




भारत सरकार
 Government of India

कविता मीना
 Kavita Meena
 जन्य तिथि/DOB: 10/06/1989
 लिंग/ GENDER: FEMALE

Issue Date: 10/06/2013



9585 4220 3662
 VID : 9188 7654 2341 5002

मेरा आधार, मेरी पहचान

कविता मीना




भारतीय विशिष्टता प्राधिकरण
 Unique Identification Authority of India

पता:
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 राजस्थान - 302039

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 C/O: Rajendra Meena, 364 N, Jamsh colony,
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DR. PIYUSH GOYAL
 MBBS, DMRD (Radiologist)
 RMC No:-037041



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
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General Physical Examination

Date of Examination: 13/01/24

Name: KAVITA MEENA Age: 34 yrs DOB: 10/08/1989 Sex: Female

Referred By: BANK OF BARODA

Photo ID: BARODHA CARD ID #: 9669

Ht: 157 (cm)

Wt: 66 (Kg)

Chest (Expiration): 99 (cm)

Abdomen Circumference: 87 (cm)

Blood Pressure: 100/80 mm Hg PR: 89/min RR: 18/min Temp: Afebrile

BMI 26.8

Eye Examination: R IE - GIG, NIG, NOB
L IE - GIG, NIG, NOB

Other: No

On examination he/she appears physically and mentally fit: Yes/No

Signature Of Examinee: Kavita Meena Name of Examinee: KAVITA MEENA

Signature Medical Examiner: Dr. PIYUSH GOYAL Name Medical Examiner: DR. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No.-037041



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NAME :- Mrs. KAVITA MEENA	Patient ID :-12234380	Date :- 13/01/2024	10:26:01
Age :- 34 Yrs 5 Mon 5 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 13/01/2024 17:23:52

HAEMOGARAM

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 FEMAL			
HAEMOGLOBIN (Hb)	12.4	g/dL	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	6.20	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	52.0	%	40.0 - 80.0
LYMPHOCYTE	40.0	%	20.0 - 40.0
EOSINOPHIL	3.0	%	1.0 - 6.0
MONOCYTE	5.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	3.63 L	x10 ⁶ /uL	3.80 - 4.80
HEMATOCRIT (HCT)	38.00	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	105.0 H	fL	83.0 - 101.0
MEAN CORP HB (MCH)	34.0 H	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	32.5	g/dL	31.5 - 34.5
PLATELET COUNT	311	x10 ³ /uL	150 - 410
RDW-CV	14.7 H	%	11.6 - 14.0



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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)

Method - Westergren

16

mm in 1st hr

00 - 20

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases. ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein. ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as



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(CBC): Methodology: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance, and MCH,MCV,MCHC,MENTZER INDEX are calculated. InstrumentName: Sysmex 6 part fully automatic analyzer XN-L,Japan





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Sex -> Female	Lab/Hosp :-		
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BIOCHEMISTRY

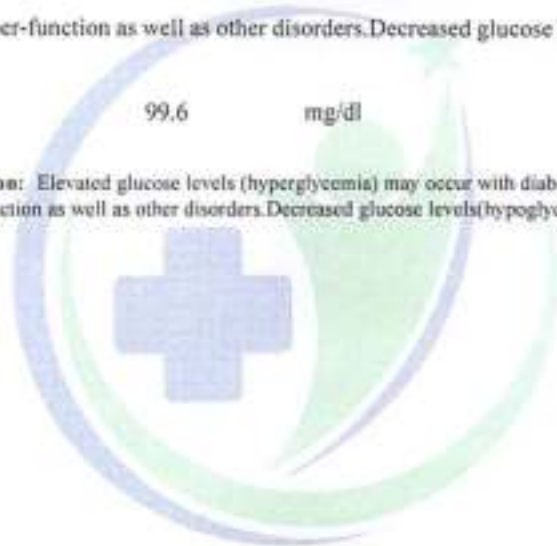
Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	84.7	mg/dl	70.0 - 115.0
Impaired glucose tolerance (IGT)	111 - 125 mg/dL		
Diabetes Mellitus (DM)	> 126 mg/dL		

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases.

BLLOOD SUGAR PP (Plasma)
Method:- GOD PAP

99.6 mg/dl 70.0 - 140.0

Instrument Name: HORIBA Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases.



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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
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GLYCOSYLATED HEMOGLOBIN (HbA1C)

Method - CAPILLARY with EDTA

5.1 %

Non-diabetic: < 5.7
Pre-diabetics: 5.7-6.4
Diabetics: = 6.5 or higher
ADA Target: 7.0
Action suggested: > 6.5

MEAN PLASMA GLUCOSE

Method - Calculated Parameter

101 mg/dL

68 - 125

INTERPRETATION

AS PER AMERICAN DIABETES ASSOCIATION (ADA)

Reference Group HbA1c in %

Non diabetic adults >=18 years < 5.7

At risk (Prediabetes) 5.7 - 6.4

Diagnosing Diabetes >= 6.5

CLINICAL NOTES

In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycaemia. The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx. - 8-9 weeks) and therefore provides much more reliable information for glycaemia 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. Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al.]

1. Erythropoiesis

- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.

3. Glycation

- Increased HbA1c: alcoholism, chronic renal failure, decreased intracellular pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH.

4. Erythrocyte destruction

- Increased HbA1c: increased erythrocyte life span: Splenectomy
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

5. Others

- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use, chronic renal failure
- Decreased HbA1c: hyperglycemia, reticulocytosis, chronic liver disease, aspirin, vitamin C and E, splenomegaly, rheumatoid arthritis or drugs

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HAEMATOLOGY

BLOOD GROUP ABO

Method - Hemagglutination reaction

"B" POSITIVE



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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Method - CHOD-PAP methodology	152.00	mg/dl	Desirable <200 Borderline 200-239 High > 240
InstrumentName MISPA PLUS Interpretation: Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.			
TRIGLYCERIDES Method - GPO-PAP	142.00	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
InstrumentName Randox Rx Imola Interpretation : Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.			
DIRECT HDL CHOLESTEROL Method - Direct clearance Method	46.20	mg/dl	MALE- 30-70 FEMALE - 30-85
Instrument Name Rx Daytona plus Interpretation: An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.			
LDL CHOLESTEROL Method - Calculated Method	82.13	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Method - Calculated	28.40	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method - Calculated	3.29		0.00 - 4.90
L.DL / HDL CHOLESTEROL RATIO Method - Calculated	1.78		0.00 - 3.50
TOTAL LIPID Method - CALCULATED	504.48	mg/dl	400.00 - 1000.00

1. Measurements in the same patient can show physiological & analytical variations. These serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol

2. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is

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BIOCHEMISTRY

recommended

➤ Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues



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BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL)

Method - DMSO/Diam

0.72 mg/dL

Infants : 0.2-8.0 mg/dL
Adult - Up to - 1.2 mg/dL

SERUM BILIRUBIN (DIRECT)

Method - DMSO/Diam

0.23 mg/dL

Up to 0.40 mg/dL

SERUM BILIRUBIN (INDIRECT)

Method - Calculated

0.49 mg/dL

0.30-0.70

SGOT

Method - IFCC

36.2 U/L

0.0 - 40.0

SGPT

Method - IFCC

32.8 U/L

0.0 - 35.0

SERUM ALKALINE PHOSPHATASE

Method - DGKC - SCT

119.00 U/L

64.00 - 306.00

InstrumentName: MISPA PLUS Interpretation: Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobiliary disease and in bone disease associated with increased osteoblastic activity. Alkaline phosphatase is also used in the diagnosis of parathyroid and intestinal disease.

SERUM GAMMA GT

Method - Spectrophotometry

Instrument Name: Random Rn Introl

Interpretation: Elevations in GGT levels are more specific and more pronounced than those with other liver enzymes in cases of obstructive jaundice and

retrograde neoplasms. It may reach 5 to 30 times normal levels in intra- or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis.

Interpretation: Elevations in GGT levels are more specific and more pronounced than those with other liver enzymes in cases of obstructive jaundice and retrograde neoplasms. It may reach 5 to 30 times normal levels in intra- or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis.

23.80 U/L

5.00 - 32.00

SERUM TOTAL PROTEIN

Method - Direct Biuret Reagent

6.89 g/dl

6.00 - 8.40

SERUM ALBUMIN

Method - Bromocresol Green

3.90 g/dl

3.50 - 5.50

SERUM GLOBULIN

Method - CALCULATION

2.99 gm/dl

2.20 - 3.50

A/G RATIO

1.30

1.30 - 2.50

Interpretation: Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A, B, C, parasitosis, toxicity and several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA 25.60 mg/dl 10.00 - 50.00
Method:- Urease/GLDH

InstrumentName: HORIBA CA 60 Interpretation : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE 1.24 mg/dl Males : 0.6-1.50 mg/dl
Females : 0.6 -1.40 mg/dl
Method:- Jaffe's Method

Interpretation :

Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID 4.67 mg/dl 2.40 - 7.00

InstrumentName: HORIBA YUMIZEN CA60 Daytona plus Interpretation: Elevated Urate: High purine diet, Alcohol, Renal insufficiency, Drugs, Polycythaemia vera, Malignancies, Hypothyroidism, Rare enzyme defects, Down's syndrome, Metabolic syndrome, Pregnancy, Gout.

SODIUM 137.3 mmol/L 135.0 - 150.0
Method:- ISE

POTASSIUM 4.03 mmol/L 3.50 - 5.50
Method:- ISE

CHLORIDE 98.3 mmol/L 94.0 - 110.0
Method:- ISE

SERUM CALCIUM 9.67 mg/dl 8.80 - 10.20
Method:- Arsenazo III Method

InstrumentName: MISPA PLUS Interpretation: Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia. Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN 6.89 g/dl 6.00 - 8.40
Method:- Direct Bismarck Reagent

SERUM ALBUMIN 3.90 g/dl 3.50 - 5.50
Method:- Bromocresol Green

SERUM GLOBULIN 2.99 gm/dl 2.20 - 3.50
Method:- CALCULATION

A/G RATIO 1.30 1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of disorders of liver, kidney and

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BIOCHEMISTRY

bone marrow as well as other metabolic or nutritional disorders.

INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR. In urine, it can remove the need for 24-hour collections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection. Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the blood increases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare, they almost always reflect low muscle mass.

Apart from renal failure Blood Urea can increase in dehydration and GI bleed.



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TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
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THYROID-TRIIODOTHYRONINE T3

Method - ECLIA

1.13

ng/mL

0.70 - 2.04

0.70-2.04

NOTE: In pregnancy total T3,T4 increase to 1.5 times the normal range.

Reference Range (T3): Premature infants 26-30 Weeks ,3-4 days

Full-Term infants 1-3 days

1 Week

1- 11 Months

Prepubertal Children

0.24 - 1.32 ng/ml

0.89 - 4.05 ng/ml

0.91 - 3.00 ng/ml

0.85 - 2.50 ng/ml

1.19 - 2.18 ng/ml

Reference Ranges (T4): Premature infants 26-30 weeks ,3-4 days

Full -Term Infants 1-3 days

1 weeks 6.00 - 15.9 ug/dl 1-11 Months

Prepubertal children 12 months-2yrs

Prepubertal children 3-9 yrs

2.60 - 14.0 ug/dl

8.20 - 19.9 ug/dl

6.10 - 14.9 ug/dl

6.80 - 13.5 ug/dl

5.50 - 12.8 ug/dl

Reference Ranges (TSH): Premature Infants 26-32 weeks ,3-4 Days

Full Term Infants 4 Days

0.80 - 6.9 uIU/ml

1.36 - 16 uIU/ml

1 - 11 Months:0.80 - 7.70 | Prepubertal children:0.60 - 5.50. Primary malfunction of the thyroid gland may result in hyper or low release of T3 or T4. In addition as TSH directly affect thyroid function malfunction of the pituitary or the hypothalamus influences the thyroid gland activity. Disease in any portion of the thyroid pituitary hypothalamus system may influence the level of T3 and T4 in the blood in Primary hypo thyroidism TSH levels

THYROID THYRONINE (T4) Method - ECLIA

Method - ECLIA

5.10 - 14.10

5.1-14.1

NOTE:-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hypothyroidism is accompanied by (serum T3 & T4 values along with ↑ TSH level 2.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis 5.HighTSH,low FT4 and Thyroid microsomal antibody normal seen in patients with iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism

7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & serum TSH levels 8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9.Normal or ↑ T3 & ↑ T4 along with ↑ TSH indicate mild / Subclinical Hypothyroidism 10.Normal T3 & ↑ T4 along with ↑ TSH is seen in Hypothyroidism 12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypoth

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL, 2nd Trimester - 0.20-3.00 uIU/mL, 3rd Trimester - 0.30-3.00 uIU/mL. The production, circulation, and degradation of thyroid hormones are altered throughout the stages of pregnancy.

REMARK- Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radioactive scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved TSH is an important marker for the diagnosis of thyroid dysfunction. Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age, and it is debatable whether this is due to a real change with age or an increasing proportion of uncorrected thyroid disease in the older

TSH

Method - ECLIA

2.350

uIU/mL

Tanu

DR.TANU RUNGTA

MD (Pathology)

RMC No. 17226

Technologist
VIKARANTSI
Page No: 14 of 15



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

📍 B-14, Vidhyadhar Enclave-II, Near Axix Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
📞 +91 141 4824885 📧 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAVITA MEENA

Age :- 34 Yrs 5 Mon 5 Days

Sex :- Female

Patient ID :-12234380

Date :- 13/01/2024

10:26:01

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 13/01/2024 17:23:52

IMMUNOASSAY

4th Generation Assay,Reference ranges vary between laboratories

PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

1st Trimester : 0.10-2.50 uIU/mL

2nd Trimester : 0.20-3.00 uIU/mL

3rd Trimester : 0.30-3.00 uIU/mL

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result.

INTERPRETATION

- 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
- 2.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
- 3.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
- 4.Normal or ↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
- 5.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism

COMMENTS: Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test.

Disclaimer-TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly

Reference ranges are from Teltz fundamental of clinical chemistry 8th ed (2018)

Test performed by Instrument : Beckman coulter Dxi 800

Note The result obtained relate only to the sample given/ received & tested. A single test result is not always indicative of a disease. It has to be correlated with clinical data for interpretation.

*** End of Report ***

Technologist
VIKARANTJI
Page No. 15 of 15

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226



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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAVITA MEENA	Patient ID :-12234380	Date :- 13/01/2024	10:26:01
Age :- 34 Yrs 5 Mon 5 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDI/WHEEL	

Final Authentication : 13/01/2024 17:23:52

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION(PH)	6.0		5.0 - 7.5
SPECIFIC GRAVITY	1.010		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
MICROSCOPY EXAMINATION			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT



Technologist
VIKARAN LSI
Page No: 12 of 15

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226



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MRS. KAVITA MEENA	Age : 34 Y/F
Registration Date: 13/01/2024	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is mildly enlarged in size (163 mm) with bright parenchymal echotexture. No focal space occupying lesion is seen within liver parenchyma. Intrahepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is well distended. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape. Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

Right kidney is measuring approx. 106 mm.

Left kidney is measuring approx. 106 mm.

Urinary bladder does not show any calculus or mass lesion.

Uterus is anteverted and normal in size (measuring approx. 69 x 37 mm).

Myometrium shows normal echo -pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 4.0 mm.

Both ovaries are visualized and are normal. No adnexal mass lesion is seen.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.

No significant free fluid is seen in pouch of Douglas.

IMPRESSION:

- Mild hepatomegaly with grade I hepatic steatosis.
- No free fluid or lymphadenopathy.

Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437



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NAME:	MRS. KAVITA MEENA	AGE	34 YRS/F
REF.BY	BANK OF BARODA	DATE	13/01/2024

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

IMPRESSION: No significant abnormality is detected

Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437

Temis (P) Ltd

#P3 HEALTH SOLUTIONS LLP B-14, Vidhyadhar nahar , Jaipur
128541925460539/Mrs Kavita Meena 34Yrs-5Months/Female
Ref: BANK OF BARODA Test Date: 13-Jan-2024(2:54:13 PM) Notch: 50Hz 0.0544 - 35Hz 10mm/mV 25mm/Sec

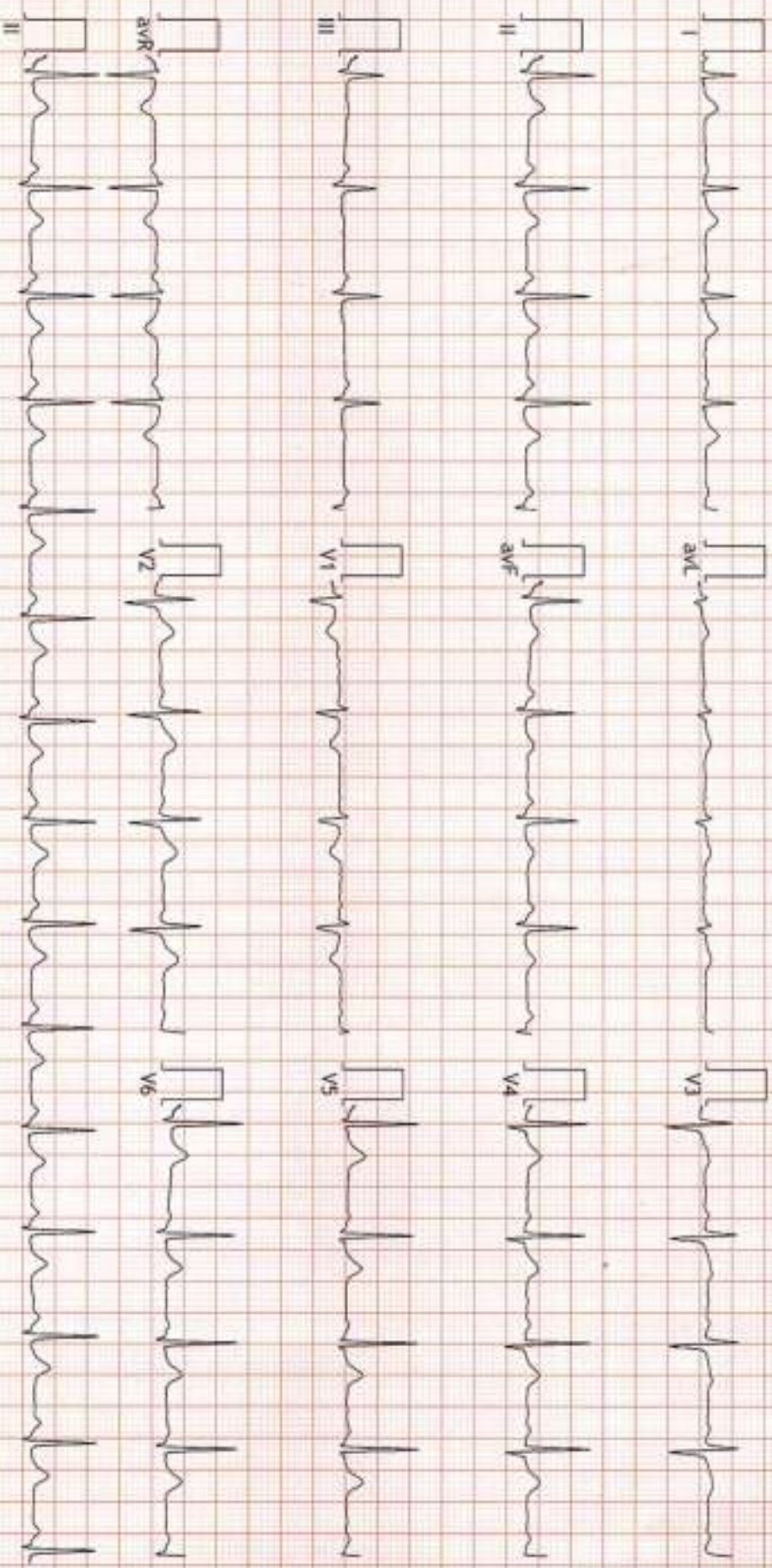
Kgs/31 Cms

BP: ___/___

mmHg

HR: 86 bpm

PR Interval: 124 ms
QRS Duration: 122 ms
QT/QTc: 349/418ms
P-QRS-T Axis: 63° 57° 30° (Deg)



