

Name: MR. HARDIKKUMAR K PARMAR *4ml 2 21/12/24*

Sex: Male Clinic No.:

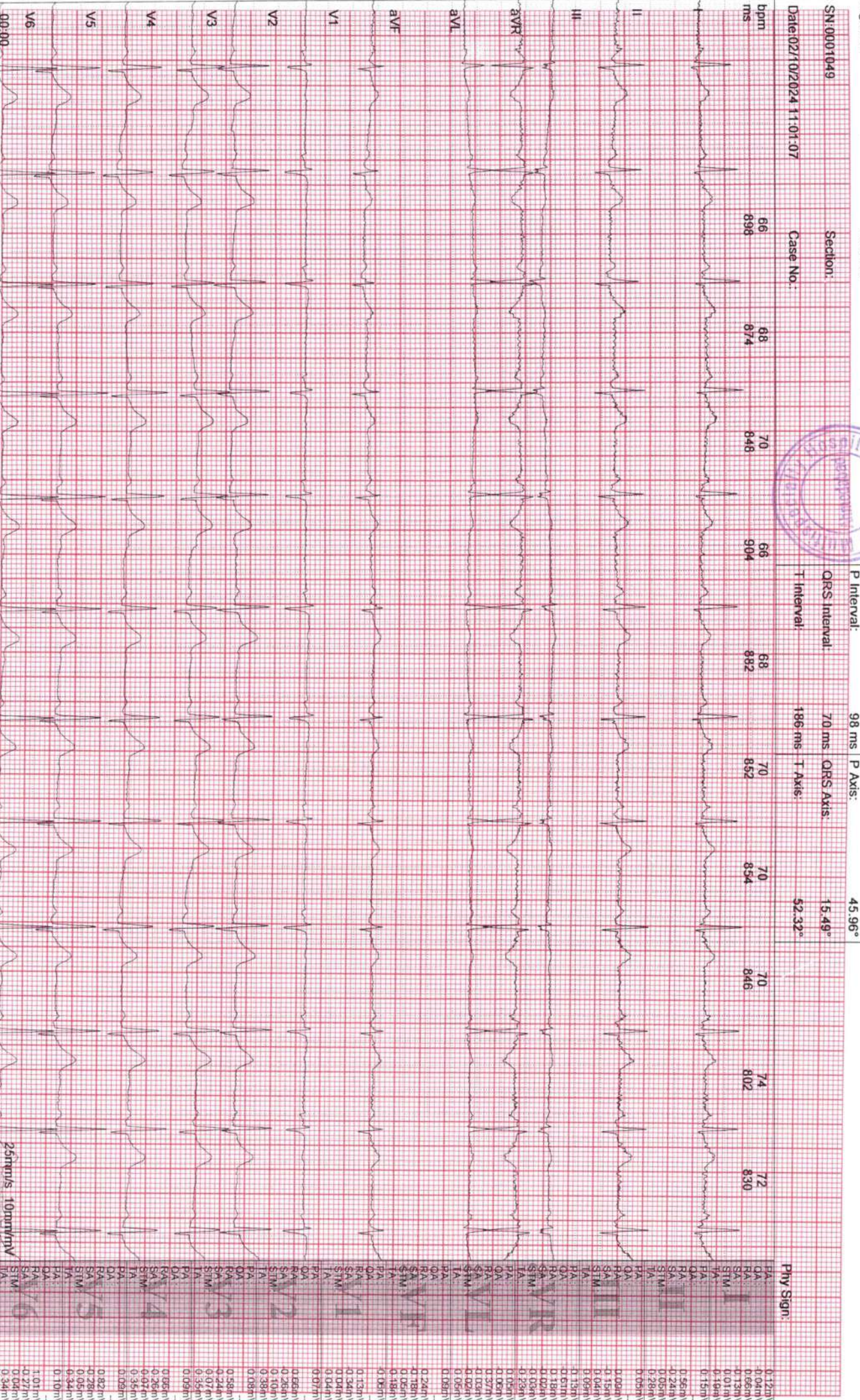
Age: 27Y Bed No.:

SN: 0001049 Section: Case No.:  
 Date: 02/10/2024 11:01:07



Frequency: 1000 Hz PR Interval: 146 ms  
 Sample Time: 15 s QT Interval: 348 ms  
 HR: 69 bpm QTc Interval: 374 ms  
 P Interval: 98 ms P Axis: 45.96°  
 QRS Interval: 70 ms QRS Axis: 15.49°  
 T Interval: 186 ms T Axis: 52.32°

Prompt: Total Beats 15, Normal Beats 15, SVE 0, VE 0.  
 Normal Heart Rate (HR between 60 and 100 bpm);  
 Light left cardiac electric axis deviation (QRS axis between 0 degree and 30 degree).



