

Medi'wheel

Dr. Anuravati

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



Name: Mr. pankaj Ingle

Date: 24/2/24

Age: 42y

Sex: M F

Weight: 76.9 kg

Height: 163.7 inc

BMI: 28.7

BP: 127/70

mmHg

Pulse: 87/m

bpm

RBS:

mg/dl

SpO2: 98%



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mr. PANKAJ INGLE	Age /Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2324079728/UMR2324038323	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 24-Feb-24 08:42 am	Report Date : 24-Feb-24 10:34 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	14.1	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		42.6	40.0 - 50.0 %	Calculated
RBC Count		5.16	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		83	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		27.4	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		33.2	31.5 - 35.0 g/l	Calculated
RDW		14.7	11.5 - 14.0 %	Calculated
Platelet count		339	150 - 450 10 ³ /cumm	Impedance
WBC Count		6100	4000 - 11000 cells/cumm	Impedance

DIFFERENTIAL COUNT

Neutrophils		56.4	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes		38.1	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils		1.6	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes		3.9	2 - 10 %	Flow Cytometry/Light microscopy
Basophils		0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		3440.4	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		2324.1	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		97.6	20 - 500 /cumm	Calculated
Absolute Monocyte Count		237.9	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
<u>PERIPHERAL SMEAR</u>				
RBC		Normochromic		
Anisocytosis		Normocytic		
WBC		Anisocytosis		
Platelets		+(Few)		
ESR		As Above		
		Adequate		
		10	0 - 15 mm/hr	Automated
		*** End Of Report ***		Westergren's Method

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100245

Test results related only to the item tested.

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Dr. VAIDEHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

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Age / Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2324079728/UMR2324038323
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 24-Feb-24 08:41 am
Report Date : 24-Feb-24 11:01 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	93	< 100 mg/dl	GOD/POD, Colorimetric
Post Prandial Plasma Glucose		111	< 140 mg/dl	GOD/POD, Colorimetric
GLYCOSYLATED HAEMOGLOBIN (HBA1C)				
HbA1c		5.4	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

*** End Of Report ***

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 CIN: U74999MH2018PTC303510



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

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LIPID PROFILE

Parameter	Specimen	Results	Method
Total Cholesterol	Serum	213	Enzymatic(CHE/CHO/POD)
Triglycerides		155	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		39	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		135.50	Enzymatic
VLDL Cholesterol		31	Calculated
Tot Chol/HDL Ratio		5	Calculation

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

*** End Of Report ***

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CLINICAL DIAGNOSTIC LABORATORY
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Patient Name : Mr. PANKAJ INGLE	Age /Gender : 42 Y(s)/Male
Bill No/ UMR No : BIL2324079728/UMR2324038323	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 24-Feb-24 11:34 am	Report Date : 24-Feb-24 12:52 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	
URINE SUGAR			
Urine Glucose		Negative	
NOTE:		Post Meal Urine Sugar	
THYROID PROFILE			
T3		1.39	0.55 - 1.70 ng/ml
Free T4		0.96	0.80 - 1.70 ng/dl
TSH		2.16	0.50 - 4.80 uIU/ml
PSA (Total)		0.308	< 4 ng/ml

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CLINICAL DIAGNOSTIC LABORATORY

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<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
RFT				
Blood Urea	Serum	14	19.0 - 43.0 mg/dl	Urease with indicator dye
Creatinine		0.81	0.66 - 1.25 mg/dl	Enzymatic (creatinine amidohydrolase)
GFR		112.9	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		141	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.88	3.5 - 5.1 mmol/L	Direct ion selective electrode
LIVER FUNCTION TEST(LFT)				
Total Bilirubin		0.53	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.27	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.26	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric
Alkaline Phosphatase		63	38 - 126 U/L	pNPP/AMP buffer
SGPT/ALT		36	10 - 40 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		27	15 - 40 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		8.28	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.81	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.46	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.39		

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DEPARTMENT OF PATHOLOGY

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Bill No/ UMR No : BIL2324079728/UMR2324038323	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 24-Feb-24 10:11 am	Report Date : 24-Feb-24 11:05 am

URINE MICROSCOPY

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<u>PHYSICAL EXAMINATION</u>			
Volume	Urine	30 ml	
Colour.		Pale yellow	
Appearance		Clear	Clear
<u>CHEMICAL EXAMINATION</u>			
Reaction (pH)		7.0	4.6 - 8.0 Indicators
Specific gravity		1.005	1.005 - 1.025 ion concentration
Urine Protein		Negative	Negative protein error of pH indicator
Sugar		Negative	Negative GOD/POD
Bilirubin		Negative	Negative Diazonium
Ketone Bodies		Negative	Negative Legal's est Principle
Nitrate		Negative	Negative
Urobilinogen		Normal	Normal Ehrlich's Reaction
<u>MICROSCOPIC EXAMINATION</u>			
Epithelial Cells		0-1	0 - 4 /hpf Manual
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		0-1	0 - 4 /hpf
Casts		Absent	Absent



CLINICAL DIAGNOSTIC LABORATORY
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Received Dt : 24-Feb-24 10:11 am **Report Date** : 24-Feb-24 11:05 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Crystals		Absent	

*** End Of Report ***

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Dr. VAIDEHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY

Patient Name : Mr. PANKAJ INGLE	Age /Gender : 42 Y(s)/Male
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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 ***	

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Dr. VAIDEHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	PANKAJ ENGLE	STUDY DATE	24-02-2024 10:13:48
AGE/ SEX	42Y / M	HOSPITAL NO.	UMR2324038323
ACCESSION NO.	BIL2324079728-17	MODALITY	DX
REPORTED ON	24-02-2024 10:46	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:	PANKAJ INGLE	AGE /SEX:	42 YRS/MALE
UMR NO:	2324038323	BILL NO:	2324079778
REF BY	DR. VIMMI GOEL	DATE:	24/02/2024

USG WHOLE ABDOMEN

LIVER is normal in size, shape but shows mild increase in 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.

