

## MEDICAL SUMMARY

NAME:	Mr. Asang Deshpande	UHID:	
AGE:	24	DATE OF HEALTHCHECK:	10-20-2024
GENDER:	M		

HEIGHT:	166	MARITAL STATUS:	Single
WEIGHT:	56.9	NO OF CHILDREN:	
BMI:	20.6		

C/O: Sickle cell Anemia

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: - Sickle cell Anemia

MOTHER: - Sickle Cell Anemia DM

O/E:

BP: 110/80 PULSE: - 84/min

LYMPHADENOPATHY:

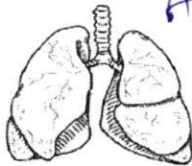
PALLOR/ICTERUS/CYNOSIS/CLUBBING:

TEMPERATURE: 37 SCARS:

OEDEMA: -

S/E:

RS:



P/A:



CVS: SIDA

Extremities & Spine: - No

CNS: Crabs, osteoarthritis

ENT: - No

Skin: - No

Vision:

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

• ANDHERI • COLABA • NASHIK • VASHI

Name: Asang S Bagेश्वर Age: 34y Date of Health check-up: 10/02/24

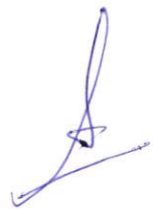
**Findings and Recommendation:**

**Findings:-**

Hb 7.1  
Cholesterol +0  
- Anisospiker → Sickle cell.

**Recommendation:-**

*Ref*

Signature: 

Consultant -

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



**OPHTHALMIC EVALUATION**

UHID No.: \_\_\_\_\_

Date: 10/12/24

Name: M. Asang Age: 34 Gender:  Male/ Female

Without Correction :

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

Near : Right Eye 26 Left Eye 26

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 : NAD

Anterior Segment Examination : \_\_\_\_\_

Pupils : NAD BC

Fundus : \_\_\_\_\_

Intraocular Pressure : 14 mm Hg BC

Diagnosis : \_\_\_\_\_

Advice : \_\_\_\_\_

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

Dr. [Signature]  
**DR. RUCHI RASHARMA**  
(Consultant Ophthalmologist)  
M. S. (OPHTH)  
CONSULTING OPHTHALMOLOGIST  
& MICRO SURGEON  
REG. No.: 3262 / 09 / 02

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dentistry

## DENTAL CHECKUP

<b>Name:</b> Asang Bageshwar	<b>MR NO:</b>
<b>Age/Gender :</b> 34/M	<b>Date:</b> 16/2/24

Medical history:  Diabetes  Hypertension  \_\_\_\_\_

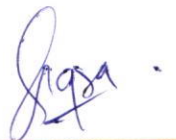
EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus& Stains				
Mobility				
Caries ( Cavities )				
a)Class 1 (Occlusal)				
b)Class 2 (Proximal)				
c)Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces	✓			✓
Impacted Tooth				
Missing Tooth				
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: \_\_\_\_\_

- Extraction of root pieces.  
 - Adv OPG.



Name : Mr. Asang Suresh Bageshwar Gender : Male Age : 34 Years  
 UHID : FVAH 10567. Bill No : Lab No : V-1308-23  
 Ref. by : SELF Sample Col.Dt : 10/02/2024 09:25  
 Barcode No : 7986 Reported On : 10/02/2024 20:21


TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

**HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)**

TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
Haemoglobin(Colorimetric method)	<b>9.7</b> g/dl	13 - 18
RBC Count (Impedance)	<b>3.04</b> Millions/cumm.	4 - 6.2
PCV/Haematocrit(Calculated)	<b>30.1</b> %	35 - 55
MCV:(Calculated)	<b>98.8</b> fl	78 - 98
MCH:(Calculated)	31.7 pg	26 - 34
MCHC:(Calculated)	32.1 gm/dl	30 - 36
RDW-CV:	16 %	11.5 - 16.5
Total Leucocyte count(Impedance)	10070 /cumm.	4000 - 10500
Neutrophils:	<b>32</b> %	40 - 75
Lymphocytes:	<b>57</b> %	20 - 40
Eosinophils:	06 %	0 - 6
Monocytes:	05 %	2 - 10
Basophils:	00 %	0 - 2
Platelets Count(Impedance method)	4.36 Lakhs/c.mm	1.5 - 4.5
MPV	8.8 fl	6.0 - 11.0
ESR(Westergren Method)	05 mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)		
RBCs:	Hypochromasia(+),Microcytosis(+),Anisocytosis(+), Poikilocytosis(++),Sickle cells seen	
WBCs:	Lymphocytosis	
Platelets	Adequate	
Note:	Test Run on 5 part cell counter. Manual diff performed.	

