

Rahul Kamat
32 yrs / male

27/01/2024

No fresh complaints

No comorbidities.

No PIH

No SH.

P/A - Mother - DM.

father - HTN.

Height - 171 cm

Weight - 78 kg

BMI - 26.7 kg/m²

(overweight)

BP - 130/60 mmHg

P - 80/min

SpO₂ - 97%

PT is fit and can resume
his normal duties.





Name - Mr. RAHUL KAMAT	Age - 32 Y/M
Ref by Dr.- Siddhivinayak Hospital	Date - 27/01/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





Name - Mr. Rahul Kamat	Age - 32 Y/M
Ref by Dr.- Siddhivinayak Hospital	Date - 27/01/2024

USG ABDOMEN & PELVIS

FINDINGS: -

The **liver** dimension is normal in size (13.7 cm). It appears normal in morphology with **raised echogenicity**. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is distended normally. Wall thickness is normal.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size (11.9 cm) and morphology.

Both **kidneys** demonstrate normal morphology.

Both kidneys show normal cortical echogenicity.

The right kidney measures 10.4 x 3.9 cm.

The left kidney measures 10.5 x 4.8 cm.

Urinary bladder: -normally distended. Wall thickness - normal.

Prostate is normal in size and morphology Size: 18.9 gms.

No **free fluid** is seen.

IMPRESSION:-

- Fatty liver (Grade I)

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST



ID: 825
 27-01-2024 08:56:00 AM
 HR : 71 bpm
 P : 109 ms
 PR : 173 ms
 QRS : 88 ms
 QT/QTcBz : 361/395 ms
 P/QRS/T : 46/57/40 °
 RV5/SV1 : 1.378/0.436 mV

Male
 Req. No. : BP: 130/60

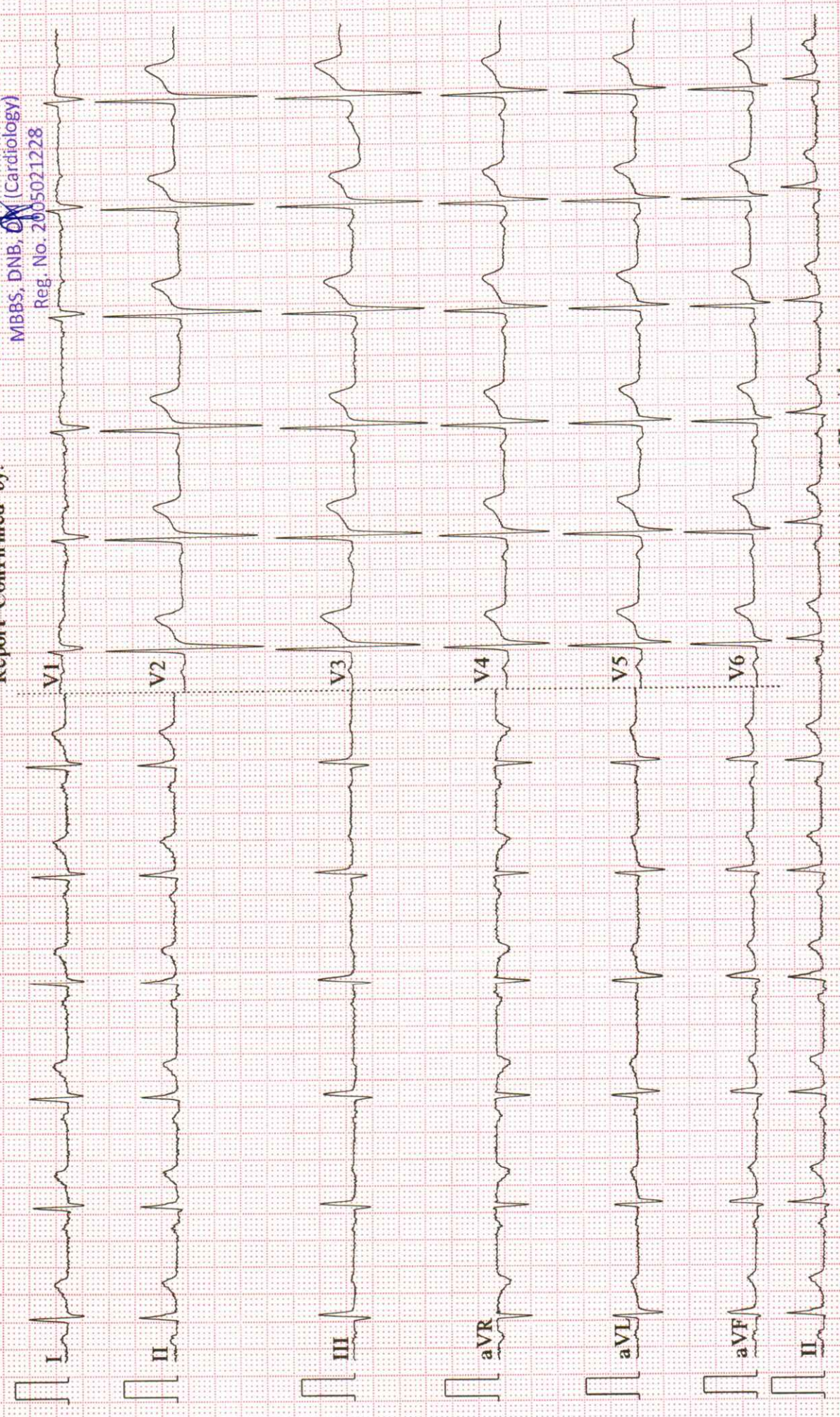
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 QT/QTcBz : 361/395 ms
 P/QRS/T : 46/57/40 °
 RV5/SV1 : 1.378/0.436 mV

