

NAME:	Mr. Vikas Patel	UHID:	
AGE:	35	DATE OF HEALTHCHECK:	10-2-2024
GENDER:	M		

HEIGHT:	174 cm	MARITAL STATUS:	M
WEIGHT:	88.2 kg	NO OF CHILDREN:	1
BMI:	29.01		

C/O: Chest pain on left

K/C/O:

PRESENT MEDICATION: - No

P/M/H: - No

P/S/H: - No

ALLERGY: - No

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

ALCOHOL:

TOBACCO/PAN:

FAMILY HISTORY FATHER: - No

MOTHER: - No

O/E:

LYMPHADENOPATHY:

BP: 110/80 PULSE: - 84/min

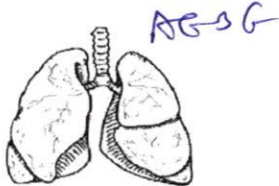
PALLOR/ICTERUS/CYNOSIS/CLUBBING:

TEMPERATURE: N SCARS:

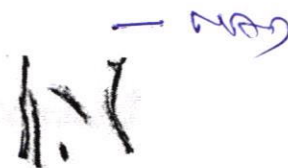
OEDEMA:

S/E:

RS:



P/A:



CVS: S1 S2

Extremities & Spine: - No

CNS: Coronary Artery Disease

ENT: - No

Skin: - No

Vision:

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

Name: Vivek Namdeo patil | Age: 35y | Date of Health check-up: 10/02/24

Findings and Recommendation:

Findings:-

- Cholesterol ↑↑
- UA - 7.1.

Recommendation:-

- Diet / Exercise
- T. Rosuvastatin 10 mg → 1 tablet
- T. Folic acid 50 mg → 1 tablet

Signature:

Consultant -



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

OPHTHALMIC EVALUATION

UHID No.: _____

Date : 10/2/24

Name : Mr. V. V. V. Age : 28 Gender : Male/Female

Without Correction :

Distance: Right Eye 6/6 NB Left Eye 6/6 NB

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance										
Near										

Colour Vision : N 4000 (BC)

Anterior Segment Examination : _____

Pupils : N 4000 (BC)

Fundus : _____

Intraocular Pressure : 12 mm Hg (BC)

Diagnosis : _____

Advice : _____

Re-Check on 1 year (This Prescription needs verification every year)

Dr. [Signature]
(Consultant Ophthalmologist)

DR. RUCHIRA SHARMA
M. S. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON
REG. No.: 3262 / 09 / 02

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

DENTAL CHECKUP

Name: Vivek Palit	MR NO:
Age/Gender : 35 IM	Date: 18/2/24

Medical history: Diabetes Hypertension _____

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: _____

- Scaling & polishing - 900
 - RCT C # - 4k.
 - Filling C # - 1200.

DR. AQSA SHAIKH
 B. D. S
 Reg. No: A 42611



• ANDHERI • COLABA • NASHIK • VASHI


Name : Mr. Vivek Namdeo Patil Gender : Male Age : 35 Years
 UHID : FVAH 10563. Bill No : Lab No : V-1301-23
 Ref. by : SELF Sample Col.Dt : 10/02/2024 08:58
 Barcode No : 7979 Reported On : 10/02/2024 20:15

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)		
Haemoglobin(Colorimetric method)	13.4 g/dl	13 - 18
RBC Count (Impedance)	6.73 Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	43 %	35 - 55
MCV:(Calculated)	63.9 fl	78 - 98
MCH:(Calculated)	20 pg	26 - 34
MCHC:(Calculated)	31.2 gm/dl	30 - 36
RDW-CV:	17.8 %	11.5 - 16.5
Total Leucocyte count(Impedance)	7830 /cumm.	4000 - 10500
Neutrophils:	54 %	40 - 75
Lymphocytes:	34 %	20 - 40
Eosinophils:	09 %	0 - 6
Monocytes:	03 %	2 - 10
Basophils:	00 %	0 - 2
Platelets Count(Impedance method)	2.66 Lakhs/c.mm	1.5 - 4.5
MPV	9.1 fl	6.0 - 11.0
ESR(Westergren Method)	05 mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)		
RBCs:	Hypochromasia(+),Microcytosis(+),Anisocytosis(+)	
WBCs:	Eosinophilia	
Platelets	Adequate	
Note:	Test Run on 5 part cell counter. Manual diff performed.	