Ms Kaveri Gaonkar  
Entered By

Ms Kaveri Gaonkar  
Verified By

Page 3 of 8  
  
 Dr. Milind Patwardhan  
 M.D(Path)  
 Chief Pathologist

End of Report  
 Results are to be correlated clinically

Name : Mr. Asang Suresh Bageshwar Gender : Male Age : 34 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)

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Sheetal Nakate  
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
<b>PLASMA GLUCOSE</b>			
Fasting Plasma Glucose :	92	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 :	123	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

Alsaba Shaikh  
Entered By

Ms Kaveri Gaonkar  
Verified By



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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

**LIPID PROFILE - Serum**

S. Cholesterol(Oxidase)	112	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	119	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	23.8	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	<b>27.2</b>	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	61	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4.1		3.5 - 5
Ratio of LDL/HDL	<b>2.2</b>		2.5 - 3.5

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL  
**LFT(Liver Function Tests)-Serum**

S.Total Protein (Biuret method)	7.82	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.59	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.23	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.42		0.9 - 2
S.Total Bilirubin (DPD):	<b>5.18*</b>	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	<b>1.04</b>	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	<b>4.14</b>	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	40	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	17	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	78	U/L	40 - 129
S.GGT(IFCC Kinetic):	26	U/L	11 - 50

Remarks :

**\* Rechecked & confirmed. Kindly Correlate Clinically**

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	<b>BIOCHEMISTRY</b>	
S.Urea(Urease Method)	19.4 mg/dl	10.0 - 45.0
BUN (Calculated)	9.05 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.56 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	16.16	9:1 - 23:1
S.Uric Acid(Uricase Method)	4.6 mg/dl	3.4 - 7.0

Alsaba Shaikh  
Entered By

Ms Kavari Gaonkar  
Verified By



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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
<b>Thyroid (T3,T4,TSH)- Serum</b>			
Total T3 (Tri-iodo Thyronine) (ECLIA)	2.11	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	108.9	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	1.38	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

Alsaba Shaikh  
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M.D(Path)

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End of Report

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

**PHYSICAL EXAMINATION**

QUANTITY	30	mL	
COLOUR	Yellow		
APPEARANCE	Clear		Clear
SEDIMENT	Absent		Absent

**CHEMICAL EXAMINATION(Strip Method)**

REACTION(PH)	6.0	4.6 - 8.0
SPECIFIC GRAVITY	1.015	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	0 - 1 / hpf	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 7 of Chief Pathologist

End of Report  
Results are to be correlated clinically

Asang Bageshwar  
10567

34 Years Male

10.02.2024 10:36:08  
Apollo Clinic  
1st Flr, The Emerald, Sector-12,  
Vashi, Mumbai-40703.

