

NAME:	Mr. Anurag Karkhanavala	UHID:	
AGE:	43	DATE OF HEALTHCHECK:	19/2/2024
GENDER:	M		

HEIGHT:	166	MARITAL STATUS:	M
WEIGHT:	71.5	NO OF CHILDREN:	2
BMI:	25.9		

C/O: Constipation,

K/C/O: HTN, Dyslipidemia

PRESENT MEDICATION: - Tab - Telmisartan

P/M/H: - Prostate enlargement, UTI

P/S/H: - No

ALLERGY: - N/A

1 - 0 - 0
Tab Atorvastatin
0 - 0 - 1.

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING: -

FAMILY HISTORY FATHER: - HTN, DM, HD

ALCOHOL: - Occ.

MOTHER: HTN, DM

TOBACCO/PAN: -

O/E:

LYMPHADENOPATHY:

BP: 110/60 PULSE: - 72/min

PALLOR/ICTERUS/CYNOSIS/CLUBBING:) N/A

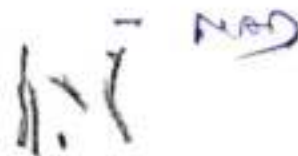
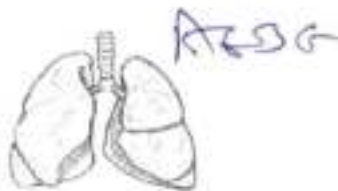
TEMPERATURE/SCARS:

OEDEMA:

S/E:

P/A:

RS:



CVS: RST

Extremities & Spine: - N/A

CNS: Conscious, Oriented

ENT: - N/A

Skin: - N/A

Vision:

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

Name: Mr Anuragjan Koolkatta Age: 45y Date of Health check-up: 13/01/2024

Findings and Recommendation:

Findings:-

- Hb⁺h
- Sy 0.1/44^{PT} r
- O B Trace
-

Recommendation:-

- Diet / Iron supplements
- Repeat LFT / Urea ^R

Signature:

Consultant

DR. ANIRBAN DAŞGUPTA
MBBS, D.N.B MEDICINE
DIPLOMA CARDIOLOGY
MMC-2005/02/0920

OPHTHALMIC EVALUATION

UHID No.: _____

Date: 19/2/24

Name: Dr. Anubhajan Age: 43 Gender: Male / Female

Without Correction:

Progressive

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction:

Distance: Right Eye _____ Left Eye _____

6/6
N6

6/6
N6

Near : Right Eye _____ Left Eye _____

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance		<u>0.75</u>	<u>85°</u>				<u>0.75</u>	<u>85°</u>		
Near	<u>+1.0</u>					<u>+1.0</u>				

Prefered Pres

Colour Vision: N70

Anterior Segment Examination: NAD / (B)

Pupils: _____

Fundus: _____

Intraocular Pressure: 12 mm Hg / (BL)

Diagnosis: _____

Advice: _____

Re-Check on 6 mths (This Prescription needs verification every year)

Dr. [Signature]
(Consultant Ophthalmologist)

DR. RUCHIRA SHARMA
M. S. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON

REG. No. 3282/09/02

DENTAL CHECKUP

Name: Mr. Anurajou Kerketia.	MR NO:
Age/Gender : 43yrs/M.	Date: 19/2/24.

Medical history: Diabetes Hypertension On medication


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: _____

 DR. NILAM PATIL
 B. D. S
 Reg. No: A 23226

• ANDHERI • COLABA • NASHIK • VASHI

Name : Mr. Anuranjan Kerketta Gender : Male Age : 43 Years
 UHID : FVAH 10650. Bill No : Lab No : V-2330-23
 Ref. by : SELF Sample Col.Dt : 19/02/2024 08:45
 Barcode No. : 9008 Reported On : 19/02/2024 16:01

