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Government of India

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नामांकन क्रम/ Enrolment No.: 2906/06864/00959

To
लक्ष्मी कुमारी
Laxmi Kumari
D/O: Rajendra Sahu
Village/Post-Karmauli, P.S-Khajauli
Kormauli
Madhubani Bihar - 847229
9570437306

Signature Not Verified
Details appear to be
UNUSUAL. EXAMINATION
AUTHORITY may perform
Check. 03/08/2016
UTC



आपका आधार क्रमांक / Your Aadhaar No. :

4692 1985 9876

VID : 9144 5192 1378 6646

मेरा आधार, मेरी पहचान



Government of India



सूचना

- आधार पहचान का प्रमाण है, नागरिकता का नहीं।
- सुरक्षित QR कोड / ऑफलाइन XML / ऑनलाइन ऑथेंटिकेशन से पहचान प्रमाणित करें।
- यह एक इलेक्ट्रॉनिक प्रक्रिया द्वारा बना हुआ पत्र है।

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लक्ष्मी कुमारी
Laxmi Kumari
जन्म तिथि/DOB: 22/03/2002
महिना/ FEMALE

4692 1985 9876

VID : 9144 5192 1378 6646

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पता:
आलमजा: राजेंद्र साहू, ग्राम/पोस्ट-करमाुली, थाना-खजौली,
कोरमाुली, मधुबनी,
बिहार - 847229

Address:
D/O: Rajendra Sahu, Village/Post-
Karmauli, P.S-Khajauli, Kormauli, Madhubani,
Bihar - 847229



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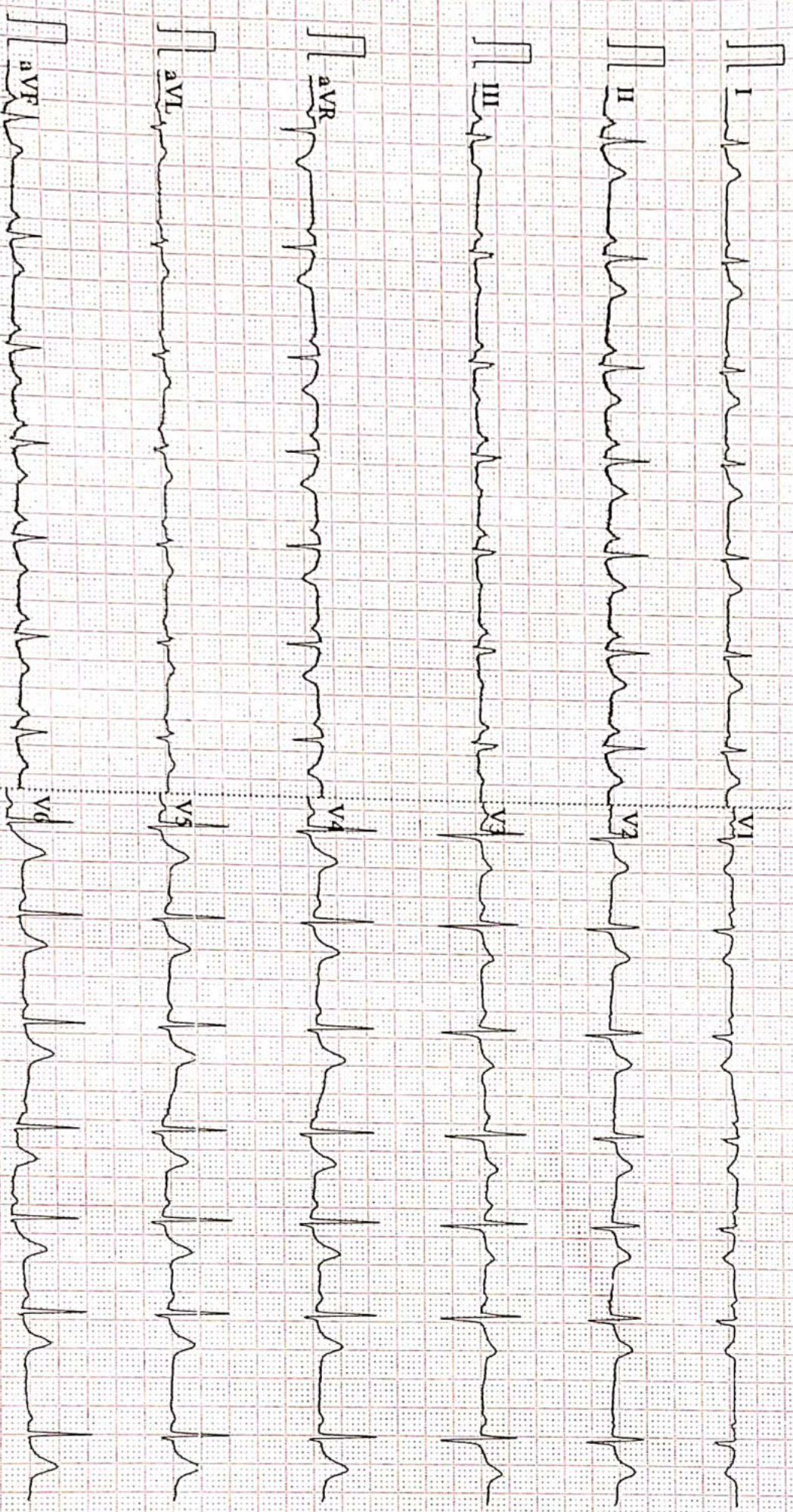
116
70

