

**Dr. Vimmi Goel**

Head - Non Invasive Cardiology  
Incharge - Preventive Health Care  
MBBS, MD (Internal Medicine)  
Reg. No: MMC-2014/07/0113

**Preventive Health Check up**

**KIMS Kingsway Hospitals**

Nagpur

Phone No.: 74999913052



**KIMS-KINGSWAY  
HOSPITALS**

Name: Mrs. Prayagi Chahande Date: 14/9/24

Age: 41y Sex: MF Weight: 57.3 kg Height: 153.2 Inc: 84.4

BP: 137/82 mmHg Pulse: 69/m 100% bpm RBS: 1mp-3/9/24 mg/dl

**Dr. Mugdha Jungari (GII)**  
 MBBS, MS, DNB (OBGY), FMAS  
 Sr. Consultant Obstetrics & Gynaecology  
 High Risk Pregnancy Expert & Laparoscopic Surgeon  
 Reg. No.: 20201219345

Name: Pamjili Date: 14/9/24  
 Age: 4 yrs Sex: M/F Weight: \_\_\_\_\_ kg Height: \_\_\_\_\_ inc BMI: \_\_\_\_\_

→ Ms - 16 yrs  
 → P<sub>2</sub>L<sub>2</sub>F<sub>1</sub> - 1♀ 13yr }  
 → 10<sup>s</sup> 8 yrs }  
 CMP - 3/5/24  
 3/30 Reg  
 Born 188g.

→ n/o DM & HT - ∴ 8 yrs.

prog smear 2 yrs - (n)  
 (kin)

P/A soft no cml P<sub>4</sub>  
 Theorem

RS - prog taken  
 Prog = Repeat

PV - V<sub>1</sub> (n) kinase  
 order

Name : Ms. Poojale Chakande Date : 14/09/24

Age : 34 yrs Sex : M/F Weight : \_\_\_\_\_ kg Height : \_\_\_\_\_ Inc BMI : \_\_\_\_\_

BP : \_\_\_\_\_ mmHg Pulse : \_\_\_\_\_ bpm RBS : \_\_\_\_\_ mg/dl

Routine Dental Checkup

PMH - K/c/o HTN, DM & medication for same.

PDH - NRI

Ch -

- Impacted tooth  $\bar{c}$  8/
- Kingually erupted  $\bar{c}$  15

Advice - ORG

Extraction  $\bar{c}$  8/

Dr. Poojale Chakande



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mrs. PRANJALI CHAHANDE	<b>Age / Gender</b> : 41 Y(s)/Female
<b>Bill No/ UMR No</b> : BIL2425047387/UMR2223139015	<b>Referred By</b> : Dr. Virmmi Goel MBBS, MD
<b>Received Dt</b> : 14-Sep-24 08:52 am	<b>Report Date</b> : 14-Sep-24 12:17 pm

**HAEMOGRAM**

<b>Parameter</b>	<b>Specimen</b>	<b>Results</b>	<b>Biological Reference</b>	<b>Method</b>
Haemoglobin	Blood	<b>11.3</b>	12.0 - 15.0 gm%	Photometric
Haematocrit(PCV)		<b>35.7</b>	36.0 - 46.0 %	Calculated
RBC Count		<b>4.84</b>	3.8 - 4.8 Millions/cumm	Photometric
Mean Cell Volume (MCV)		<b>74</b>	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		<b>23.4</b>	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		<b>31.7</b>	31.5 - 35.0 g/l	Calculated
RDW		<b>16.8</b>	11.5 - 14.0 %	Calculated
Platelet count		<b>431</b>	150 - 450 10 <sup>3</sup> /cumm	Impedance
WBC Count		<b>7600</b>	4000 - 11000 cells/cumm	Impedance
<b><u>DIFFERENTIAL COUNT</u></b>				
Neutrophils		<b>55.0</b>	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes		<b>36.7</b>	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils		<b>3.6</b>	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes		<b>4.7</b>	2 - 10 %	Flow Cytometry/Light microscopy
Basophils		<b>0.0</b>	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		<b>4180</b>	2000 - 7000 /cumm	Calculated



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF PATHOLOGY**

**Patient Name** : Mrs. PRANJALI CHAHANDE **Age / Gender** : 41 Y(s)/Female  
**Bill No/ UMR No** : BIL2425047387/UMR2223139015 **Referred By** : Dr. Vinmi Goel MBBS, MD  
**Received Dt** : 14-Sep-24 08:52 am **Report Date** : 14-Sep-24 12:17 pm