Phys Sign:

Lead	PA	QA	RA	SA	TA
I	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
II	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
III	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
aVR	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
aVL	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
aVF	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
V1	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
V2	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
V3	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
V4	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
V5	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV
V6	0.12mV	-0.04mV	0.66mV	0.13mV	0.01mV



**PATIENT NAME****MR. HARDIKKUMAR PARMAR****AGE / SEX****27YRS/MALE****REF. DOCTOR****DR. DHS DOCTOR TEAM****DATE****02/10/2024****2D ECHO CARDIOGRAPHY REPORT****Observation:**

1. Normal LV size with normal LV systolic function. LVEF: 65%.
2. No RWMA at rest.
3. Normal LV compliance.
4. Normal sized LA, RA and RV. Normal RV function.
5. All valves are normal in structure.
6. IAS and IVS are intact.
7. No PAH. RVSP = 26 mmHg.
8. No clot/ vegetation / pericardial effusion.
9. Doppler: Trivial MR, NO TR, No AR, No PR.
10. IVC is normal in size and well collapse on inspiration.

**Conclusion:****Normal LV systolic function.****No RWMA.****No PAH.****Measurements :**

<b>LVIDD</b>	<b>45.0 mm</b>	<b>AO</b>	<b>23.0mm</b>
<b>LVIDS</b>	<b>27.0 mm</b>	<b>LA</b>	<b>33.0mm</b>
<b>LVEF</b>	<b>65%</b>		
<b>IVSD/LVPWD</b>	<b>08.0mm/08.0mm</b>		

**DOPPLER STUDY:**

<b>Valves</b>	<b>velocity</b>	<b>Max gradient</b>	<b>Mean gradient</b>	<b>Area</b>	<b>Regurgitation</b>
<b>Aortic</b>	<b>1.2</b>	<b>5.5</b>			<b>No AR</b>
<b>Mitral</b>	<b>E:0.4 A: 0.5</b>				<b>Trivial MR</b>
<b>Pulmonary</b>	<b>0.6</b>	<b>3.5</b>			<b>No PR</b>
<b>Tricuspid</b>	<b>0.5</b>	<b>1.2</b>			<b>No TR</b>

**Dr.ARCHIT PARIKH****DR. ARCHIT PARIKH****G - 30352****M. D.(General Medicine)****DHS MULTISPECIALTY HOSPITAL**

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**HARDIKKUMAR PARMAR**  
27 Y/M  
HEALTH CHECK UP  
02/10/2024

**U.S.G. OF ABDOMEN AND PELVIS**

**Liver:** appears normal in size & shows normal echopattern. No focal lesion is seen. No dilated IHBR is seen. Portal vein and CBD appear normal in course and caliber.

**Gall bladder:** is moderately distended & appears normal. No calculus, sludge or mass is seen. Gall bladder wall thickness appears normal.

**Pancreas:** appears normal in size & echopattern. No focal lesion is seen.

**Spleen:** appears normal in size and shows normal echotexture. No focal lesion is seen.

**Both Kidneys** appear normal in size, position and echopattern.

**Small 4 mm sized calculus is noted in mid calyx of right kidney. No hydronephrosis.**

C-M differentiation is well preserved on either side.

No calculus or hydronephrosis on left side.

Cortical thickness appears normal on both sides.

No focal lesion is seen on either side.

**Urinary bladder** is moderately distended & appears normal. No calculus, internal echoes or mass is seen. Urinary bladder wall thickness appears normal.

**Prostate** appears normal in size and echopattern.

Para-aortic region appears normal.

No abdominal lymphadenopathy is seen.

Bowel loops appear normal in caliber & show normal peristalsis.

No abnormal dilatation of bowel loops or wall thickening is seen.

No fluid collection or lump formation is seen in RIF.

No ascites is seen.

**IMPRESSION:**

**Small right renal calculus**

Clinical correlation suggested. Thanks for reference.



**DR. BHADRESH CHUDASAMA**  
MD RADIOLOGY

<b>Patient Name</b>	<b>HARDIKKUMAR K PARMAR</b>	<b>Patient ID</b>	<b>UHID27200</b>
<b>Age/Gender</b>	<b>27 Years / M</b>	<b>Study Date</b>	<b>02-Oct-2024</b>
<b>Referred By</b>		<b>Reported Date</b>	<b>02-Oct-2024</b>

**X – RAY CHEST PA VIEW:**

Both lung fields under vision appear normal.  
Cardiac size appears normal.  
Both costophrenic angles are clear.  
Hilar regions are normal.  
Both domes appear normal in position.  
Bony thorax under vision appears normal.