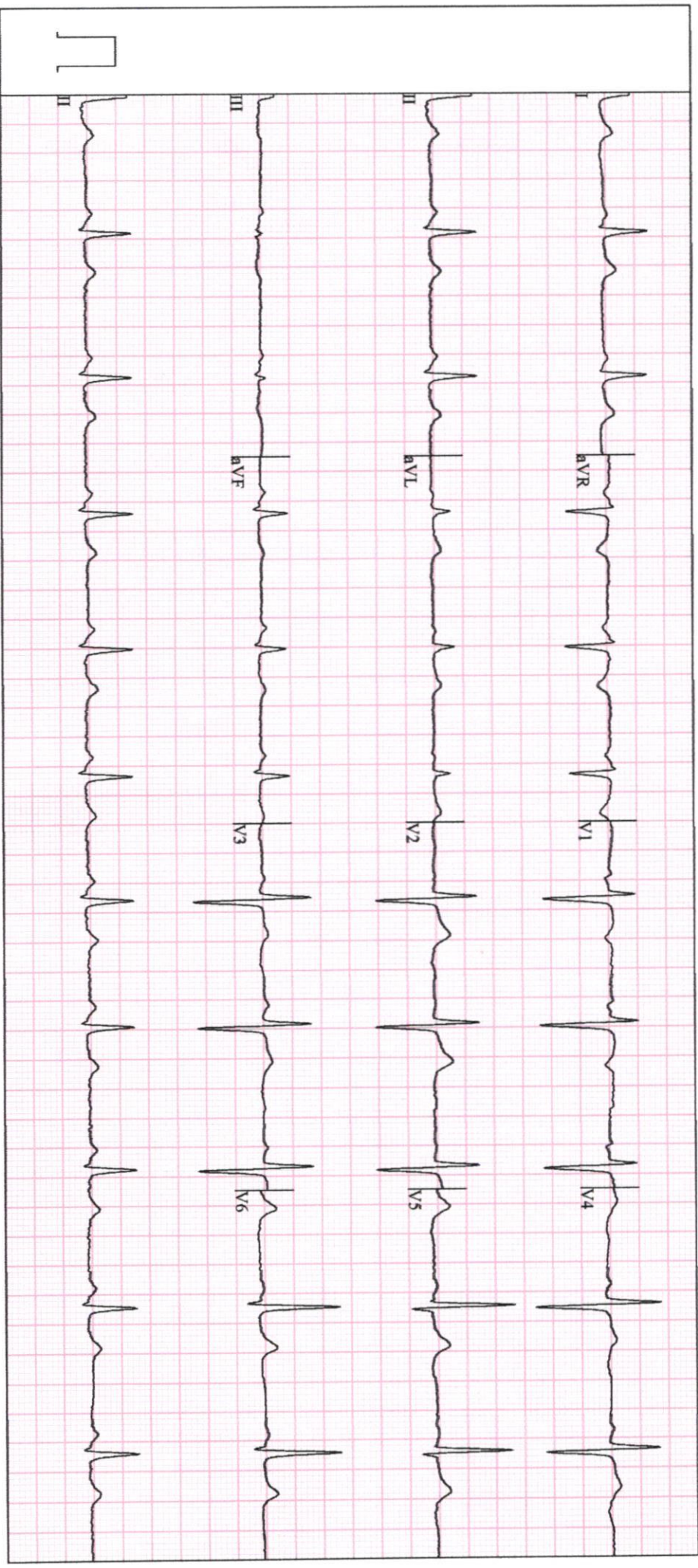
65 bpm

# NORMAL ECG

QRS : 82 ms  
 QT/QTcBaz : 388 / 403 ms  
 PR : 142 ms  
 P : 100 ms  
 RR/PP : 924 / 923 ms  
 P/QRS/T : 46 / 37 / 26 degrees

Normal sinus rhythm  
 Normal ECG

Dr. ANIRBAN DASGUPTA  
 M.B., B.S., D.N.B., Medicine  
 Diploma Cardiology  
 MMC - 2005/02/0920



GE MAC2000 I.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz Unconfirmed 4x2.5x3\_25\_R1 1/1

<b>PATIENT'S NAME</b>	<b>ASANG SURESH BAGESHWAR</b>	<b>AGE :- 34Y/M</b>
<b>UHID</b>	<b>10567</b>	<b>DATE :- 10-02-24</b>

### **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	19 mm
Left Atrium	33 mm
LVID(Systole)	25 mm
LVID(Diastole)	44 mm
IVS(Diastole)	09 mm
PW(Diastole)	10 mm
LV ejection fraction.	55-60%

### Conclusion

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



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

PATIENT'S NAME	ASANG S BAGESHWAR	AGE :- 34 Y/M
UHID NO	10567	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	ASANG SURESH BAGESHWAR	AGE :- 34y/M
UHID NO	10567	10 Feb 2024

**USG ABDOMEN AND PELVIS (TAS)**

**Liver** is normal in size, shape and echotexture. There is no focal lesion seen. The portal vein and common bile duct are normal in course and caliber. There is no evidence of intra-hepatic biliary duct dilatation seen. PV = 11 mm. CBD = 2.9 mm.

**Gall Bladder** is distended with about 3-4 mobile calculi within each measuring 8.8mm, 8.3mm and 8.0mm showing posterior acoustic shadowing. No abnormal wall thickening or pericholecystic fluid collection is seen.

The visualized **Pancreas** is normal in size, shape and echotexture. There is no focal lesion seen.

**Spleen** is not visualized in left hypochondriac region.

**Right Kidney** measures 10.2 x 5.4 cm. **Left Kidney** measures 10.9 x 6.2 cm.

Both kidneys are normal in size, shape and echotexture. No evidence of any focal lesion is noted. No hydronephrosis, hydroureter or calculus is noted in both kidneys. Cortico medullary differentiation is well maintained.

**Urinary Bladder** is well distended. There is no evidence of focal lesion. No evidence of any calculus is seen.

**Prostate gland** is normal in size, shape and echopattern.

There is no free fluid or abdominal lymphadenopathy.

**IMPRESSION: - FINDINGS REVEAL:-**

- CHOLELITHIASIS.
- NON-VISUALIZATION OF SPLEEN IN LEFT HYPOCHONDRIC REGION.
- NO OTHER SIGNIFICANT ABNORMALITY IS DETECTED.

Clinico-haematological correlation and imaging follow-up is recommended.

Thanking you for the referral,  
With regards,



**DR. SIDDHI PATIL**  
Con. Radiologist