Parameter	Specimen	Results	Biological Reference Method
Absolute Lymphocyte Count		2789.2	1000 - 4800 /cumm Calculated
Absolute Eosinophil Count		273.6	20 - 500 /cumm Calculated
Absolute Monocyte Count		357.2	200 - 1000 /cumm Calculated
Absolute Basophil Count		0	0 - 100 /cumm Calculated

**PERIPHERAL SMEAR**

**RBC**  
 Microcytosis  
 + (Few),  
 Hypochromia  
 + (Few),  
 Anisocytosis  
 + (Few)  
 As above  
 Adequate  
 17  
 0 - 20 mmv/hr  
 Automated  
 Westergren's Method

**WBC**  
**Platelets**  
**E S R**  
 \*\*\* End Of Report \*\*\*

Suggested Clinical Correlation \* If neccessary, Please discuss  
 Verified By : 11100245  
 Test results related only to the item tested.  
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*Prerna*

**Dr. PURVA JAISWAL, MBBS, MD, DNB  
CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mrs. PRANJALI CHAHANDE  
**Age /Gender** : 41 Y(s)/Female  
**Bill No/ UMR No** : BILL2425047387/UMR2223139015  
**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 14-Sep-24 08:51 am  
**Report Date** : 14-Sep-24 11:40 am

Parameter	Specimen	Results	Biological Reference	Method
Fasting Plasma Glucose	Plasma	135	< 100 mg/dl	GOD/POD, Colorimetric
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>				
Hba1c		7.5	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 Diabetic : >= 6.5 %	HPLC

\*\*\* End Of Report \*\*\*

Suggested Clinical Correlation \* If necessary, please discuss

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**Dr. PURVA JAISWAL, MBBS,MD,DNB**

**SPANVY CONSULTANT PATHOLOGIST**

41, Banowara Bhandari, Kirtiway, Noida - 440,001, Maharashtra, India  
Phone: +91 0712 6789100  
CIN: U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mrs. PRANJALI CHAUDHARI  
**Age / Gender** : 41 Yrs/Female  
**Bill No./ UMR No** : BL12425047887/JMR2223139015  
**Referred By** : Dr. Virendra Goyal MBBS,MD  
**Received Dt** : 14 Sep 24 08:52 am  
**Report Date** : 14 Sep 24 11:40 am

**LIPID PROFILE**

Parameter:	Specimen	Results	Method
Total Cholesterol	Serum	196	Enzymatic(CHE/CHO/PO D)
Triglycerides		124	
HDL Cholesterol Direct		44	
LDL Cholesterol Direct		<b>133.58</b>	
VLDL Cholesterol		25	
Tot Chol/HDL Ratio		4	

**Initiate therapeutic:**

CHD OR CHD risk equivalent	>100	Consider Drug therapy	LDC-C
Multiple major risk factors conferring 10 yrs CHD risk >20%	>130	>130, optional at 100-129	<100
Two or more additional major risk factors, 10 yrs CHD risk <20%	>160	10 yrs risk 10-20 % >130	<130
No additional major risk or one additional major risk factor		10 yrs risk <10% >160	<160
		>190, optional at 160-189	<160

\*\*\* End Of Report \*\*\*

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**Dr. PURVA JAISWAL, MBBS,MD,DNB  
CONSULTANT PATHOLOGIST**





**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mrs. PRANJALI CHAHANDE	<b>Age /Gender</b> : 41 Y(s)/Female
<b>Bill No / UMR No</b> : BIL2425047387/UMR2223139015	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 14-Sep-24 08:52 am	<b>Report Date</b> : 14-Sep-24 11:40 am

**LIVER FUNCTION TEST (LFT)**

<b>Parameter</b>	<b>Specimen</b>	<b>Results</b>	<b>Biological Reference</b>	<b>Method</b>
Total Bilirubin	Serum	0.34	0.2 - 1.3 mg/dl	
Direct Bilirubin		0.17	0.1 - 0.3 mg/dl	
Indirect Bilirubin		0.17	0.1 - 1.1 mg/dl	
Alkaline Phosphatase		63	38 - 126 U/L	
SGPT/ALT		16	13 - 45 U/L	
SGOT/AST		19	13 - 35 U/L	
Serum Total Protein		7.57	6.3 - 8.2 gm/dl	
Albumin Serum		4.19	3.5 - 5.0 gm/dl	
Globulin		3.38		Bromocresol green Dye
A/G Ratio		1.24	2.0 - 4.0 gm/dl	Binding