TURVIL

FINDINGS: Normal Sinus Rhythm
Vent Rate : 86 bpm; PR Interval : 124 ms; QRS Duration: 122 ms; QT/QTc Int : 349/418 ms
P-QRS-T axis: 63° 57° 30° (Deg)
Comments :

on 13/01/24

Dr. Naresh Kumar Mohanka
RMC No: 35703
MBBS, DIPP, DATT, DPT, DSC (DRTS)
D.E.M. (RCGP-UK)

B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur
 12234380/MRS KAVITA MEENA
 Date: 13-Jan-2024 02:55:28 PM
 34 Yrs/Female 0 Kg/0 Cms

Ref By : BALKRISHNA BARODA
 Medication : Nil
 Objective :

Protocol : ST/UC
 History : Nil

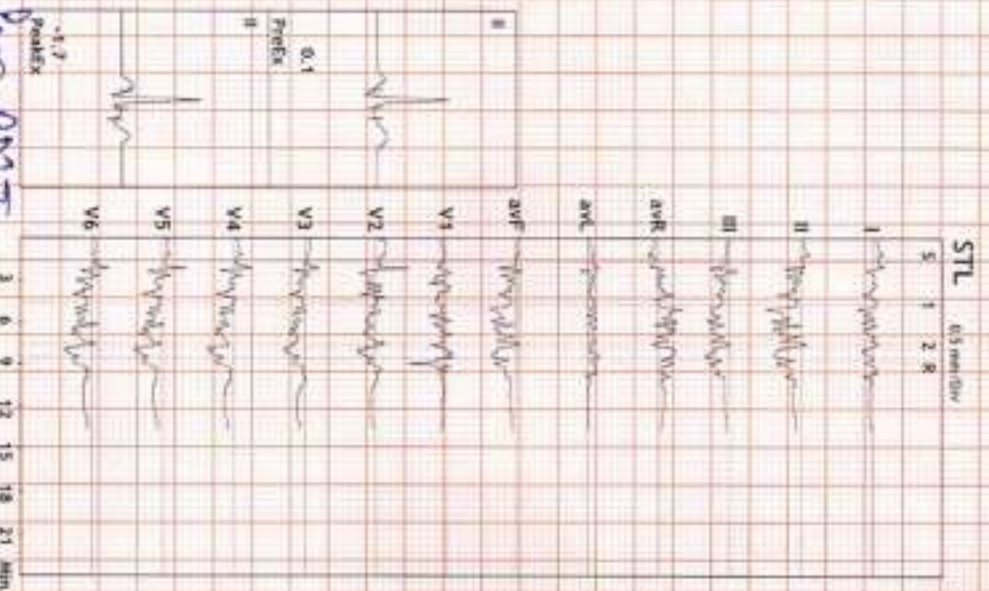
Stage	StageTime	PhaseTime	Speed	Grade	METS	H.R.	B.P.	R.P.P.	PVC	Comments
	(min:sec)	(min:sec)	(mph)	(%)		(bpm)	(mmHg)	(mmHg)		
Supine					1.0	88	130/80	114	-	
Standing					1.0	89	130/80	115	-	
HV					1.0	112	130/80	145	-	
ExStart					1.0	111	130/80	144	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	137	140/80	191	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	150	150/85	225	-	
PeakEx	1:00	6:59	3.4	14.0	8.1	158	150/85	237	-	
Recovery	1:00		0.0	0.0	1.2	125	160/85	200	-	
Recovery	2:00		0.0	0.0	1.0	103	150/85	154	-	
Recovery	3:00		0.0	0.0	1.0	104	140/80	145	-	
Recovery	4:00		0.0	0.0	1.0	104	130/80	135	-	
Recovery	5:00		0.0	0.0	1.0	101	130/80	131	-	

Findings :
 Exercise Time :06:58
 Max HR Attained :158 bpm 85% of Max Predictable HR 186
 Max BP : 160/85(mmHg)
 Max Workload attained :8.1(Fair Effort Tolerance)

Advice/Comments:

on fast start

TMT is negative for PMT



Dr. Nareesh Kumar Mohanka
 RMC No.: 35703
 MBBS, DIP. CARDIO (ESCORTS)
 D. FPM, NAREESH KUMAR MOHANKA



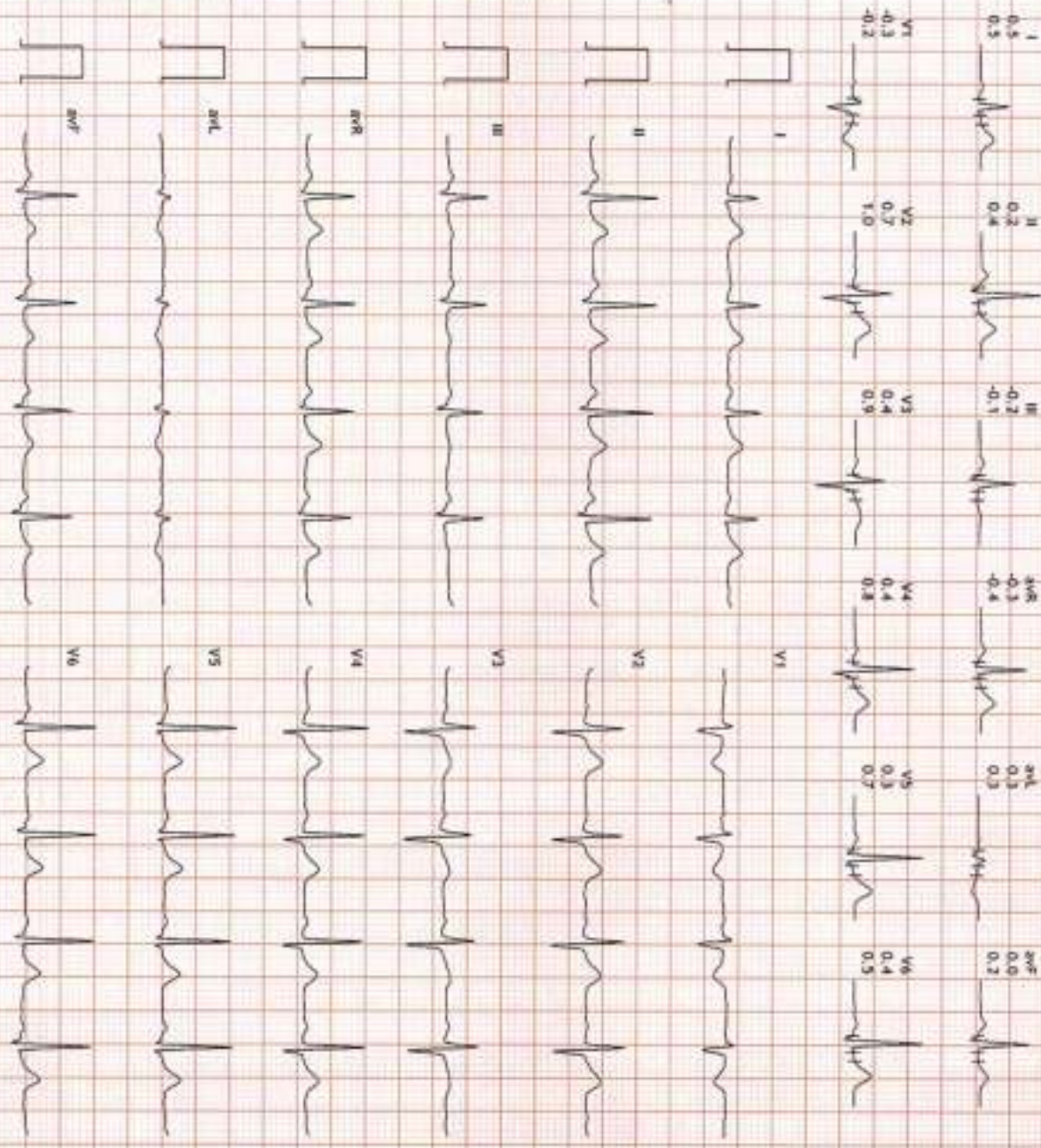
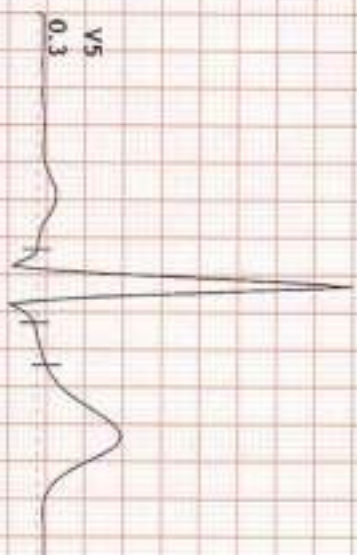
HR: 88 bpm
METTS: 1.0
BP: 130/80

