hospital

Kalwad Road, Rajkot - 360 007 Tel. : 0781-669 4256

Email : contact.rjl@wockhardthospitals.com Website : www.wockhardthospitals.com

CIN : U85100MH1991PLCD63096 GSTIN : 24AAACW3342G12N



DEPARTMENT OF RADIODIAGNOSTICS

Patient Name : MR. AHMAD SHEKH
Age/Sex : 33 Yrs / Male
UHID : WHRJ.0000663458
Reporting Date : 09/11/2024 10:21 AM
Bill No. : OCR6/25/0005-03
Order Date : 09/11/2024 10:14 AM
Referred by :
Order No. : 18258

X RAY CHEST PA

Both lung fields are clear.

The costophrenic angles and domes of diaphragm appear normal.

Cardiac silhouette is within normal limits.

Visualised bony thorax and soft tissues appear normal.

COMMENTS:

Normal chest x ray

The CT Scan/MRI/USG/ X RAY investigation has technical limitations as well as inaccuracies. It should always be viewed with clinical-pathological correlation and other investigations.



Verified By: Dr KHYATI VADERA

Authorized By:

****END OF REPORT****

DEPARTMENT OF CARDIOLOGY

Patient Name : MR. AHMAD SHEKH
Age/Sex : 33 Yrs / Male
UHID : WHRJ.0000663459
Reporting Date : 09/11/2024 11:08 AM
Bill No. : OCR6/25/0003189
Order Date : 09/11/2024 10:14 AM
Referred by :
Order No. : 9552


T.M.T. REPORT

Interpretation

• Patient reaches exercise limit of 11.8 Mets.
• Adequate increase of Blood Pressure & Heart Rate.
• No significant ST T changes seen during test & recovery. No arrhythmia seen.
• The stress test was terminated after 10:02 mins. As he/she achieved 85% of MHR without chest pain.
• The recovery was uneventful.

FINAL IMPRESSION.

• THE TEST IS **NEGATIVE** FOR INDUCED MYOCARDIAL ISCHEMIA AT THE WORKLOAD ACHIEVED.


Dr. Bhoomi Virpariya

M.B.B.S., P.G.D.C.C.
Noninvasive Cardiologist

Verified By: SHILPA KATARIYA

Authorized By:

END OF REPORT

N M Virani Wockhardt Hospital

Kalawad Road, Rajkot - 360007 | Tel : 0281-669 4266

Email : contact.rjb@wockhardthospitals.com Website : www.wockhardthospitals.com

CIN : U85100MH1991PLC063096 GSTIN : 24AAACW3342G1ZK



PERIODIC MEDICAL EXAMINATION REPORT

Name: *per. Ahmad*

SYSTEMIC EXAMINATION

Cardiovascular System

Peripheral pulsations : Normal
 Pulse rate at rest : *78* per minute
 Apex beat : Normal/
 Heart sounds : Normal/
 Murmurs : Nil/

Respiratory System

Shape of chest : Normal/
 Chest Movement : Normal/
 Trachea : Normal/
 Breath Sounds : Normal/
 Adventitious Sounds : Absent/
 Pleural Rub : Absent/
 Chest Inspiration : Normal/

Abdomen : Normal/
 Abdominal Girth : Normal/
 Liver : Normal/
 Spleen : Normal/
 Any Lumps : Nil/

FINAL IMPRESSIONS :

*W. by DM
 Satisfactory
 Negative*

S/b Dr. Shyam k.

*No known co-morbidities
 & no constipation*

MEDICAL ADVICE :

*Adv
 - Lifestyle - Diet + modification
 - Regular Exercise as per doctor*

PERIODIC MEDICAL EXAMINATION REPORT

Name :

PHYSICAL EXAMINATION

Height : *162* cm
 Weight : *62.0* kg
 Blood Pressure : Supine : mm/hg
 Temperature : *110/80* Normal/
 Respiration : Normal/
 Nutritional Status : Normal/
 Mental Status : Normal/
 Skin : Normal/
 Lymph Nodes : Not Enlarged
 Oedema : Absent/
 Nails : Normal/
 Tongue : Normal/
 Teeth / Gums : *Normal*
 Thyroid : Normal/
 Extremities : Normal/
 JVP : Not Raised
 Pallor : Normal/
 ENT : Normal/

Doctor's Name :

WHL/CC/15



Doctor's Sign. :

Date :