\*\*\* End Of Report \*\*\*

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*Pranjal*

**Dr. PURVA JAISWAL, MBBS,MD,DNB**  
**CONSULTANT PATHOLOGIST**





**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mrs. PRANJALI CHAHANDE      **Age / Gender** : 41 Y(s)/Female  
**Bill No/ UMR No** : BIL2425047387/UMR2223139015      **Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 14-Sep-24 08:52 am      **Report Date** : 14-Sep-24 11:40 am

**RFT**

Parameter	Specimen	Result Values	Biological Reference	Method
Blood Urea	Serum	11	15.0 - 36.0 mg/dl	
Creatinine		0.65	0.52 - 1.04 mg/dl	
GFR		113.4	>90 mL/min/1.73m square.	
Sodium		140	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.09	3.5 - 5.1 mmol/L	

\*\*\* End Of Report \*\*\*

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**Dr. PURVA JAISWAL, MBBS,MD,DNB**  
**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mrs. PRANJALI CHAHANDE  
**Age / Gender** : 41 Y(s)/Female  
**Bill No / UMR No** : BIL2425047387/UMR2223139015  
**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 14-Sep-24 08:52 am  
**Report Date** : 14-Sep-24 11:40 am

**THYROID PROFILE**

Parameter	Specimen	Results	Biological Reference	Method
T3	Serum	1.35	0.55 - 1.70 ng/ml	
Free T4		1.23	0.80 - 1.70 ng/dl	Enhanced
TSH		2.28	0.50 - 4.80 uIU/ml	Chemiluminescence
*** End Of Report ***				

Suggested Clinical Correlation \* If neccessary, Please discuss

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**Dr. PURVA JAISWAL, MBBS,MD,DNB**  
**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF IMMUNO HAEMATOLOGY**


<b>Patient Name</b> : Mrs. PRANJALI CHAHANDE	<b>Age / Gender</b> : 41 Y(s)/Female
<b>Bill No/ UMR No</b> : BL2425047387/UMR2223139015	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 14-Sep-24 08:52 am	<b>Report Date</b> : 14-Sep-24 12:32 pm

**BLOOD GROUPING AND RH**

<b>Parameter</b> BLOOD GROUP.	<b>Specimen Results</b> EDTA Whole " O " Blood & Plasma/ Serum	<b>Gel Card Method</b>
----------------------------------	--	------------------------

Rh (D) Typing. " Positive "(+Ve)  
\*\*\* End Of Report \*\*\*

Suggested Clinical Correlation \* If necessary, Please discuss  
Verified By : : 11100245  
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**Dr. PURVA JAISWAL, MBBS,MD,DNB  
CONSULTANT PATHOLOGIST**

**DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE**

NAME	PRANALICHANDHE	STUDY DATE	14-09-2024 10:39:31
AGE/SEX	41Y 2M 6D / F	HOSPITAL NO.	UMR2223139015
ACCESSION NO.	BH.2425047387-9	MODALITY	DX
REPORTED ON	14-09-2024 13:01	REFERRED BY	Dr. Vimali Joel

**X-RAY CHEST PA VIEW**

Small nodular opacity seen in right upper zone.

Otherwise lung fields are clear.

Heart and Aorta are normal

Both hilar shadows appear normal

Diaphragm domes and CP angles are clear.

Bony cage is normal

**IMPRESSION**

Small nodular opacity in right upper zone.

No other pleuro-parenchymal abnormality seen.

Suggest clinical /HRCT for further evaluation



**DR NAVEEN PUGALIA**  
**MBBS, MD [076125]**  
**SENIOR CONSULTANT RADIOLOGIST.**

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	PRANU/AL CHAHANDE	STUDY DATE	14-09-2024 10:39:31
AGE/SEX	41Y2M6D / F	HOSPITAL NO.	UMR2223139015
ACCESSION NO.	BLI2425047387-9	MODALITY	DX
REPORTED ON	14-09-2024 13:01	REFERRED BY	Dr. Vinod Gaei

**X-RAY CHEST PA VIEW**

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No other pleuro-parenchymal abnormality seen.