Dr.Sunny Shivilani  
MD Radiology REG-33548

**Date Reported: 02-Oct-2024**

This Report is done and digitally signed via Tele Radiology Done at Radiscan Diagnostic Ahmedabad. For any clinical discrepancy, please discuss with the Radiologist. This report is not valid for any medico-legal purposes



**TEST REPORT**

Reg. No : 2410100033      UHID : UHID27200      Reg. Date : 02-Oct-2024  
Name : HARDIKKUMAR K PARMAR      Collected On : 02-Oct-2024 09:10  
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Parameter	Result	Unit	Reference Interval
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**COMPLETE BLOOD COUNT (CBC)**

Hemoglobin (SLS method)	15.0	g/dL	13.0 - 17.0
Hematocrit (Electrical Impedance)	45.0	%	40 - 54
RBC Count (Electrical Impedance)	5.43	million/cmm	4.5 - 5.5
WBC Count (Flowcytometry)	6610	/cmm	4000 - 10000
Platelet Count (Electrical Impedance)	285000	/cmm	150000 - 410000
MCV (Calculated)	<b>82.9</b>	fL	83 - 101
MCH (Calculated)	27.7	Pg	27 - 32
MCHC (Calculated)	33.4	%	31.5 - 34.5
RDW (Calculated)	12.3	%	11.5 - 14.5

**DIFFERENTIAL WBC COUNT**

Neutrophils (%)	54	%	38 - 70
Lymphocytes (%)	37	%	20 - 45
Monocytes (%)	07	%	2 - 8
Eosinophils (%)	02	%	1 - 4
Basophils (%)	00	%	0 - 1
Neutrophils (Absolute)	3590	/cmm	1800 - 7700
Lymphocytes (Absolute)	2430	/cmm	1000 - 3900
Monocytes (Absolute)	480	/cmm	200 - 800
Eosinophils (Absolute)	90	/cmm	20 - 500
Basophils (Absolute)	20	/cmm	0 - 100
Neutrophil-Lymphocyte Ratio(NLR)	1.48	/cmm	0.7 - 4.0

**PERIPHERAL SMEAR EXAMINATION**

RBC Morphology      RBCs are Normochromic Normocytic.  
WBC Morphology      Total WBC and differential count is within normal.  
Platelets      Platelets are adequate with normal morphology.  
Parasites      Malarial parasite is not detected.

**ERYTHROCYTE SEDIMENTATION RATE**

ESR (After 1 hour)      12      mm/hr      0 - 14

----- End Of Report -----

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Approved by:

  
Dr. Yesha H. Shah  
(MD.Pathology)

  
Mr. Akshay Parmar  
M.Sc(Biochemistry)

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<b>LIVER FUNCTION TEST</b>			
SGPT <i>Optimized UV-IFCC</i>	56.8	U/L	1 - 45
SGOT <i>Optimized UV-IFCC</i>	34.1	U/L	1 - 35
Total Bilirubin <i>DCA method</i>	0.68	mg/dL	0 - 2.0
Direct Bilirubin <i>DCA method</i>	0.29	mg/dL	0.0 - 0.4
INDIRECT BILIRUBIN <i>Calculated</i>	0.39	mg/dL	0.0 - 1.6
Alkaline Phosphatase <i>PNP-AMP Buffer, Multiple-point rate</i>	104	U/L	53 - 128
Total Protein	6.95	g/dL	6.4 - 8.2
Albumin <i>By Bromocresol Green</i>	3.98	g/dL	3.5 - 5.2
Globulin <i>Calculated</i>	2.97	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	1.34		0.8 - 2.0
GGT	38.2	U/L	1 - 55
HBsAg <i>Immunochromatography</i>	Non - Reactive		

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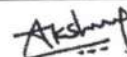
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<b>RENAL FUNCTION TEST</b>			
Creatinine <i>Enzymatic ,IDMS Traceable</i>	0.75	mg/dL	0.7 - 1.3
Urea <i>Urease-GLDH, enzymatic UV</i>	21.1	mg/dL	19.0 - 45.0
BUN <i>Calculated</i>	9.86	mg/dL	7 - 18
Uric Acid <i>Enzymatic using TBHBA</i>	5.8	mg/dL	3.5 - 7.2
Sodium <i>Direct ISE</i>	138.6	mmol/L	137 - 145
Potassium <i>Direct ISE</i>	4.52	mmol/L	3.6 - 5.1
Chloride <i>Direct ISE</i>	95.3	mmol/L	94 - 110
Ionized Calcium <i>Direct ISE</i>	4.56	mg/dL	4.4 - 5.4