ID: 168
Laxmi Kumari
Female 20Years

09-10-2022 11:14:46 AM
HR : 87 bpm
P : 103 ms
PR : 144 ms
QRS : 81 ms
QT/QTc : 335/404 ms
P/QRS/T : 74/57/41 °
RV5/SV1 : 1.111/0.302 mV

Diagnosis Information:
Sinus Arrhythmia

Ref-Phys :
Report Confirmed by:





ISO 9001 : 2015

AAROGYAM DIAGNOSTICS

(A UNIT OF CULPAM HEALTH CARE PVT.LTD.)

F-41, P.C. Colony, Opp. Madhuban Complex,
Near Malahi Pakari Chowk, Kankarbagh, Patna-20
9264278360, 9065875700, 8789391403
info@aarogyamdiagnostics.com
www.aarogyamdiagnostics.com

Name :- Mrs. Laxmi Kumari
Refd by : BOB.

Age/Sex:-20Yrs/F
Date :-09/10/22

Thanks for referral.

REPORT OF USG OF WHOLE ABDOMEN

- Liver** :- Normal in size (11.7cm) with normal echotexture. No focal or diffuse lesion is seen. IHBR are not dilated. PV is normal in course and calibre with echofree lumen.
- G. Bladder** :- It is normal in shape, size & position. It is echofree & shows no evidence of calculus, mass or sludge.
- CBD** :- It is normal in calibre & is echofree.
- Pancreas** :- Normal in shape, size & echotexture. No evidence of parenchymal / ductal calcification is seen. No definite peripancreatic collection is seen.
- Spleen** :- Normal in size (8.5cm) with normal echotexture. No focal lesion is seen. No evidence of varices is noticed.
- Kidneys** :- Both kidneys are normal in shape, size & position. Sinus as well as cortical echoes are normal. No evidence of calculus, space occupying lesion or hydronephrosis is seen.
Right Kidney measures 7.6cm and Left Kidney measures 7.8cm.
- Ureters** :- Ureters are not dilated.
- U. Bladder** :- It is echofree. No evidence of calculus, mass or diverticulum is seen.
- Uterus** :- Antiverted Gravid Uterus contains a live Embryo of about 07 Weeks 04 days size seen within. Movemnet and cardiac activities are seen at scan time.
C.R.L - 13.4mm. F.H.R. - 169 Beat/Mt. Regular. E.D.D. - 24/05/23.
- Ovaries** :- Both ovaries show normal echotexture and follicular pattern. Right ovary measures 26mm x 17mm and Left ovary measures 24mm x 13mm.
No pelvic (POD) collection is seen.
- Others** :- No ascites or abdominal adenopathy is seen.
No free subphrenic / basal pleural space collection is seen.