Suggest clinical/HRCT for further evaluation



**DR NAVLEEN PUGALUA**  
MBBS, MD [076125]  
SENIOR CONSULTANT RADIOLOGIST.

NAME OF PATIENT:	MRS. PRANJALI CHAHANDE	AGE & SEX:	41 YRS
UMR NO:	2223139015	BILL NO	2425047387
REF BY:	DR. VIMMI GOEL	DATE:	14/09/2024

**X RAY MAMMOGRAPHY OF BOTH BREASTS**

**TECHNIQUE:** Bilateral MLO and CC projections taken. Markers placed in external aspect in CC view and superior in MLO view.

**OBSERVATION:**

Both breast show type D parenchyma – dense fibroglandular parenchyma, which lowers sensitivity of mammogram.

**Right breast:**

Right breast does not show any dominant mass, architectural distortion or suspicious microcalcification.

No skin or trabecular thickening noted.  
No enlarged axillary nodes seen.

**Left breast:**

Left breast does not show any dominant mass, architectural distortion or suspicious microcalcification.

No skin or trabecular thickening noted.  
No enlarged axillary nodes seen.

**Bilateral hypertrophied axillary fat.  
On USG screening, no significant abnormality noted.**

**IMPRESSION: X RAY mammography reveals:**

**No mammographically detectable significant abnormality.**

**ACR – BIRADS Category 1- Negative for malignancy.**

**Note:**

- The false negative of mammography is approximately 10%
  - Investigations have their limitations. Solitary Radiological/pathological and other investigations never confirm the final diagnosis of disease.
- Please correlate accordingly



**DR. RUTUJA RANGREJ**  
**MBBS, MD**  
**CONSULTANT RADIOLOGIST.**

<b>NAME OF PATIENT:</b>	MRS. PRANALI CHAHANDE	<b>AGE &amp; SEX:</b>	41 YRS
<b>UMR NO:</b>	2223139015	<b>BILL NO</b>	2425047387
<b>REF BY:</b>	DR. VIMMI GOEL	<b>DATE:</b>	14/09/2024

**USG WHOLE ABDOMEN**

LIVER is normal in size (12.1 cm), shape and echotexture.  
No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated.  
PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is partially distended. No sludge or calculus seen.  
Wall thickness is within normal limits.

Visualized head and body of PANCREAS is normal in shape, size and echotexture.  
SPLEEN is normal in size shape and echotexture. No focal lesion seen.

Right kidney measures 9.5 x 4.0 cm. Left kidney measures 9.2 x 4.5 cm.  
Both KIDNEYS are normal in shape, size and echotexture.  
No evidence of calculus or hydronephrosis seen.  
URETERS are not dilated.

URINARY BLADDER is partially distended. No calculus or mass lesion seen.  
Uterus appears normal in size, shape and echotexture. It measures 5.8 x 4.7 x 10 cm.

No focal myometrial lesion seen.

Endometrial echo-complex appears normal. ET - 8.1 mm.

Right ovary volume 3.5 cc.

Left ovary volume 8 cc.

Both ovaries are normal in size, shape and echotexture.  
No adnexal mass lesion seen.

There is no free fluid or abdominal lymphadenopathy seen.

**IMPRESSION:**

- No significant visceral abnormality seen.  
Suggest clinical correlation.



**DR. RUTUJA RANGREJ**  
MBBS, MD

**CONSULTANT RADIOLOGIST.**



Kingsway Hospitals  
44 Kingsway, Mohan Nagar,  
Near Kasturbaad Park, Nagpur

Station  
Telephone:

## EXERCISE STRESS TEST REPORT

Patient Name: Mrs. Pranjali, Chhabunde  
Patient ID: 39015  
Height:  
Weight:  
Study Date: 14.09.2024  
Test Type: Treadmill Stress Test  
Protocol: BRUCE

DOB: 10.07.1983  
Age: 41yrs  
Gender: Female  
Race: Indian  
Referring Physician: Medirhee HCU  
Attending Physician: Dr. Vimmi Goel  
Technician: --

### Medications:

Medical History:  
HTN/DM

### 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	00:14	0.00	0.00	78	130/80	
	STANDING	00:15	0.00	0.00	77	130/80	
	HYPERY.	00:01	0.00	0.00	77		
EXERCISE	WARM-UP	00:06	0.60	0.00	76		
	STAGE 1	03:00	1.70	10.00	115	130/80	
	STAGE 2	03:00	2.50	12.00	127	130/80	
RECOVERY	STAGE 3	01:30	3.40	14.00	137	130/80	
		02:00	0.00	0.00	116	130/80	
		00:23	0.00	0.00	96	130/80	

The patient exercised according to the BRUCE for 7:02 mins, achieving a work level of Max. METS: 10.10. The resting heart rate of 79 bpm rose to a maximal heart rate of 137 bpm. This value represents 76 % of the maximal, age-predicted heart rate. The resting blood pressure of 130/80 mmHg, rose to a maximum blood pressure of 130/80 mmHg. The exercise test was stopped due to ST-T changes seen.