APHR: 47% of 186
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE

EC Time: 00:31
BLC: 0h
Reacr: 0h

Supine
10.0 mm/mV
25 mm/Sec



HR: 89 bpm

MCETS: 1.0

BP: 130/80

MPHR: 47% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

DRUCE

10:05-10:07

Ex Time: 00:42

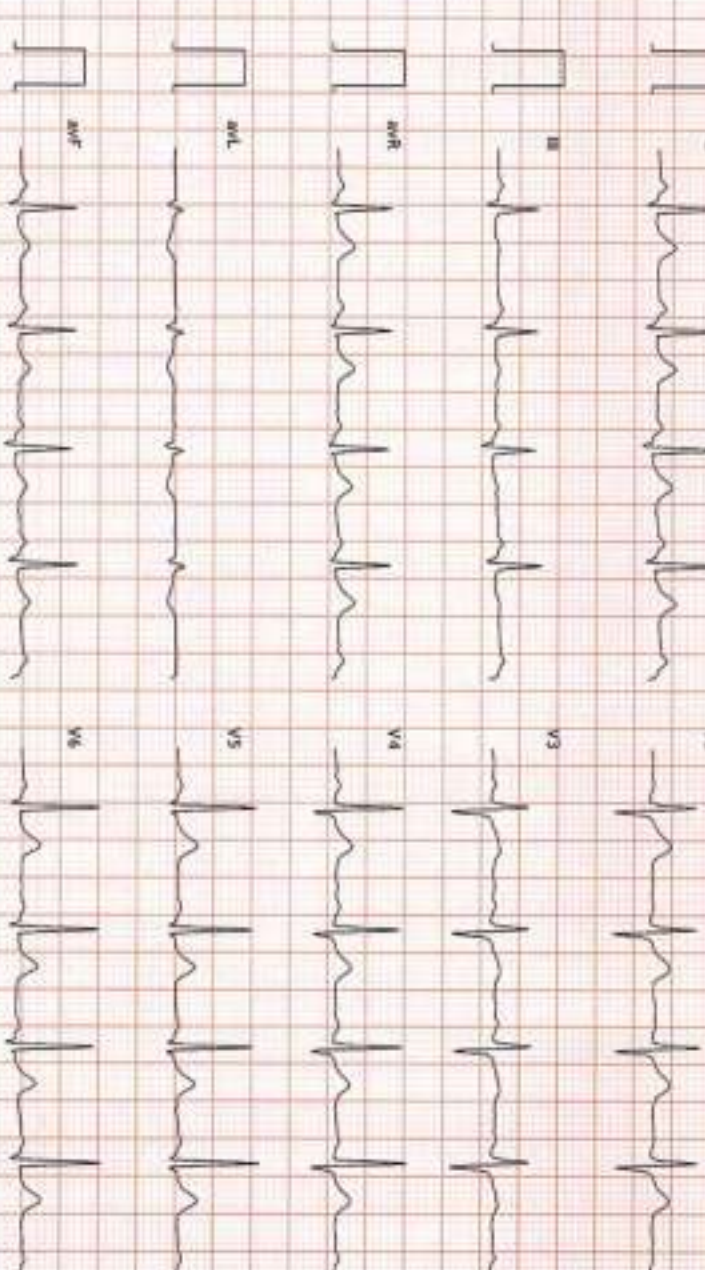
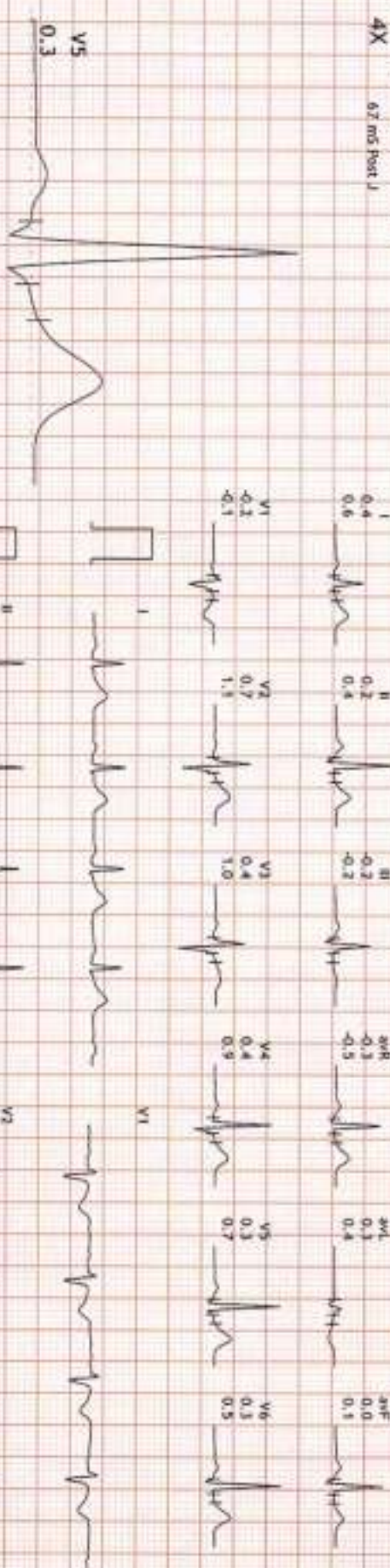
BLC: On

Monitor: On

Standing

10.0 mm/mv

25 mm/Sec



HR: 113 bpm

MEETS: 1.0

BP: 130/80

APHR: 5% of 186

Speed: 0.10 mph

Grade: 0.0%

Raw ECG

BRUCE

10.05-100/1st

Ex Time 01:03

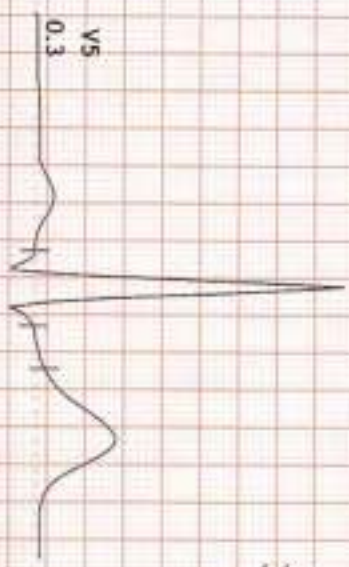
ILC : On

Mount: On

HW

10.0 mm/mV

25 mm/Sec



B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur
12234380/WRS KAVITA MEENA
34 Yrs/Female

HR: 108 bpm
METS: 1.0

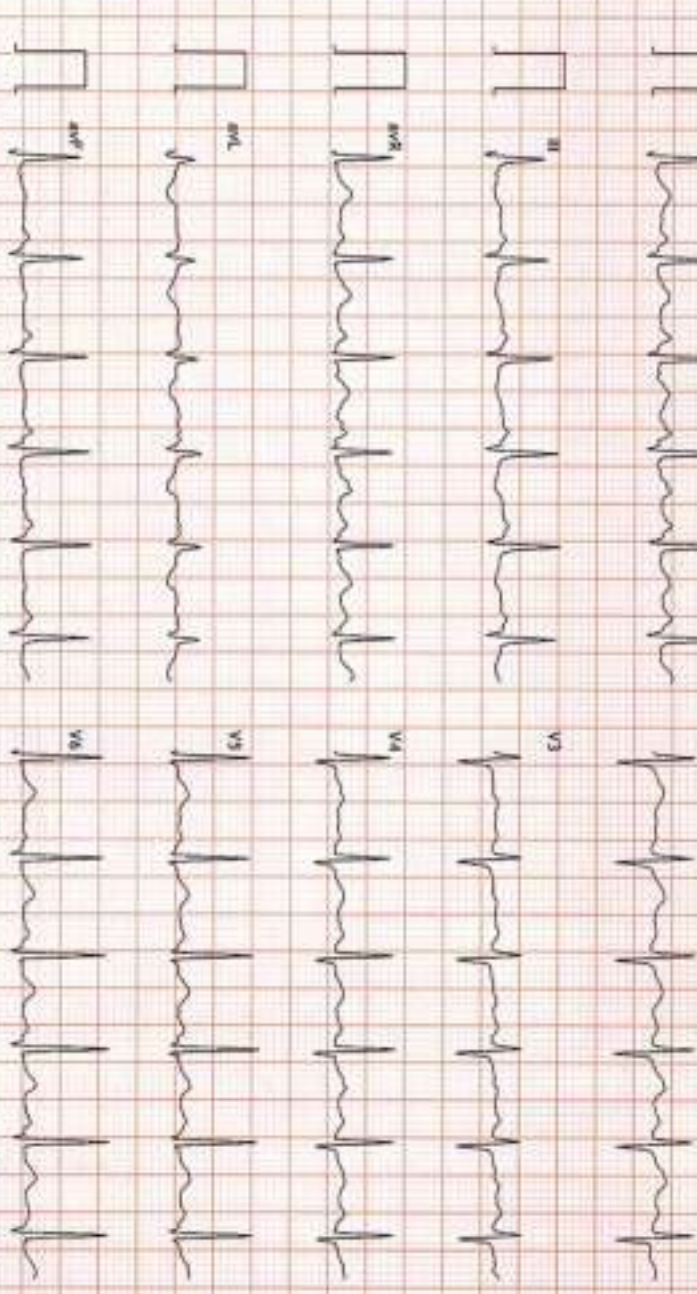
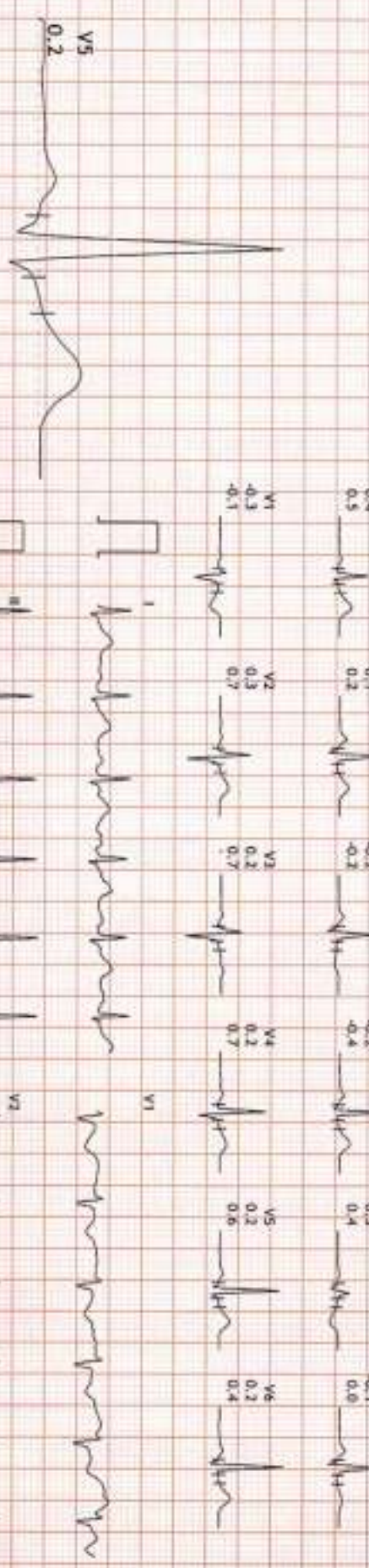
MPHR: 56% of 186
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE