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**BLOOD GROUP & RH****SPECIMEN: EDTA AND SERUM; METHOD: HAEMAGGLUTINATION**

ABO	'A'
Rh (D)	Negative

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**HEMOGLOBIN A1 C ESTIMATION**

Specimen: Blood EDTA

Hb A1C <i>HPLC, NGSP Certified</i>	5.8	%	>8 : Action Suggested , 7-8 : Good Control , <7 : Goal , 6-7 : Near Normal Glycemia, <6 : Non-diabetic Level
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Mean Blood Glucose <i>Calculated</i>	119.76	mg/dL	
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**Criteria for the diagnosis of diabetes:**

1. HbA1c  $\geq 6.5$  \*Or
  2. Fasting plasma glucose  $>126$  gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.Or
  3. Two hour plasma glucose  $\geq 200$ mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucosedissolved in water.Or
  4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose  $\geq 200$  mg/dL.
- \*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34;S11.

**Importance of HbA1C (Glycated Hb.) in Diabetes Mellitus:**

- HbA1C, also known as glycated hemoglobin, is the most important test for the assessment of long term blood glucose control( also called glycemic control).
- HbA1C reflects mean glucose concentration over past 6-8 weeks and provides a much better indication of longterm glycemic control than blood glucose determination.
- HbA1c is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy (Eye-complications), nephropathy (kidney-complications) and neuropathy (nerve complications), are potentially serious and can lead to blindness, kidney failure, etc.- Glycemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD ) is considered most important. (Ref. National Glycohaemoglobin Standardization Program - NGSP).

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**POST PRANDIAL BLOOD SUGAR**

SPECIMEN: FLOURIDE PLASMA/ SERUM

**PPBS**

Post Prandial Blood Sugar (PPBS)      125.3      mg/dL      110 - 140

Glucose Oxidase-Peroxidase

**FASTING BLOOD SUGAR**

SPECIMEN: FLOURIDE PLASMA/ SERUM

**FBS**

Fasting Blood Sugar (FBS)      105.1      mg/dL      70 - 110

Glucose Oxidase-Peroxidase

**Criteria for the diagnosis of diabetes** 1. HbA1c  $\geq$  6.5 \*

Or

2. Fasting plasma glucose  $>$ 126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.

Or

3. Two hour plasma glucose  $\geq$  200mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucose dissolved in water.

Or

4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose  $\geq$  200 mg/dL.

\*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing.

American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34:S11.

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**LIPID PROFILE**

Cholesterol <i>CHOD-PAP method</i>	151	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride <i>Enzymatic with GPO method</i>	100.2	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL <i>Calculated</i>	20.04	mg/dL	15 - 35
LDL CHOLESTEROL	151.3	mg/dL	Optimal : < 100.0 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190.0
HDL Cholesterol <i>Magnetic Cholesterol Oxidase</i>	32.6	mg/dL	Low : < 40 High : > 60
Cholesterol /HDL Ratio <i>Calculated</i>	4.63		0 - 5.0
LDL / HDL RATIO <i>Calculated</i>	<b>4.64</b>		0 - 3.5
Total Lipids <i>Calculated</i>	462.40		400 - 1000

- Pre-analytical requirements for given tests are -Fasting status anywhere between 10-12 hours before collection. Avoid alcohol beverages before lipid panel - minimum 24 hrs.
- Lipid profile results can be erroneous if pre-analytical requirements are not met properly.
- Any medical decision based on test results is to be taken with 2 or more consecutive results suggesting pattern.
- Please note that any lipid lowering drug may interfere in results estimation.
- Sudden commencement or sudden withdrawal of Lipid lowering drug will interfere with test result.

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**THYROID FUNCTION TEST**

T3 (Triiodothyronine) CMA	1.25	ng/mL	0.6 - 1.81
T4 (Thyroxine) CMA	5.89	µg/dL	4.5 - 12.5
TSH ELFA-Enzyme Linked Fluorescent Assay	0.960	µIU/ml	0.35 - 4.94

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4. Quantification of TSH is significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.



TSH levels During Pregnancy :

First Trimester : 0.1 to 2.5 µIU/mL  
Second Trimester : 0.2 to 3.0 µIU/mL  
Third trimester : 0.3 to 3.0 µIU/mL

Reference : Carl A. Burtis, Edward R. Ashwood, David E. Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Edition.  
Philadelphia: WB Saunders, 2012:2170

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