

Dr. Vimmi Goel
MBBS, MD (Internal Medicine)
Sr. Consultant Non Invasive Cardiology
Reg. No: MMC-2014/01/0113

Preventive Health Check up
KIMS Kingsway Hospitals
Nagpur
Phone No.: 7499913052

 **KIMS-KINGSWAY
HOSPITALS**

Name: Mrs. Aparna Gase Date: 8/10/24

Age: 32y Sex: M/F Weight: 42.5 kg Height: 144.9 inc BMI: 20.2

BP: 120/90 mmHg Pulse: 88 bpm RBS: _____ mg/dl

SpO₂ - 99%

LMP - 29/12/23



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

| | |
|--|---|
| Patient Name : Mrs. APARNA WASE | Age / Gender : 32 Y(s)/Female |
| Bill No/ UMR No : BIL2324068005/UMR2324033094 | Referred By : Dr. Vimmi Goel MBBS,MD |
| Received Dt : 08-Jan-24 09:49 am | Report Date : 08-Jan-24 11:42 am |

HAEMOGRAM

| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | <u>Biological Reference</u> | <u>Method</u> |
|--|-----------------|----------------|-----------------------------|---------------|
| Haemoglobin | Blood | 13.8 | 12.0 - 15.0 gm% | Photometric |
| Haematocrit(PCV) | | 40.5 | 36.0 - 46.0 % | Calculated |
| RBC Count | | 4.75 | 3.8 - 4.8 Millions/cumm | Photometric |
| Mean Cell Volume (MCV) | | 85 | 83 - 101 fl | Calculated |
| Mean Cell Haemoglobin (MCH) | | 29.1 | 27 - 32 pg | Calculated |
| Mean Cell Haemoglobin Concentration (MCHC) | | 34.1 | 31.5 - 35.0 g/l | Calculated |
| RDW | | 13.3 | 11.5 - 14.0 % | Calculated |
| Platelet count | | 255 | 150 - 450 10^3 /cumm | Impedance |
| WBC Count | | 5300 | 4000 - 11000 cells/cumm | Impedance |

DIFFERENTIAL COUNT

| | | | |
|---------------------------|--------|-------------------|---------------------------------|
| Neutrophils | 60.3 | 50 - 70 % | Flow Cytometry/Light microscopy |
| Lymphocytes | 33.6 | 20 - 40 % | Flow Cytometry/Light microscopy |
| Eosinophils | 3.1 | 1 - 6 % | Flow Cytometry/Light microscopy |
| Monocytes | 3.0 | 2 - 10 % | Flow Cytometry/Light microscopy |
| Basophils | 0.0 | 0 - 1 % | Flow Cytometry/Light microscopy |
| Absolute Neutrophil Count | 3195.9 | 2000 - 7000 /cumm | Calculated |



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| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | <u>Biological Reference</u> | <u>Method</u> |
|---------------------------|-----------------|----------------------------|-----------------------------|----------------------------------|
| Absolute Lymphocyte Count | | 1780.8 | 1000 - 4800 /cumm | Calculated |
| Absolute Eosinophil Count | | 164.3 | 20 - 500 /cumm | Calculated |
| Absolute Monocyte Count | | 159 | 200 - 1000 /cumm | Calculated |
| Absolute Basophil Count | | 0 | 0 - 100 /cumm | Calculated |
| PERIPHERAL SMEAR | | | | |
| RBC | | Normochromic Normocytic | | |
| WBC | | As Above | | |
| Platelets | | Adequate | | |
| ESR | | 13 | 0 - 20 mm/hr | Automated Westergren's Method |
| *** End Of Report *** | | | | |

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100245

Test results related only to the item tested.