Ex Time 01:35
BLC: On

EXStart
10.0 mm/mV

0.1g/10 Cms
Date: 13-Jan-2024 02:55:28 PM
4X 6.7 ms/Post-J



HR: 139 bpm

BP: 140/80

MPHR: 74% of 186

Speed: 1.7 mph

Raw ECG

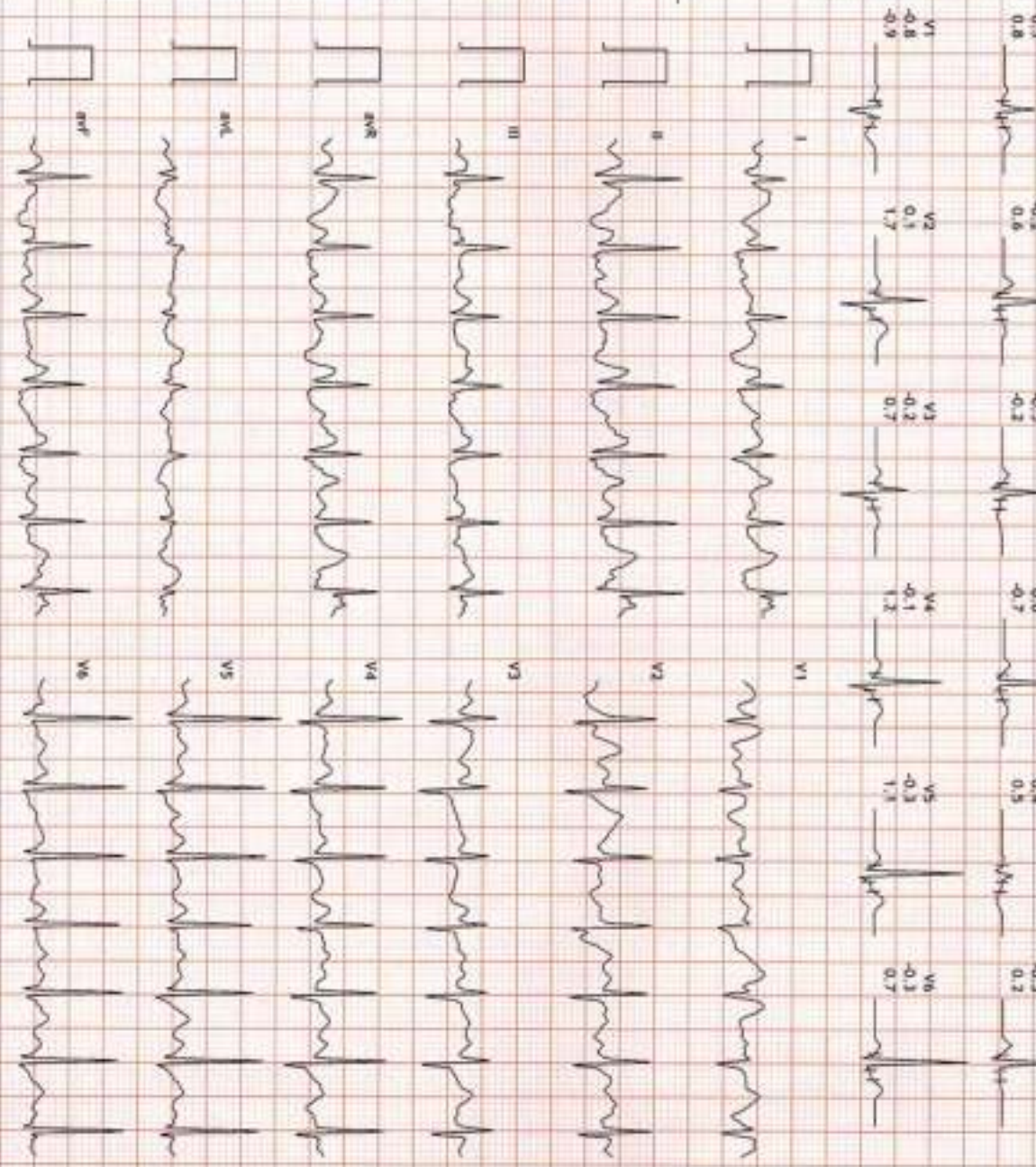
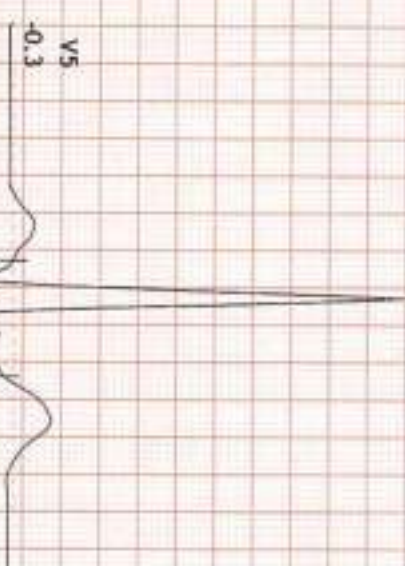
GRUCE

Ex Time 02:59

BLC :On

BRUCE: Stage 1 (3:00)

10.0 mm/mV



HR: 150 bpm

MEETS: 7.1

BP: 150/85

WPR: 80% of 186

Speed: 2.5 mph

Grade: 12.0%

Raw ECG

BRUCE

10.05-100/Hz

Ex Time 05:59

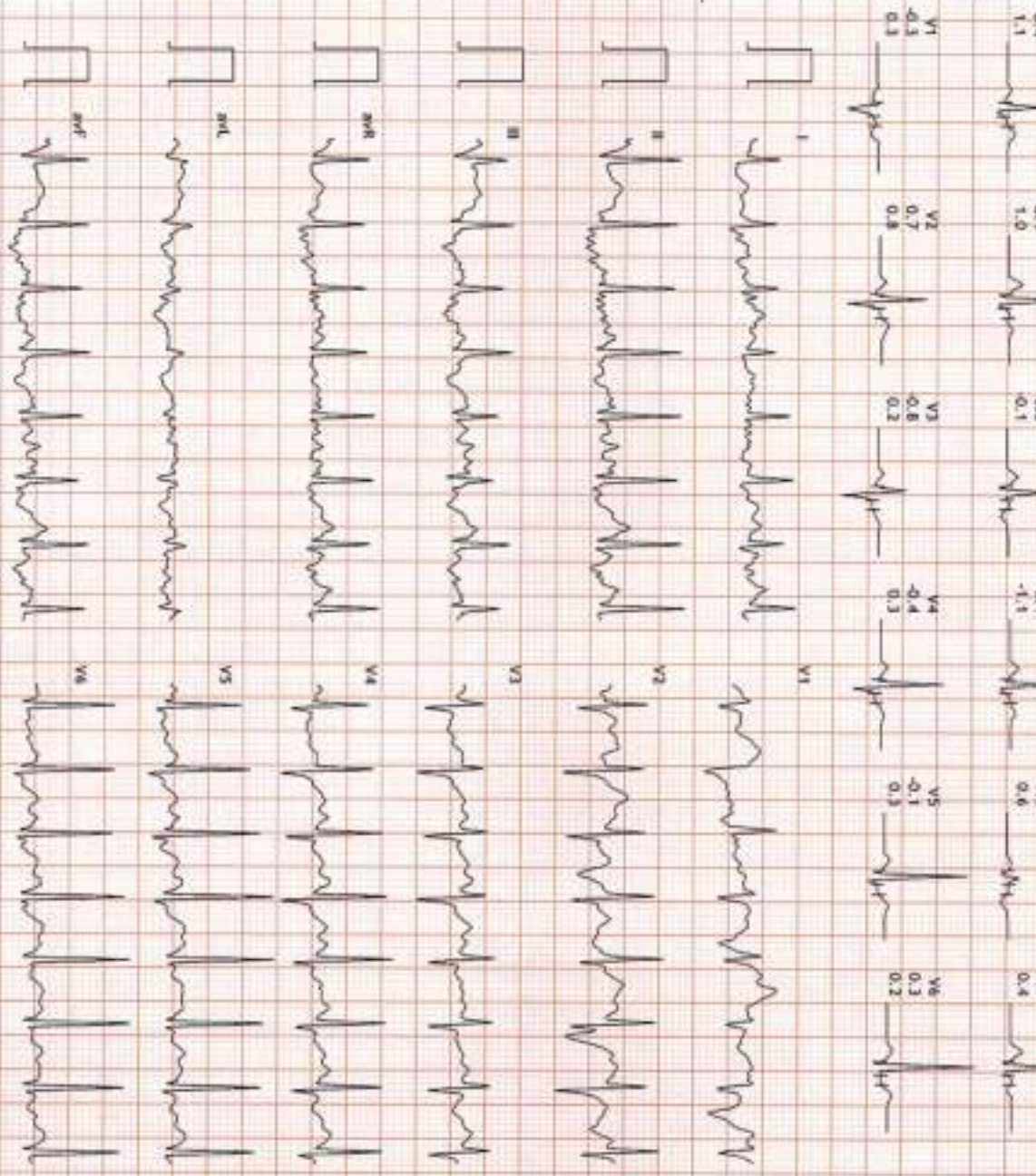
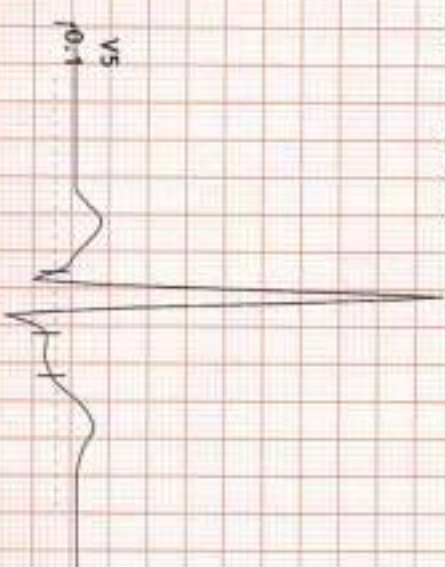
RLC -On

Medch: 30%

BRUCE: Stage 2(3:00)