IMPRESSION:- *A/V Gravid Uterus contains single live Embryo of about 07 Weeks 04 Days size.
E.D.D. by sonography is 24/05/23.
Otherwise Normal Scan.*

Dr. V. Kumar
MBBS, MD (Radio-Diagnosis)
Consultant Radiologist



Date	09/10/2022	Srl No.	14	Patient Id	2210090014
Name	Mrs. LAXMI KUMARI	Age	20 Yrs.	Sex	F
Ref. By	Dr.BOB				

Test Name	Value	Unit	Normal Value
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HAEMATOLOGY

HB A1C	5.2	%	
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EXPECTED VALUES :-

Metabolically healthy patients	=	4.8 - 5.5 % HbA1C
Good Control	=	5.5 - 6.8 % HbA1C
Fair Control	=	6.8-8.2 % HbA1C
Poor Control	=	>8.2 % HbA1C

REMARKS:-

In vitro quantitative determination of **HbA1C** in whole blood is utilized in long term monitoring of glycemia

The **HbA1C** level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose.

It is recommended that the determination of **HbA1C** be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy.

Results of **HbA1C** should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.

**** End Of Report ****

Dr.R.B.RAMAN
MBBS, MD
CONSULTANT PATHOLOGIST



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 info@aarogyamdiagnostics.com
 www.aarogyamdiagnostics.com

Date	09/10/2022	Srl No. 14	Patient Id 2210090014
Name	Mrs. LAXMI KUMARI	Age 20 Yrs.	Sex F
Ref. By Dr.BOB			

Test Name	Value	Unit	Normal Value
COMPLETE BLOOD COUNT (CBC)			
HAEMOGLOBIN (Hb)	10.8	gm/dl	11.5 - 16.5
TOTAL LEUCOCYTE COUNT (TLC)	8,100	/cumm	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHIL	64	%	40 - 75
LYMPHOCYTE	32	%	20 - 45
EOSINOPHIL	02	%	01 - 06
MONOCYTE	02	%	02 - 10
BASOPHIL	00	%	0 - 0
ESR (WESTEGREN's METHOD)	17	mm/1st hr.	0 - 20
R B C COUNT	3.61	Millions/cmm	3.8 - 4.8
P.C.V / HAEMATOCRIT	38.4	%	35 - 45
M C V	106.37	fl.	80 - 100
M C H	29.92	Picogram	27.0 - 31.0
M C H C	28.1	gm/dl	33 - 37
PLATELET COUNT	2.27	Lakh/cmm	1.50 - 4.00
BLOOD GROUP ABO	"O"		
RH TYPING	POSITIVE		

**** End Of Report ****

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Date 09/10/2022	Srl No. 14	Patient Id 2210090014
Name Mrs. LAXMI KUMARI	Age 20 Yrs.	Sex F
Ref. By Dr.BOB		

Test Name	Value	Unit	Normal Value
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BIOCHEMISTRY

BLOOD SUGAR FASTING	81.5	mg/dl	70 - 110
SERUM CREATININE	0.72	mg%	0.5 - 1.3
BLOOD UREA	23.5	mg /dl	15.0 - 45.0
BLOOD UREA NITROGEN (BUN)	10.981	mg%	6.0 - 20.0
SERUM URIC ACID	3.8	mg%	2.5 - 6.0

LIVER FUNCTION TEST (LFT)