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Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

| | |
|--|---|
| Patient Name : Mrs. APARNA WASE | Age /Gender : 32 Y(s)/Female |
| Bill No/ UMR No : BIL2324068005/UMR2324033094 | Referred By : Dr. Vimmi Goel MBBS,MD |
| Received Dt : 08-Jan-24 09:46 am | Report Date : 08-Jan-24 11:42 am |

| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | <u>Biological Reference</u> | <u>Method</u> |
|---|-----------------|----------------|--|----------------------|
| Fasting Plasma Glucose | Plasma | 78 | < 100 mg/dl | GOD/POD,Colorimetric |
| GLYCOSYLATED HAEMOGLOBIN (HBA1C) | | | | |
| HbA1c | | 4.7 | Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 % | HPLC |

*** End Of Report ***

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Phone : +91 0712 6789100

City : U72199MH2018PTC300510

**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

| | |
|--|---|
| Patient Name : Mrs. APARNA WASE | Age / Gender : 32 Y(s)/Female |
| Bill No/ UMR No : BIL2324068005/UMR2324033094 | Referred By : Dr. Vimmi Goel MBBS,MD |
| Received Dt : 08-Jan-24 12:23 pm | Report Date : 08-Jan-24 01:57 pm |

| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | <u>Biological Reference</u> | <u>Method</u> |
|------------------------------|-----------------|----------------|-----------------------------|-----------------------|
| Post Prandial Plasma Glucose | Plasma | 75 | < 140 mg/dl | GOD/POD, Colorimetric |

Interpretation:

Clinical Decision Value as per ADA Guidelines 2021

Diabetes Mellites If,
Fasting \geq 126 mg/dl
Random/2Hrs. OGTT \geq 200 mg/dl
Impaired Fasting = 100-125 mg/dl
Impaired Glucose Tolerance = 140-199 mg/dl

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

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LIPID PROFILE

| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | <u>Method</u> |
|------------------------|-----------------|-------------------|--|
| Total Cholesterol | Serum | 189 < 200 mg/dl | Enzymatic(CHE/CHO/PO D) |
| Triglycerides | | 56 < 150 mg/dl | Enzymatic (Lipase/GK/GPO/POD) |
| HDL Cholesterol Direct | | 75 > 50 mg/dl | Phosphotungstic acid/mgcl-Enzymatic (microslide) |
| LDL Cholesterol Direct | | 94.81 < 100 mg/dl | Enzymatic |
| VLDL Cholesterol | | 11 < 30 mg/dl | Calculated |
| Tot Chol/HDL Ratio | | 3 3 - 5 | Calculation |

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

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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**Dr. GAURI HARDAS, MBBS,MD
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**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

| | |
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LIVER FUNCTION TEST(LFT)

| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | <u>Biological Reference</u> | <u>Method</u> |
|----------------------|-----------------|----------------|-----------------------------|------------------------------------|
| Total Bilirubin | Serum | 0.72 | 0.2 - 1.3 mg/dl | Azobilirubin/Dyphylline |
| Direct Bilirubin | | 0.21 | 0.1 - 0.3 mg/dl | Calculated |
| Indirect Bilirubin | | 0.51 | 0.1 - 1.1 mg/dl | Dual wavelength spectrophotometric |
| Alkaline Phosphatase | | 178 | 38 - 126 U/L | pNPP/AMP buffer |
| SGPT/ALT | | 25 | 13 - 45 U/L | Kinetic with pyridoxal 5 phosphate |
| SGOT/AST | | 32 | 13 - 35 U/L | Kinetic with pyridoxal 5 phosphate |
| Serum Total Protein | | 8.34 | 6.3 - 8.2 gm/dl | Biuret (Alkaline cupric sulphate) |
| Albumin Serum | | 4.45 | 3.5 - 5.0 gm/dl | Bromocresol green Dye Binding |
| Globulin | | 3.89 | 2.0 - 4.0 gm/dl | Calculated |
| A/G Ratio | | 1.1 | | |