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)		
Haemoglobin(Colorimetric method)	11.8 g/dl	13 - 18
RBC Count (Impedance)	5.13 Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	38.9 %	35 - 55
MCV:(Calculated)	75.8 fl	78 - 98
MCH:(Calculated)	23 pg	26 - 34
MCHC:(Calculated)	30.4 gm/dl	30 - 36
RDW-CV:	13.9 %	11.5 - 16.5
Total Leucocyte count(Impedance)	7140 /cumm.	4000 - 10500
Neutrophils:	47 %	40 - 75
Lymphocytes:	44 %	20 - 40
Eosinophils:	04 %	0 - 6
Monocytes:	05 %	2 - 10
Basophils:	00 %	0 - 2
Platelets Count(Impedance method)	1.53 Lakhs/c.mm	1.5 - 4.5
MPV	13.2 fl	6.0 - 11.0
ESR(Westergren Method)	03 mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)	Hypochromasia(+), Microcytosis(Mild)	
RBCs:	Lymphocytosis	
WBCs:	Adequate on smear with large platelets seen.	
Platelets	Test Run on 5 part cell counter. Manual diff performed.	
Note:		

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Verified By

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

End of Report
 Results are to be correlated clinically

Name : Mr. Anuranjan Kerketta Gender : Male Age : 43 Years
UHID : FVAH 10680 Bill No : Lab No : V-2330-23
Ref. by : SELF Sample Col.Dt : 19/02/2024 08:45
Barcode No : 9008 Reported On : 19/02/2024 16:01

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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Name : Mr. Anuranjan Kerketta Gender : Male Age : 43 Years
 UHID : FVAH 10680. Bill No : Lab No : V-2330-23
 Ref. by : SELF Sample Col Dt : 19/02/2024 08:45
 Barcode No : 9008 Reported On : 19/02/2024 16:01

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c[Glycosylated Haemoglobin]WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.3 % Normal < 5.7 %
 Pre Diabetic 5.7 - 6.5 %
 Diabetic > 6.5 %
 Target for Diabetes on therapy < 7.0 %
 Re-evaluation of therapy > 8.0 %

Mean Blood Glucose : 105.41 mg/dL

Correlation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Method High Performance Liquid Chromatography (HPLC).

INTERPRETATION

- The HbA1c levels correlate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
- This Methodology is better than the routine chromatographic methods & also for the diabetic pts having HEMOGLOBINOPATHIES OR UREMIA as Hb variants and uremia does not INTERFERE with the results in this methodology.
- It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts. & every 3 - 4 months in well controlled diabetics.
- Mean blood glucose (MBG) in first 30 days (0-30) before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

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
Name	: Mr. Anuranjan Kerketta	Gender	: Male	Age	: 43 Years
UHID	: FVAH 10680.	Bill No	:	Lab No	: V-2330-23
Ref. by	: SELF	Sample Col.Dt	: 19/02/2024 08:45		
Barcode No	: 9008	Reported On	: 19/02/2024 16:01		

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	88	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)
Post Prandial Plasma Glucose :	90	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : ≥ 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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Name	: Mr. Anuranjan Kerketta	Gender	: Male	Age	: 43 Years
UHID	: FVAH 10680.	Bill No	:	Lab No	: V-2330-23
Ref. by	: SELF	Sample Col.Dt	: 19/02/2024 08:45		
Barcode No	: 9008.	Reported On	: 19/02/2024 16:01		

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LIPID PROFILE - Serum			
S. Cholesterol(Oxidase)	140	mg/dL	Desirable < 200 Borderline: >200- <240 Undesirable: >240
S. Triglyceride(GPO-POD)	104	mg/dL	Desirable < 150 Borderline: >150- <499 Undesirable: >500
S. VLDL:(Calculated)	20.8	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	37.3	mg/dL	Desirable > 60 Borderline: >40- <59 Undesirable: <40
S. LDL:(calculated)	81.9	mg/dL	Desirable < 130 Borderline: >130- <159 Undesirable: >160
Ratio Cholesterol/HDL	3.8		3.5 - 5
Ratio of LDL/HDL	2.2		2.5 - 3.5

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Name : Mr. Anuranjan Kerketta Gender : Male Age : 43 Years
UHID : FVAH 10680. Bill No : Lab No : V-2330-23
Ref. by : SELF Sample Col.Dt : 19/02/2024 08:45
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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL


LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.14	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.42	g/dL	3.5 - 5.2
S.Globulin (Calculated)	2.72	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.62		0.9 - 2
S.Total Bilirubin (DPD):	0.37	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.16	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.21	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P): 48		U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P): 29		U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic): 64		U/L	40 - 129
S.GGT(IFCC Kinetic): 17		U/L	11 - 50