Neha More
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Ms Kaveri Gaonkar
Verified By

End of Report
Results are to be correlated clinically

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

Name : Mr. Vivek Namdeo Patil Gender : Male Age : 35 Years
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TEST

RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group:

:AB:

Rh Type:

Positive

Method :

Matrix gel card method (forward and reverse)

Sheetal Nakate
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Chief Pathologist

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	91	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	115	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.5 %
 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 : 111.15 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 then the routine chromatographic methods & also for the daibetic pts.having HEMOGLBINOPATHIES OR UREMIA as Hb varaints 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 daibetics .
- * 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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 Dr. M. D. Patwardhan
 Page 4 of 9
 M.D(Path)
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Name : Mr. Vivek Namdeo Patil Gender : Male Age : 35 Years
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
LIPID PROFILE - Serum			
S. Cholesterol(Oxidase)	228	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	157	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	31.4	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	<u>34.5</u>	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	<u>162.1</u>	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	<u>6.6</u>		3.5 - 5
Ratio of LDL/HDL	<u>4.7</u>		2.5 - 3.5

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.66	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.66	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.0	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.55		0.9 - 2
S.Total Bilirubin (DPD):	0.62	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.22	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.4	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	23	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	31	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	70	U/L	40 - 129
S.GGT(IFCC Kinetic):	36	U/L	11 - 50

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Dr. Milind Patwardhan
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Chief Pathologist

Name : Mr. Vivek Namdeo Patil

Gender : Male Age : 35 Years

UHID : FVAH 10563.

Bill No : Lab No : V-1301-23

Ref. by : SELF

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Barcode No : 7979

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	23.3 mg/dl	10.0 - 45.0
BUN (Calculated)	10.87 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	1.06 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	10.25	9:1 - 23:1
S.Uric Acid(Uricase Method)	<u>7.1</u> mg/dl	3.4 - 7.0

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

Thyroid (T3,T4,TSH)- Serum

Total T3 (Tri-iodo Thyronine) (ECLIA)	1.67	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	115.9	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	3.26	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), Nerphrosis 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
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY	10	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent

CHEMICAL EXAMINATION(Strip Method)

REACTION(PH)	8.0		4.6 - 8.0
SPECIFIC GRAVITY	1.020		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	Absent		Absent
Nitrites	Absent		Absent

MICROSCOPIC EXAMINATION

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

Anushka Chavan
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Ms Kaveri Gaonkar
Verified By



Dr. Milind Patwardhan
M.D(Path)

Page 8 of 8 Chief Pathologist

End of Report
Results are to be correlated clinically

QRS : 82 ms
QT/QTcBaz : 358/389 ms
PR : 142 ms
P : 126 ms
RR/PP : 842/845 ms
P/QRS/T : 47/-9/15 degrees