10.0 mm/mV

25 mm/Sec



HR: 158 bpm

MEFS: 8.1

BP: 150/85

MPHR-B4L of 186

Speed: 3.4 mph

Grade: 14.0%

Raw ECG

BRUCE

10.05-1001Hz

EC Time 06:56

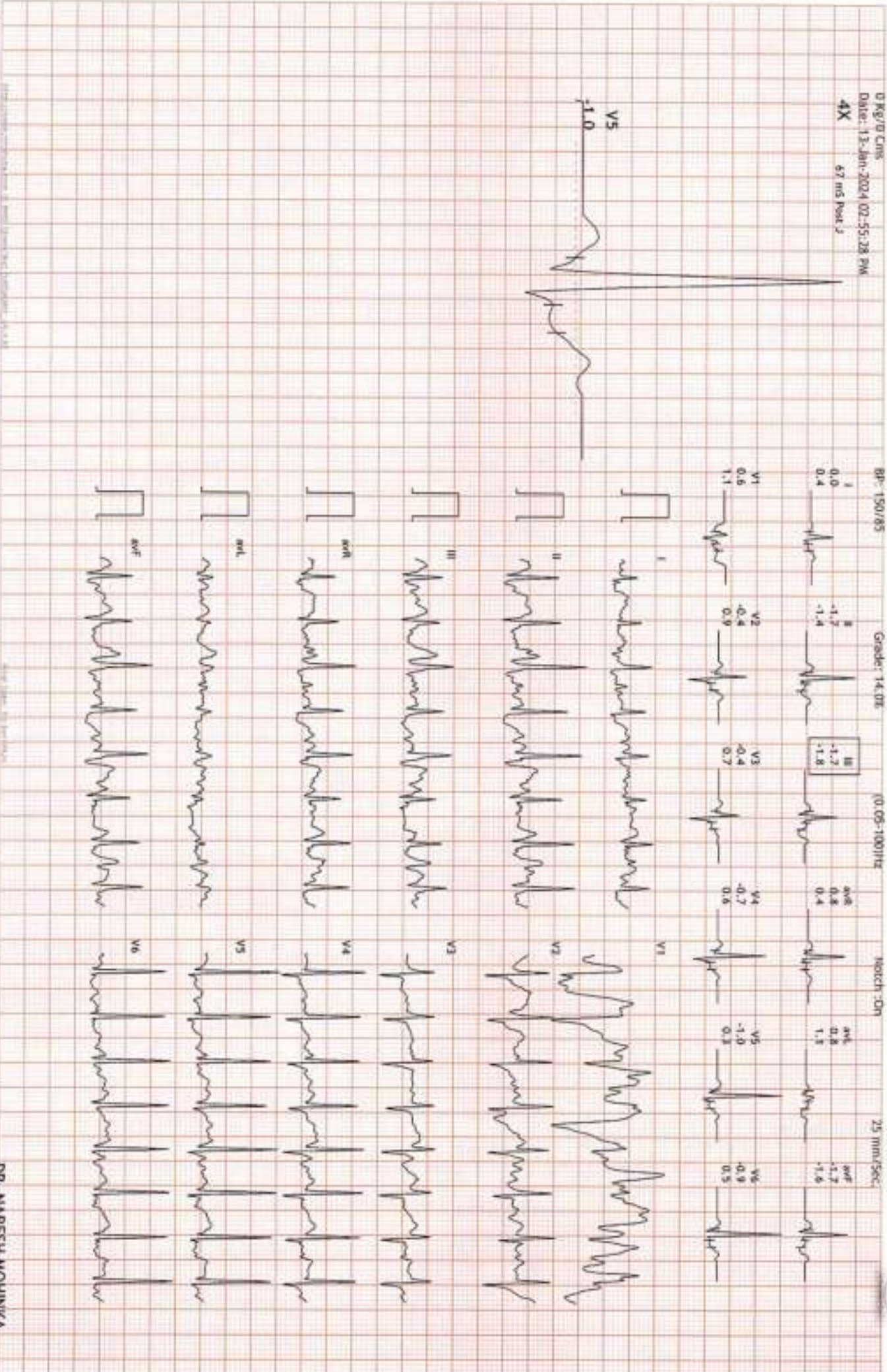
RLC :On

Meach :On

BRUCE:Peakex(0:56)

10.0 mm/mv

25 mm/5sec



HR: 129 bpm

MEETS: 1.3

BP: 160/85

APHR: 69% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

8RUCE

10.05-100 Jt

Ex Time 06:58

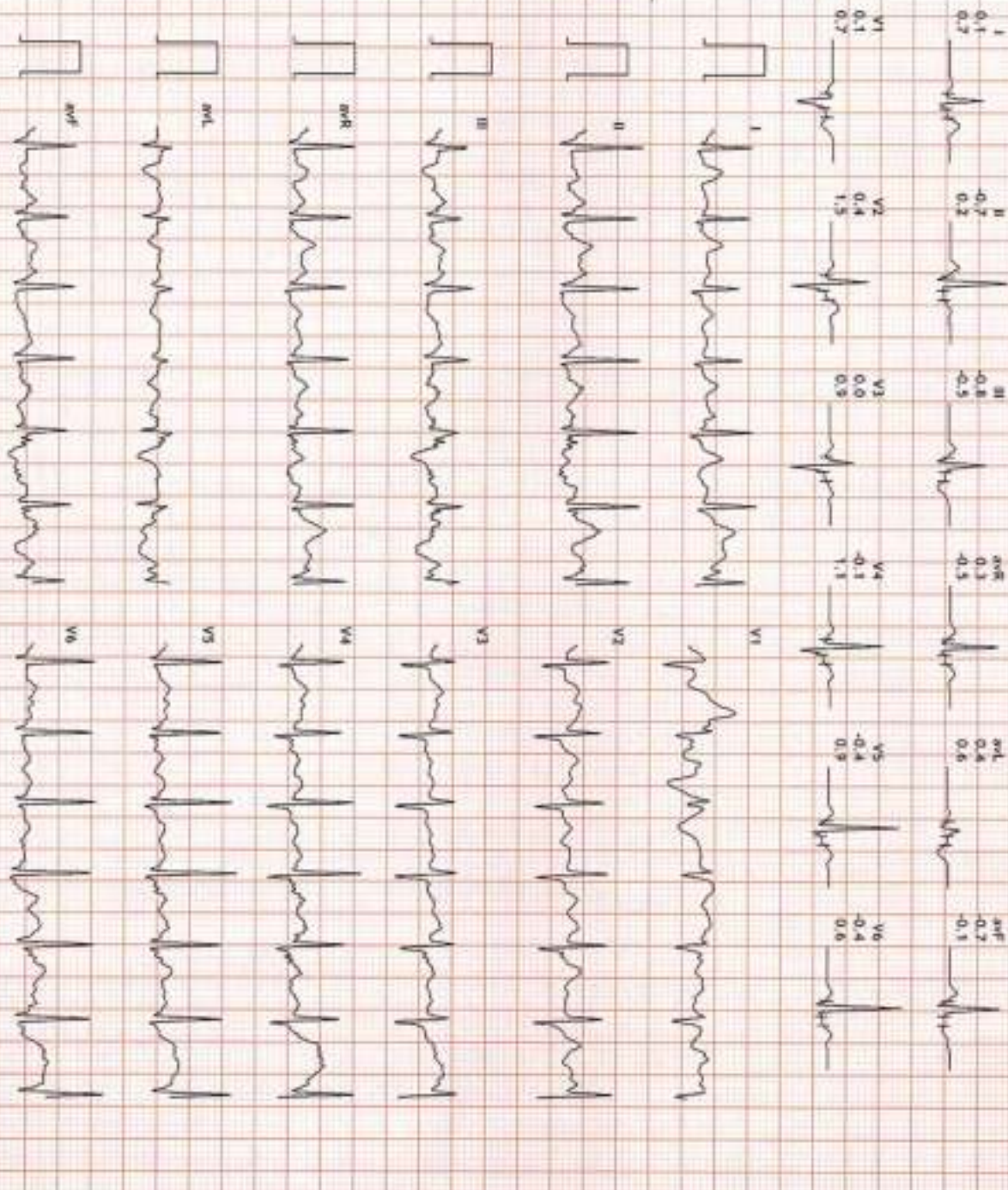
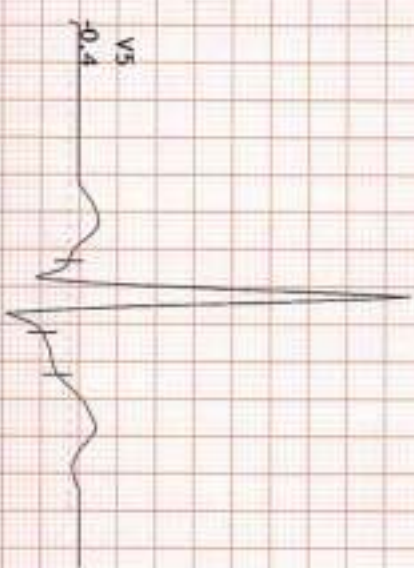
ILC: 0h

March: 0h

Recovery(1:00)