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Name : Mr. Anuranjan Kerketta Gender : Male Age : 43 Years
UHID : FVAH 10680. Bill No : Lab No : V-2330-23
Ref. by : SELF Sample Col.Dt : 19/02/2024 08:45
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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	24.9 mg/dl	10.0 - 45.0
BUN (Calculated)	11.62 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.99 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	11.74	9:1 - 23:1
S.Uric Acid(Uricase Method)	5.7 mg/dl	3.4 - 7.0

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UHID	: FVAH 10680.	Bill No	:	Lab No	: V-2330-23
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Barcode No	: 9008	Reported On	: 19/02/2024 16:01		

TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3, T4, TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.72	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	95.48	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	5.23	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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Dr. Milind Patwardhan
M.D(Path)
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End of Report
Results are to be correlated clinically

Name : Mr. Anuranjan Kerketta Gender : Male Age : 43 Years
UHID : FVAH 10680. Bill No : Lab No : V-2330-23
Ref. by : SELF Sample Col.Dt : 19/02/2024 08:45
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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	PROSTATE SPECIFIC ANTIGEN	
Prostate Specific Antigen (ECLIA):	0.530 ng/mL	0.03 - 3.5 ng/ml

INTERPERETATION

Serum PSA is a useful diagnostic tool for diagnosis of prostatic cancer. PSA levels should always be assessed in conjunction with the patient's medical history, clinical examination, prostatic acid phosphatase and radiological findings
Elevated levels are indicative of pathologic conditions of prostatitis, Benign hyperplasia or Prostatic adenocarcinoma
Rate of the fall of PSA levels to non detectable levels can occur following radiotherapy, hormonal therapy or radical surgical removal of the prostate & provides information of the success of treatment.
Inflammation or trauma of prostate can lead to elevated PSA levels of varying magnitude and duration.

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M.D(Path)
Chief Pathologist

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Name	: Mr. Anuranjan Karketta	Gender	: Male	Age	: 43 Years
UHID	: FVAH 10680.	Bill No	:	Lab No	: V-2330-23
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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
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URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)


REACTION(PH)	6.0		4.6 - 8.0
SPECIFIC GRAVITY	1.010		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	Trace		Absent
Nitrites	Absent		Absent

MICROSCOPIC EXAMINATION

PUS CELLS	1 - 2/hpf		0 - 3/hpf
RED BLOOD CELLS	Occasional		Absent
EPITHELIAL CELLS	Occasional		3 - 4/hpf
CASTS	Absent		Absent
CRYSTALS	Absent		Absent
BACTERIA	Absent		Absent

Vasanti Gondal
Entered By

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 Dr. Milind Patwardhan
 M.D(Path)
 Page 2 of Chief Pathologist

End of Report
 Results are to be correlated clinically

Name	: Mr. Anuranjan Kerkelta	Gender	: Male	Age	: 43 Years
UHID	: FVAH 10680.	Bill No	:	Lab No	: V-2330-23
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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
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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
LARVAE	Absent	Absent