BILIRUBIN TOTAL	0.61	mg/dl	0 - 1.0
CONJUGATED (D. Bilirubin)	0.19	mg/dl	0.00 - 0.40
UNCONJUGATED (I.D. Bilirubin)	0.42	mg/dl	0.00 - 0.70
TOTAL PROTEIN	6.8	gm/dl	6.6 - 8.3
ALBUMIN	3.7	gm/dl	3.4 - 5.2
GLOBULIN	3.1	gm/dl	2.3 - 3.5
A/G RATIO	1.194		
SGOT	33.5	IU/L	5 - 35
SGPT	34.8	IU/L	5.0 - 45.0
ALKALINE PHOSPHATASE IFCC Method	81.9	U/L	35.0 - 104.0
GAMMA GT	26.3	IU/L	6.0 - 42.0

LFT INTERPRET

LIPID PROFILE

TRIGLYCERIDES	91.6	mg/dL	25.0 - 165.0
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Date	09/10/2022	Srl No. 14	Patient Id 2210090014
Name	Mrs. LAXMI KUMARI	Age 20 Yrs.	Sex F
Ref. By Dr.BOB			

Test Name	Value	Unit	Normal Value
TOTAL CHOLESTEROL	159.2	mg/dL	29.0 - 199.0
H D L CHOLESTEROL DIRECT	53.7	mg/dL	35.1 - 88.0
V L D L	18.32	mg/dL	4.7 - 22.1
L D L CHOLESTEROL DIRECT	87.18	mg/dL	63.0 - 129.0
TOTAL CHOLESTEROL/HDL RATIO	2.965		0.0 - 4.97
LDL / HDL CHOLESTEROL RATIO	1.623		0.00 - 3.55
THYROID PROFILE			
T3	0.86	ng/ml	0.60 - 1.81
T4	7.43	ug/dl	4.5 - 10.9
Chemiluminescence			
TSH	1.342	uIU/ml	
Chemiluminescence			
REFERENCE RANGE			
PAEDIATRIC AGE GROUP			
0-3 DAYS	1-20	ulu/ ml	
3-30 DAYS	0.5 - 6.5	ulu/ml	
1 MONTH -5 MONTHS	0.5 - 6.0	ulu/ml	
6 MONTHS- 18 YEARS	0.5 - 4.5	ulu/ml	
ADULTS	0.39 - 6.16	ulu/ml	

Note: TSH levels are subject to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm to 6 am. Nadir concentrations are observed during the afternoon. Diurnal variation in TSH level approximates $\pm 50\%$, hence time of the day has influence on the measured serum TSH concentration.



Date	09/10/2022	Srl No. 14	Patient Id 2210090014
Name	Mrs. LAXMI KUMARI	Age 20 Yrs.	Sex F
Ref. By Dr.BOB			

Test Name	Value	Unit	Normal Value
-----------	-------	------	--------------

Assay performed on enhanced chemi luminescence system (Centaur-Siemens)

Serum T3,T4 & TSH measurements form the three components of Thyroid screening panel, useful in diagnosing various disorders of Thyroid gland function.

1. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH level.
2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 levels along with depressed TSH values.
3. Normal T4 levels are accompanied by increased T3 in patients with T3 thyrotoxicosis.
4. Slightly elevated T3 levels may be found in pregnancy and estrogen therapy, while depressed levels may be encountered in severe illness, renal failure and during therapy with drugs like propranolol and propyl thiouracil.
5. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, and may be seen in secondary thyrotoxicosis.

URINE EXAMINATION TEST

PHYSICAL EXAMINATION

QUANTITY	10	ml.
COLOUR	PALE YELLOW	
TRANSPARENCY	CLEAR	
SPECIFIC GRAVITY	1.015	
PH	6.0	



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Name	Mrs. LAXMI KUMARI	Age 20 Yrs.	Sex F
Ref. By Dr.BOB			

Test Name	Value	Unit	Normal Value
-----------	-------	------	--------------

CHEMICAL EXAMINATION

ALBUMIN	NIL		
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SUGAR	NIL		
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MICROSCOPIC EXAMINATION

PUS CELLS	0-1	/HPF	
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RBC'S	NIL	/HPF	
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CASTS	NIL		
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CRYSTALS	NIL		
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EPITHELIAL CELLS	0-1	/HPF	
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BACTERIA	NIL		
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OTHERS	NIL		
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**** End Of Report ****

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