Diagnosis Information:
 Sinus Rhythm
 Normal ECG

Report Confirmed by:

Dr. Anant Ram Vishanrao Munde
 MBBS, DNB, DM (Cardiology)
 Reg. No. 2005021228

TNSR
 No Significant ST-T changes
 ADN - No acute infarction
 requiring treatment



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

KAMAT RAHUL KUMAR

AGE

32

DATE -

27.01.2024

Specs : Without Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/6	6/6
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS



ECHOCARDIOGRAM

NAME	MR. RAHUL KAMAT
AGE/SEX	32 YRS/M
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	27/01/2024

2D/M-MODE ECHOCARDIOGRAPHY

<u>VALVES:</u> MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	<u>CHAMBERS:</u> LEFT ATRIUM: Normal <ul style="list-style-type: none"> • Left atrial appendage: Normal LEFT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
<u>GREAT VESSELS:</u> <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	<u>SEPTAE:</u> <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact
<u>CORONARIES:</u> Proximal coronaries normal <u>CORONARY SINUS:</u> Normal <u>PULMONARY VEINS:</u> Normal	<u>VENACAVAE:</u> <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration <u>PERICARDIUM:</u> Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	21 mm	Left atrium	38 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	45.2 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	28.0 mm	RVEF	%
Ascending aorta	mm	IVSd	8.9 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.9 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	68 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MR. RAHUL KAMAT
AGE/SEX	32YRS/M
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	27 /01/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.44	1.24
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm ²)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)				
REGURGITATION		TRJV= m/s PASP= mmHg		
E/A				
E/E'				

FINAL IMPRESSION: NORMAL STUDY

- No RWMA
- Normal LV systolic function (LVEF 68 %)
- Good RV systolic function
- Normal diastolic function
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE: Nil

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

Dr. Anant Ramkishanrao Munde
MBBS, DNB, DM (Cardiology)
Reg. No. 2005021228



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***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	158.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	36.4	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease: >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	131.5	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	26	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	95	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	2.61		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.34		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
SHAISTA Q

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





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COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	14.1	gm/dl	13 - 18
HEMATOCRIT (PCV)	42.3	%	42 - 52
RBC COUNT	5.57	x10 ⁶ /uL	4.70 - 6.50
MCV	76	fl	80 - 96
MCH	25.3	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	15.7	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	6120	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	66	%	40 - 80
LYMPHOCYTES	23	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	09	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	271000	/cumm	150000 - 450000
MPV	10.4	fl	6.5 - 11.5
PDW	16.5	%	9.0 - 17.0
PCT	0.280	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	20ml		
COLOUR	Pale yellow		Pale Yellow
APPEARANCE	Clear		CLEAR
<u>CHEMICAL EXAMINATION</u>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent		Absent
PUS CELLS	0-2	/ HPF	0 - 5
EPITHELIAL	0-2	/ HPF	0 - 5
CASTS	Absent		

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		

REMARK Result relates to sample tested. Kindly correlate with clinical findings.

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>TFT (THYROID FUNCTION TEST)</u>			
SPACE		Space	-
SPECIMEN	Serum		
T3	110.4	ng/dl	84.63 - 201.8
T4	6.12	µg/dl	5.13 - 14.06
TSH	2.32	µIU/ml	0.270 - 4.20
T3 (Triiodo Thyronine hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating hormone)	
AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

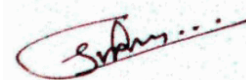
INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GROUP</u>			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'O'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
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***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	22.7	mg/dL	19 - 45
BLOOD UREA NITROGEN (Calculated)	10.61	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.97	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	7.5	mg/dL	3.5 - 7.2
S. SODIUM (ISE Direct Method)	139.6	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.21	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	101.4	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.88	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.5	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.7	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.2	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.50	g/dl	1.9 - 3.5
A/G RATIO calculated	1.68		0 - 2

NOTE

BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200)
ANALYZER.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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Age/Sex : 32 Years / Male
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS

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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Normocytic Normochromic
WBC	Total leucocyte count is normal on smear. Neutrophils:65 % Lymphocytes:25 % Monocytes:08 % Eosinophils:02 % Basophils:00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No parasite seen.

Result relates to sample tested, Kindly correlate with clinical findings.
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LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.38	mg/dL	0.0 - 2.0
DIRECT BILLIRUBIN (Method-Diazo)	0.16	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.22	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	20.9	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	44.1	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	94.0	U/L	53 - 128
S. PROTIEN (Method-Biuret)	6.70	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.20	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.50	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.68		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	15	mm/1hr.	0 - 20

METHOD - WESTERGREIN

Result relates to sample tested, Kindly correlate with clinical findings.

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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BLOOD GLUCOSE FASTING & PP

BLOOD GLUCOSE FASTING	93.0	mg/dL	70 - 110
BLOOD GLUCOSE PP	120.2	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms + Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

GAMMA GT	39.7	U/L	13 - 109
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GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.8	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	120.0	mg/dL	NON - DIABETIC : ≤ 5.6 PRE - DIABETIC : 5.7 - 6.4 DIABETIC : > 6.5

METHOD Particle Enhanced Immunoturbidimetry

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood. It indicates average blood sugar level over past three months.

Result relates to sample tested, Kindly correlate with clinical findings.

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