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Chief Pathologist

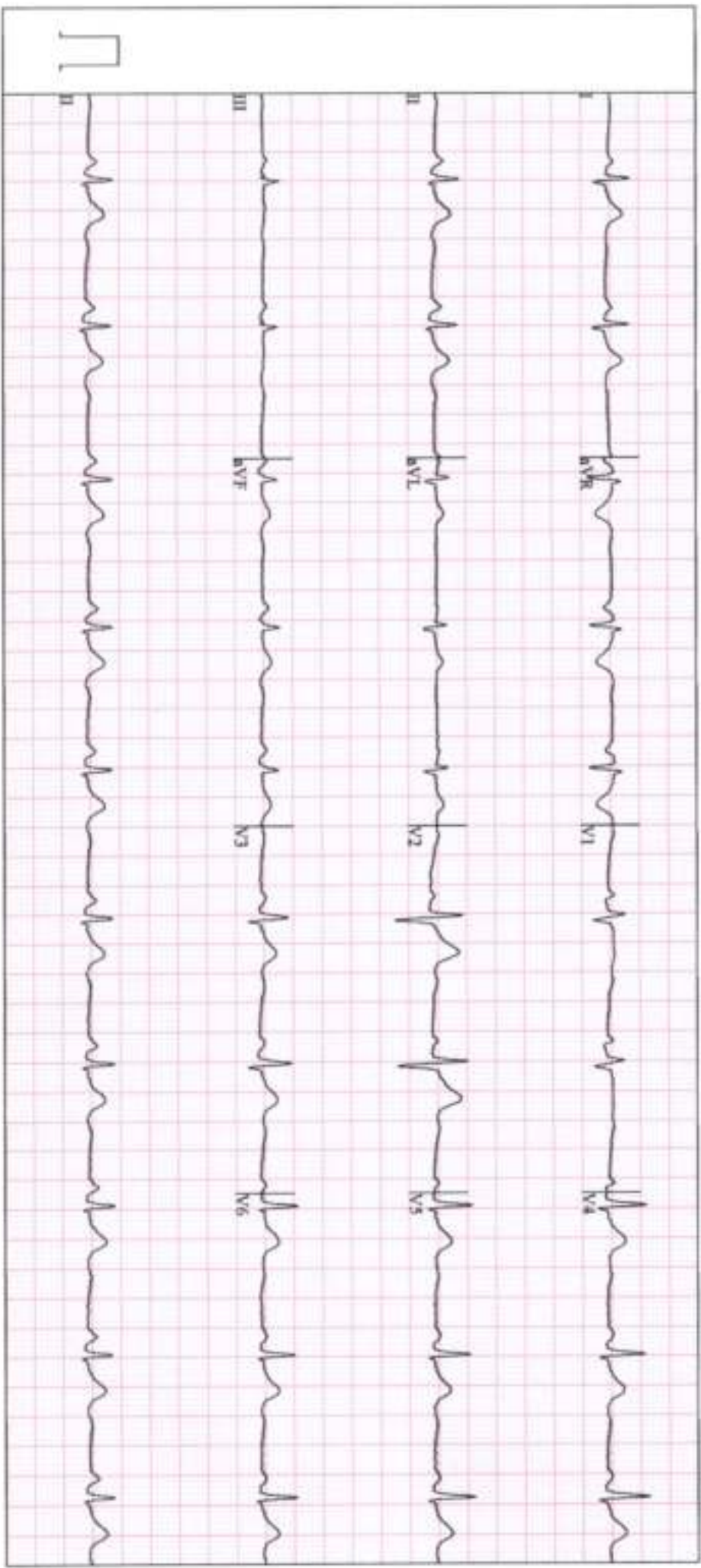
End of Report
Results are to be correlated clinically

QRS	74 ms
QT / QTc/ Baz	388 / 388 ms
PR	146 ms
P	116 ms
RR / PP	994 / 1000 ms
P / QRS / T	57 / 55 / 40 degrees

Normal sinus rhythm
Normal ECG

NORMAL ECG

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



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

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: ANURANJAN, KERKETTA
Patient ID: 10680
Height:
Weight:

DOB: 25.06.1980
Age: 43yrs
Gender: Male
Race: Asian

Study Date: 19.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR. ANIRBAN DASGUPTA
Technician: Anita Gaikwad

Medications:
AHA

Medical History:
HTN

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	00:17	0.00	0.00	76	110/80	
	STANDING	00:15	0.00	0.00	68		
	HYPERV.	00:15	0.00	0.00	64		
	WARM-UP	00:04	0.00	0.00	64		
EXERCISE	STAGE 1	03:00	1.70	10.00	122	120/80	
	STAGE 2	03:00	2.50	12.00	142	140/90	
	STAGE 3	01:01	3.40	14.00	157	150/90	
RECOVERY		01:05	0.00	0.00	127	170/90	

The patient exercised according to the BRUCE for 7:01 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 77 bpm rose to a maximal heart rate of 157 bpm. This value represents 88 % of the maximal, age-predicted heart rate. The resting blood pressure of 110/80 mmHg, rose to a maximum blood pressure of 170/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

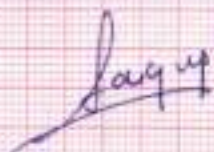
Interpretation

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



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

PATIENT'S NAME	ANURANJAN KERKETTA	AGE :- 43 Y/M
UHID NO	10680	19 Feb 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 IN CURRENT RADIOGRAPH.

Clinico-haematological correlation is recommended.

Thanking you for the referral,
With regards,



DR. SIDDHI PATIL
Cons. Radiologist

PATIENT'S NAME	ANURANJAN KERKETTA	AGE :- 43y/M
UHID NO	10680	19 Feb 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 8.9 x 4.0 cm. **LEFT KIDNEY** measures 9.7 x 4.5 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. It measures approximately 15 gms.

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

IMPRESSION -

- No 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. DISHA MINOCHA
DMRE (RADIOLOGIST)