*** End Of Report ***

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CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

| | |
|--|---|
| Patient Name : Mrs. APARNA WASE | Age / Gender : 32 Y(s)/Female |
| Bill No/ UMR No : BIL2324068005/UMR2324033094 | Referred By : Dr. Vimmi Goel MBBS,MD |
| Received Dt : 08-Jan-24 09:49 am | Report Date : 08-Jan-24 11:42 am |

| <u>Parameter</u> | <u>Specimen</u> | <u>Result Values</u> | <u>Biological Reference</u> | <u>Method</u> |
|------------------------|-----------------|----------------------|-----------------------------|--------------------------------|
| RFT | | | | |
| Blood Urea | Serum | 16 | 15.0 - 36.0 mg/dl | |
| Creatinine | | 0.5 | 0.52 - 1.04 mg/dl | |
| GFR | | 127.7 | >90 mL/min/1.73m square. | |
| Sodium | | 143 | 136 - 145 mmol/L | |
| Potassium | | 4.08 | 3.5 - 5.1 mmol/L | Direct ion selective electrode |
| THYROID PROFILE | | | | |
| T3 | | 1.74 | 0.55 - 1.70 ng/ml | Enhanced chemiluminescence |
| Free T4 | | 1.64 | 0.80 - 1.70 ng/dl | Enhanced Chemiluminescence |
| TSH | | 0.63 | 0.50 - 4.80 uIU/ml | Enhanced chemiluminescence |

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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Dr. GAURI HARDAS, MBBS,MD

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Phone: +91 0712 6789100

CIN: U74999MH2018PTC303510

**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

| | |
|--|---|
| Patient Name : Mrs. APARNA WASE | Age /Gender : 32 Y(s)/Female |
| Bill No/ UMR No : BIL2324068005/UMR2324033094 | Referred By : Dr. Vimmi Goel MBBS,MD |
| Received Dt : 08-Jan-24 12:36 pm | Report Date : 08-Jan-24 01:55 pm |

URINE SUGAR**Parameter**

Urine Glucose

NOTE:

Result Values

Negative

urine sugar postmeal

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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**Dr. VAIDEHEE NAIK, MBBS,MD****CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF PATHOLOGY

| | |
|--|---|
| Patient Name : Mrs. APARNA WASE | Age / Gender : 32 Y(s)/Female |
| Bill No/ UMR No : BIL2324068005/UMR2324033094 | Referred By : Dr. Vimmi Goel MBBS,MD |
| Received Dt : 08-Jan-24 10:31 am | Report Date : 08-Jan-24 11:53 am |

| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | <u>Method</u> |
|---------------------------------|-----------------|----------------|---------------|
| URINE MICROSCOPY | | | |
| PHYSICAL EXAMINATION | | | |
| Volume | Urine | 30 ml | |
| Colour. | | Pale yellow | |
| Appearance | | Clear | Clear |
| CHEMICAL EXAMINATION | | | |
| Reaction (pH) | Urine | 7.0 | 4.6 - 8.0 |
| Specific gravity | | 1.005 | 1.005 - 1.025 |
| Urine Protein | | Negative | Negative |
| Sugar | | Negative | Negative |
| Bilirubin | | Negative | Negative |
| Ketone Bodies | | Negative | Negative |
| Nitrate | | Negative | Negative |
| Urobilinogen | | Normal | Normal |
| MICROSCOPIC EXAMINATION | | | |
| Epithelial Cells | Urine | 0-1 | 0 - 4 /hpf |
| R.B.C. | | Absent | 0 - 4 /hpf |
| Pus Cells | | 0-1 | 0 - 4 /hpf |
| Casts | | Absent | Absent |
| Crystals | | Absent | Absent |
| USF(URINE SUGAR FASTING) | | | |
| Urine Glucose | Urine | Negative | |

*** End Of Report ***

STRIP

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100400

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Dr. GAURI HARDAS, MBBS,MD

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Phone: +91 0712 6789100

CIN: U74999MH2018PTC303510



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY

| | |
|--|---|
| Patient Name : Mrs. APARNA WASE | Age / Gender : 32 Y(s)/Female |
| Bill No/ UMR No : BIL2324068005/UMR2324033094 | Referred By : Dr. Vimmi Goel MBBS,MD |
| Received Dt : 08-Jan-24 09:49 am | Report Date : 08-Jan-24 11:42 am |