10.0 mm/My

25 mm/Sec



HR: 104 bpm

NETS: 1.0

BP: 140/80

MP-R: 55% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

10.05-100)Hz

Ex Time 06:58

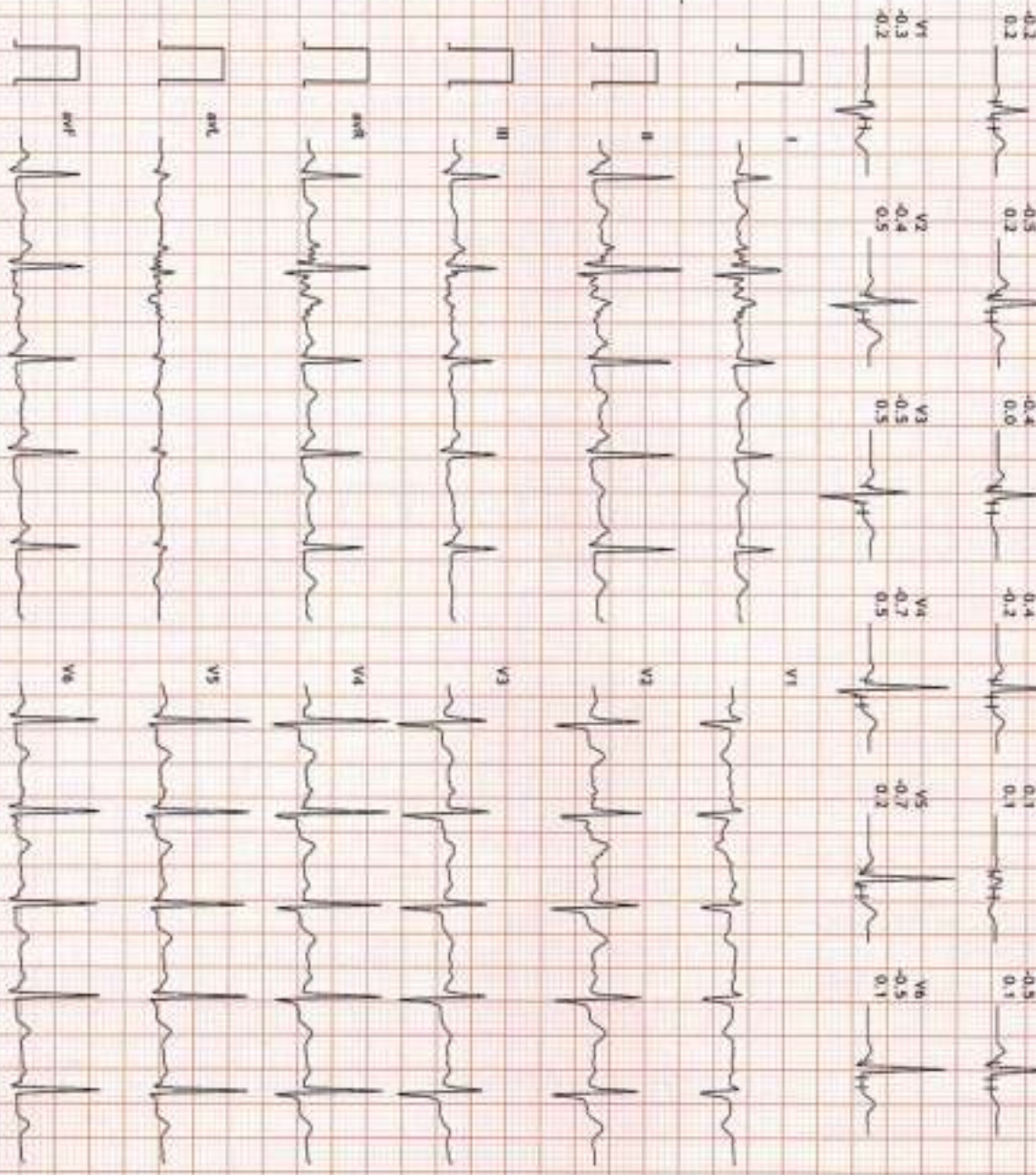
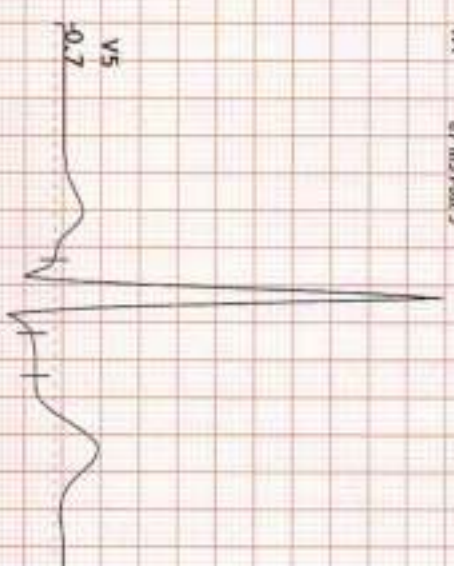
R/C: 0h

Meach: 30s

Recovery(3:00)

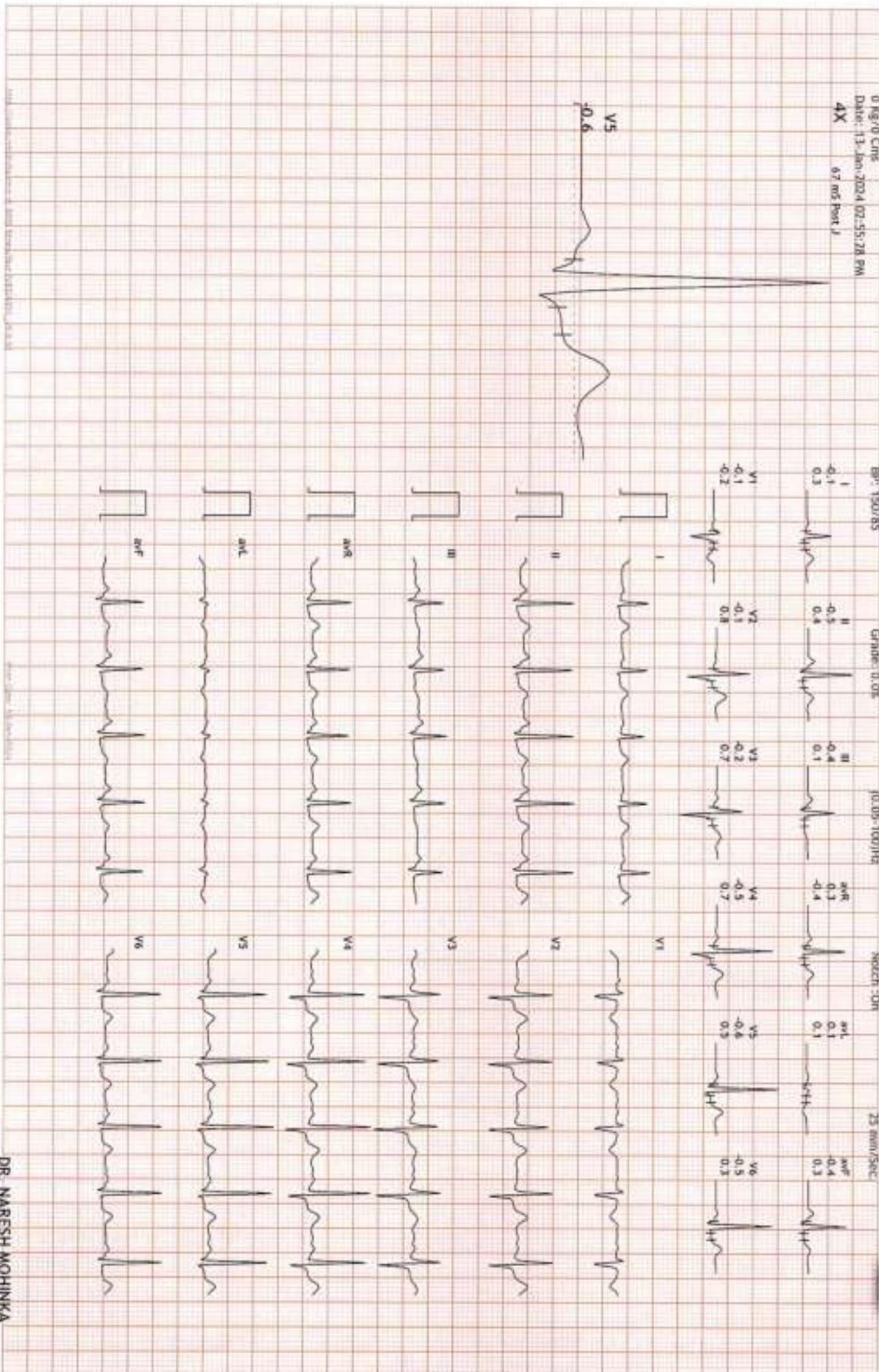
10.0 mm/mV

25 mm/Sec



B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur
12234380/MRS KAVITA MEDNA
34 Yrs/Female
0 Kg/0 Cms
Date: 13-Jan-2024 02:55:28 PM
4X 67 ms Post J

HR: 103 bpm
RR: 190/85
SpO2: 98%
Temp: 36.5°C
Pain: 0/10
BP: 120/80
ECG: 10.05-100/145
Ex Time: 06:58
Recovery: (2:00)
10.0 mm/mV
25 mm/Sec



B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur
12224380/MRS KAVITA MEENA
34 Yrs/Female
0 Kg/0 Cms
Date: 13-Jan-2024 02:55:28 PM
4X 67 ms Beat U