Prostate is normal in size, shape and echotexture. Wt – 16.6 gms.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

Mild fatty infiltration in liver.

No other significant abnormality seen.

Suggest clinical correlation / further evaluation.



DR NAVEEN PUGALIA
MBBS, MD [076125]
SENIOR CONSULTANT RADIOLOGIST

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

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: Mr. Pankaj, Ingle
Patient ID: 038323
Height:
Weight:
Study Date: 24.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

DOB: 28.06.1982
Age: 41 yrs
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	00:09	0.00	0.00	89	120/70	
	WARM-UP	00:04	0.00	0.00	86		
EXERCISE	STAGE 1	03:00	1.70	10.00	122	120/70	
	STAGE 2	03:00	2.50	12.00	125	130/70	
	STAGE 3	03:00	3.40	14.00	141	130/70	
	STAGE 4	00:39	4.20	16.00	155		
RECOVERY		01:00	0.00	0.00	118	130/70	
		02:00	0.00	0.00	100	130/70	
		00:23	0.00	0.00	98		

The patient exercised according to the BRUCE for 9:39 min:s, achieving a work level of Max. METS: 12.10. The resting heart rate of 90 bpm rose to a maximal heart rate of 157 bpm. This value represents 87% of the maximal, age-predicted heart rate. The resting blood pressure of 120/70 mmHg, rose to a maximum blood pressure of 130/70 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation:

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: appropriate.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: Insignificant ST-T changes seen..

Overall impression: Normal stress test.

Conclusions:

TMT is negative for inducible ischemia.

Insignificant ST-T changes seen.

Dr. VIMMI GOEL
MBBS, MD
Sr. Consultant-Non Invasive Cardiology
Reg No: 201410110113

Rate 82 . Sinus rhythm.....normal P axis, V-rate 50- 99

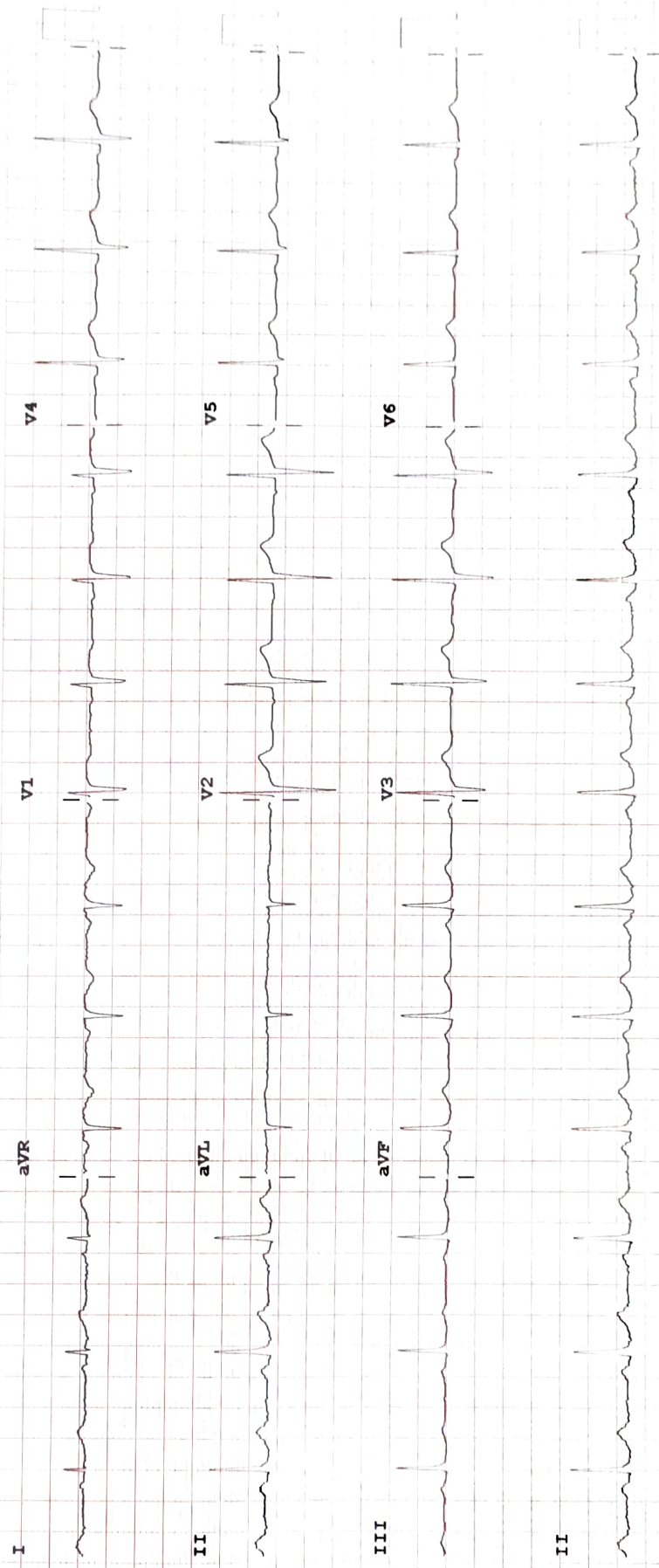
PR 147
QRSd 80
QT 360
QTc 421

--AXIS--
P 66
QRS 74
T 50

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



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

F 50~ 0.50-150 Hz W

100B CL

P?