BLOOD GROUPING AND RH

| <u>Parameter</u> | <u>Specimen</u> | <u>Results</u> | |
|------------------|----------------------------------|-----------------------|-----------------|
| BLOOD GROUP. | EDTA Whole Blood & Plasma/ Serum | * O * | Gel Card Method |
| Rh (D) Typing. | | * Positive *(+Ve) | |
| | | *** End Of Report *** | |

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100245

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Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

| | | | |
|---------------|------------------|--------------|---------------------|
| NAME | APARNA WASE | STUDY DATE | 08-01-2024 10:55:20 |
| AGE/ SEX | 32Y 1D / F | HOSPITAL NO. | UMR2324033094 |
| ACCESSION NO. | BBL2324068005-10 | MODALITY | DX |
| REPORTED ON | 08-01-2024 12:28 | REFERRED BY | Dr. Vimmi Goel |

X-RAY CHEST PA VIEW

Both the 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 -

No pleuro-parenchymal abnormality seen.



DR. R.R. KHANDELWAL

SENIOR CONSULTANT

MD, RADIODIAGNOSIS [MMC-55870]

N.B: This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations. Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

| | | | |
|---------------|------------------|-----------|------------|
| PATIENT NAME: | MRS. APARNA WASE | AGE /SEX: | 32 YRS/F |
| UMR NO: | 2324033094 | BILL NO: | 2324068005 |
| REF BY | DR. VIMMI GOEL | DATE: | 08/01/2024 |

USG WHOLE ABDOMEN

LIVER is normal in size, shape and shows normal 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 physiologically distended. No sludge or calculus seen.
Wall thickness is within normal limits.

PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in shape, size and echotexture. No focal lesion seen.

Both KIDNEYS are normal in shape, size and echotexture.
No evidence of calculus or hydronephrosis seen.
URETERS are not dilated.


BLADDER is partially distended. No calculus or mass lesion seen.

Uterus is anteverted and normal.
No focal myometrial lesion seen.
Endometrial echo-complex appear normal.
No adnexal mass lesion seen.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION -

No significant abnormality seen.
Suggest clinical correlation / further evaluation.



DR. R.R. KHANDELWAL
SENIOR CONSULTANT
MD RADIO DIAGNOSIS [MMC-55870]

Kingsway Hospitals
Kingsway, Mohan Nagar,
Near Kasturchand Park, Nagpur

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Mrs. Apama, Wase
Patient ID: 033094
Height:
Weight:
Study Date: 08.01.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

DOB: 05.06.1991
Age: 32yrs
Gender: Female
Race: Indian
Referring Physician: Mediwheel HCU
Attending Physician: Dr. Vimmi Goel
Technician: -

Medications:

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 | 01:17 | 0.00 | 0.00 | 94 | 110/70 | |
| | WARM-UP | 00:05 | 0.00 | 0.00 | 94 | | |
| EXERCISE | STAGE 1 | 03:00 | 1.70 | 10.00 | 111 | 110/70 | |
| | STAGE 2 | 02:19 | 2.50 | 12.00 | 139 | 110/70 | |
| RECOVERY | | 01:00 | 0.00 | 0.00 | 94 | 120/70 | |
| | | 02:00 | 0.00 | 0.00 | 90 | 120/70 | |
| | | 00:13 | 0.00 | 0.00 | 83 | | |


The patient exercised according to the BRUCE for 5:18 min's, achieving a work level of Max. METS: 7.00. The resting heart rate of 87 bpm rose to a maximal heart rate of 142 bpm. This value represents 75% of the maximal, age-predicted heart rate. The resting blood pressure of 110/70 mmHg, rose to a maximum blood pressure of 120/70 mmHg. The exercise test was stopped due to Fatigue.

Interpretation:

Summary: Resting ECG: normal.
Functional Capacity: normal.
Response to Exercise: THR not achieved.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Inconclusive.