### Interpretation:

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: THR not achieved.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: ST-T changes seen.

Overall Impression: Borderline Positive.

### Conclusions:

TMT is Borderline Positive for inducible ischemia. by ST-T changes seen during exercise & recovery.

No angina.

To be correlated clinically.

**Dr. VIMMI GOEL**

MBBS, MD

Sr. Consultant-Non Invasive Cardiology

Reg. No.: 2014/01/0113

41 Years

PHC DEPT.

Rate 73 Sinus rhythm.....normal P axis, V-rate 50-99

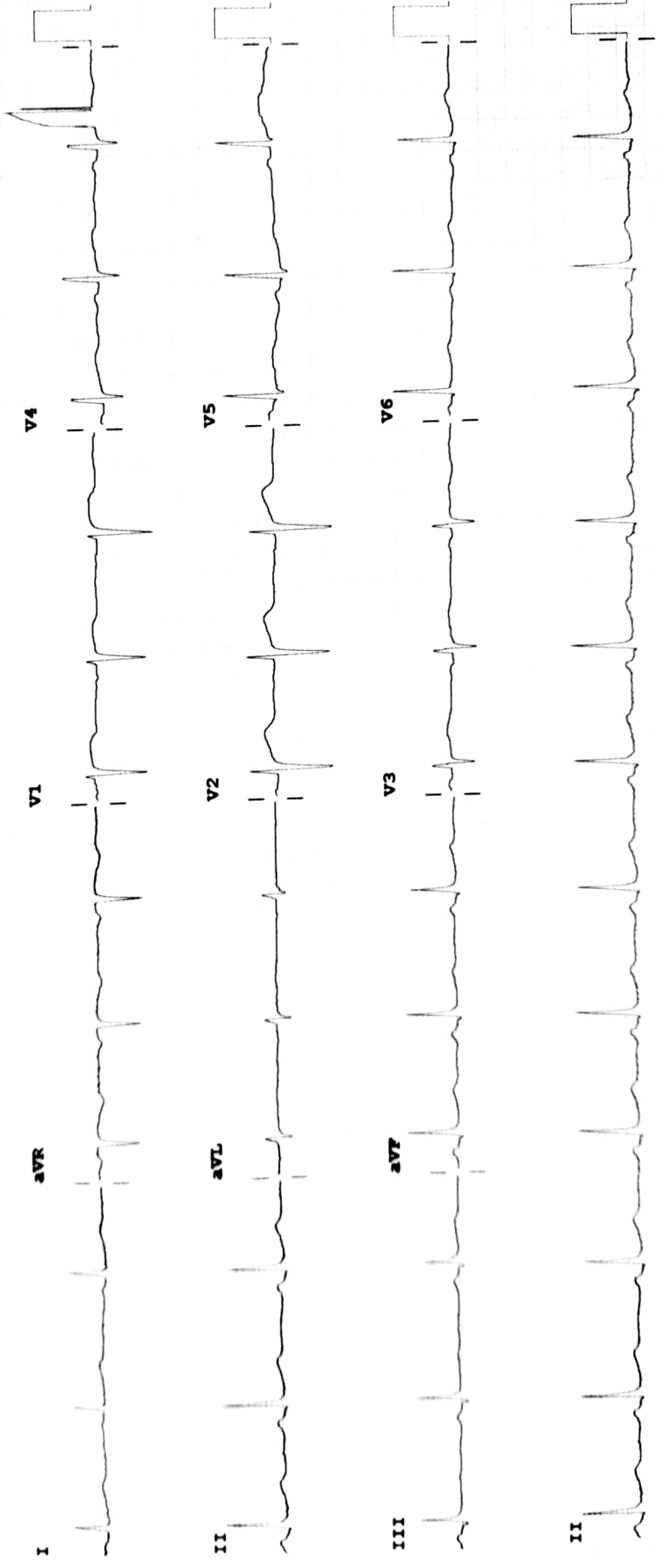
PR 154  
QRSD 92  
QT 390  
QTc 430

--AXIS--  
P 73  
QRS 58  
T 54

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec    Limb: 10 mm/mV    Chest: 10.0 mm/mV

F 50- 0.50-150 Hz W

100B CL

P?