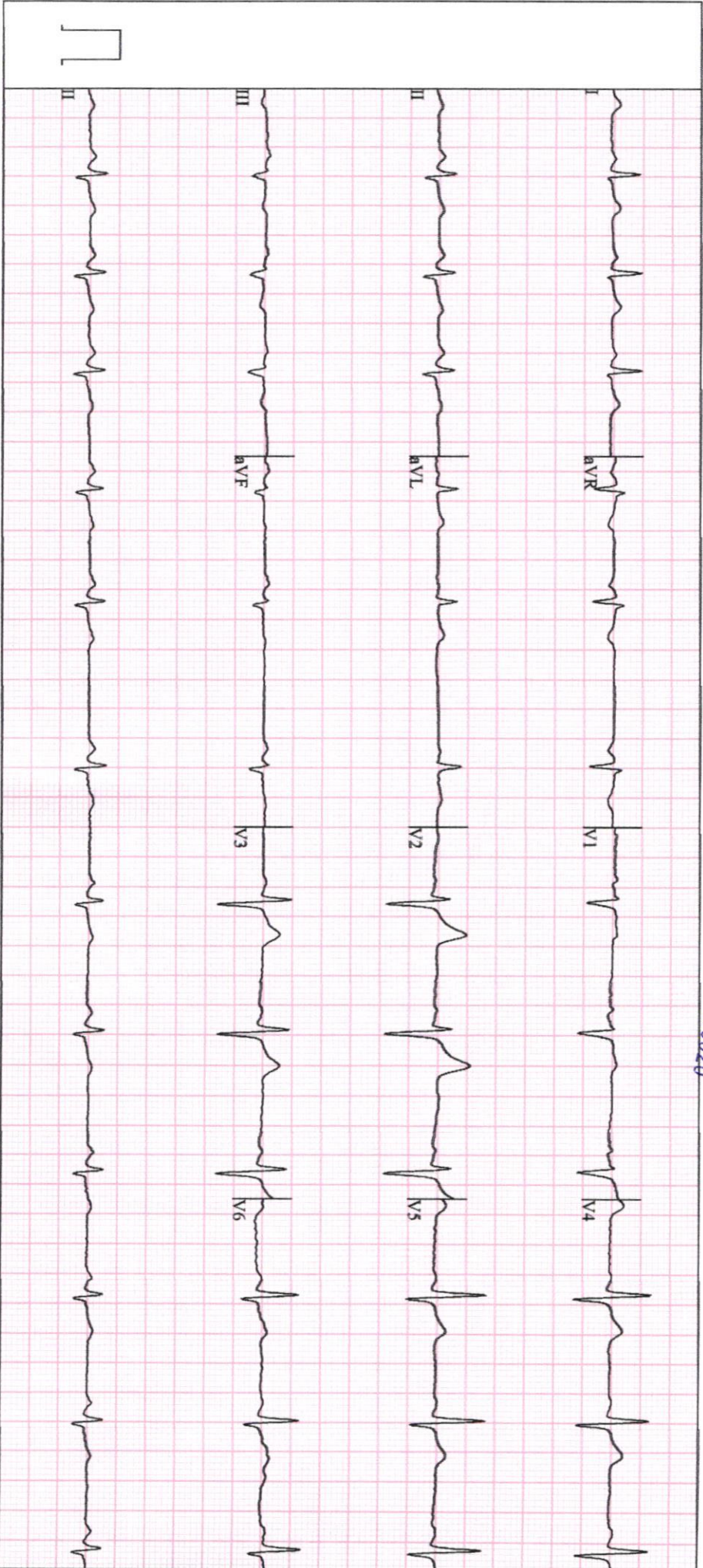
Sinus rhythm with marked sinus arrhythmia
Otherwise normal ECG

Sinus Arrhythmia

DR. ANIRBAN DASGUPTA

M.B., B.S., D.N.B. Medicine
Diploma Cardiology

MMC-2005/02/0920



PATIENT'S NAME	VIVEK NAMDEO PATIL	AGE :- 35Y/M
UHID	10563	DATE :- 10-02-24

2D Echo and Colour Doppler Report

All cardiac chambers are normal in dimension

No obvious resting regional wall motion abnormalities (RWMA)

Interatrial and Interventricular septum – Appears Normal

Valves – Structurally normal

Trivial TR

Good biventricular function.

IVC is normal.

Pericardium is normal.

Great vessels - Origin and visualized proximal part are normal.

No coarctation of aorta.

Doppler study

Normal flow across all the valves.

No pulmonary hypertension.

No diastolic dysfunction.

Measurements

Aorta annulus	21 mm
Left Atrium	34 mm
LVID(Systole)	17 mm
LVID(Diastole)	37 mm
IVS(Diastole)	10 mm
PW(Diastole)	08 mm
LV ejection fraction.	55-60%

Conclusion

- Good biventricular function
- No RWMA
- Valves – Structurally normal
- No diastolic dysfunction
- No PAH

Anirban Dasgupta

Performed by: Dr. Anirban Dasgupta
D.N.B. Internal Medicine, Diploma Cardiology (PGDCC-IGNOU).

PATIENT'S NAME	VIVEK N PATIL	AGE :- 35 Y/M
UHID NO	10563	10 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	VIVEK N PATIL	AGE :- 35y/M
UHID NO	10563	10 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 10.8 x 5.1 cm. **LEFT KIDNEY** measures 10.9 x 4.6 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.

Visualized 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.CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg: No. 073826