Conclusions:

TMT is Inconclusive for inducible ischemia.
Poor effort tolerance.
Physical deconditioning noted.
To be correlated clinically.


Dr. VIMMI GOEL
MBBS, MD
Sr. Consultant Non Invasive Cardiology
Reg.No: 2014/01/0113

32 Years

FBC DEPT.

Rate 81 Sinus rhythm. Normal P axis, V-rate 50-99

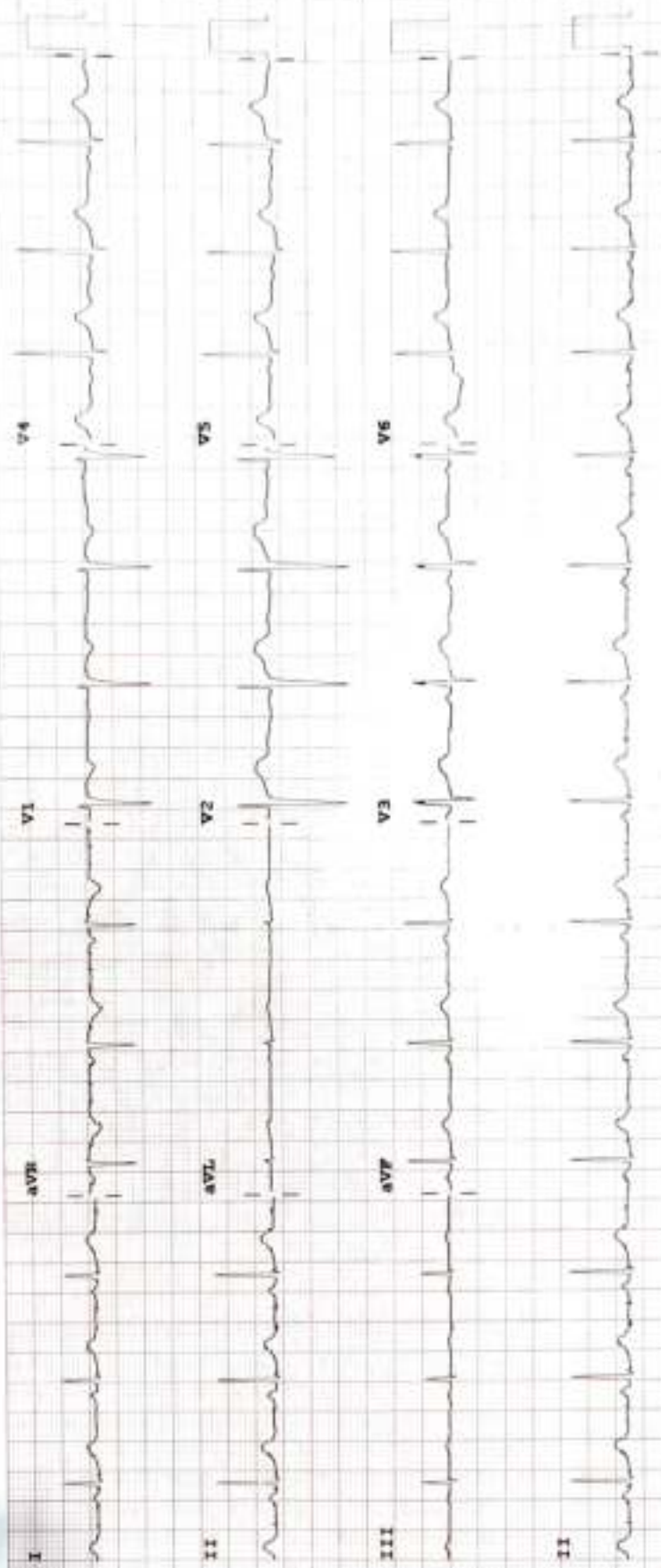
PR 121
QRSD 76
QT 360
QTc 418

--AXIS--
P 45
QRS 55
T 41

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



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

P 50- 0.50-150 Hz W 1.00B CL P?