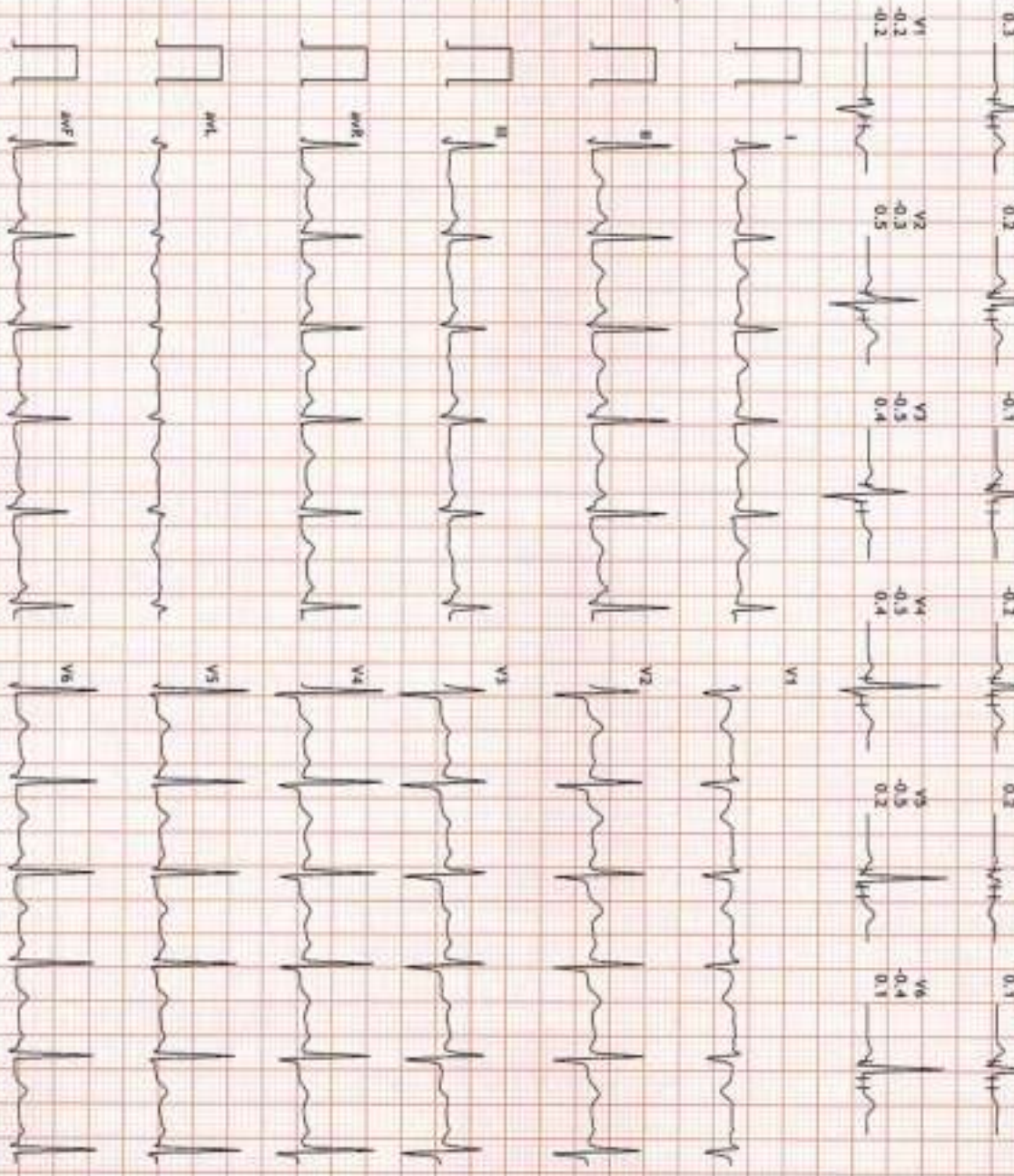
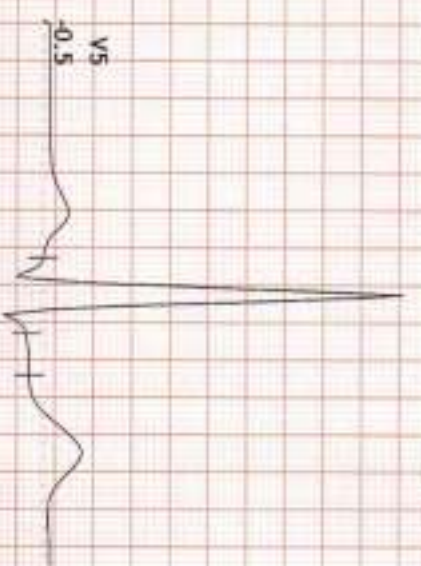
HR: 105 bpm
METTS: 1.0
BP: 130/80

APHR: 50% of 186
Speed: 0.0 mph
Graph: 0.0%

Raw ECG
BRUCE
10.05-100/Hz

Ex Time: 06:58
BLC: On
Noch: On

Recovery(4:00)
10.0 mm/My
25 mm/Sec



HR: 103 bpm

METS: 1.0

BP: 130/80

MP-R: 55% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

10.05-100/11E

Ex Time 06:58

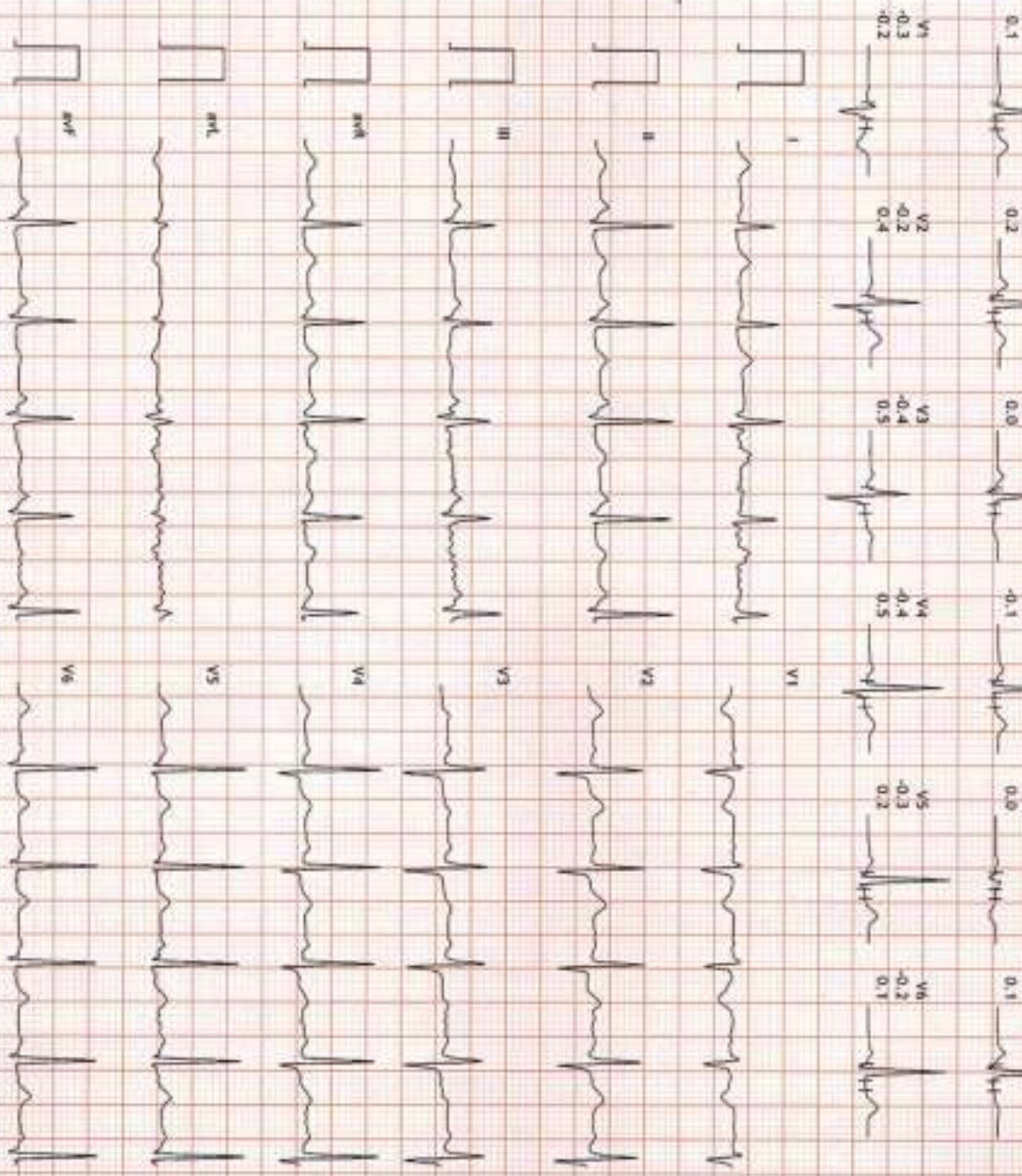
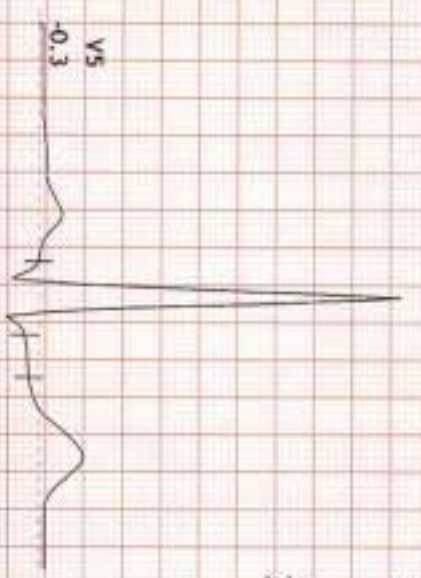
SLC :On

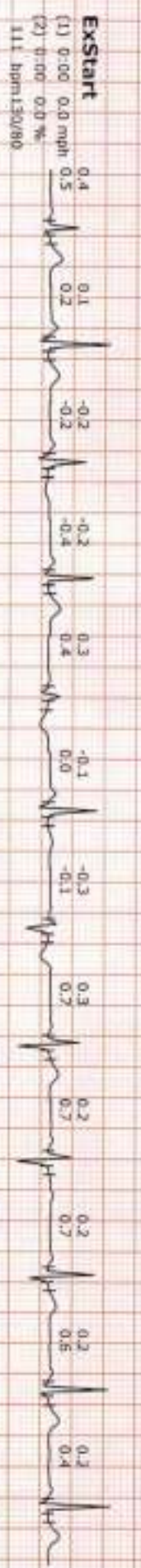
Match :On

Recovery(5:00)

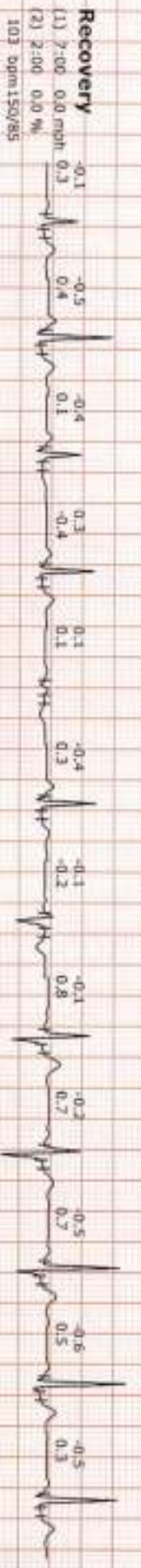
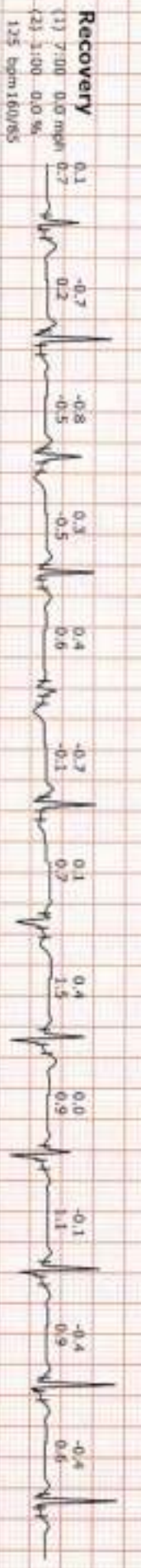
10.0 mm/mV

25 mm/Sec





Average



R

12234380 KAVITA MEENA 34 YRS , MEDIWHEEL F
13 JAN 2024
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)

