



Cloud36, Cloud 36 Rd, Jijamata Nagar,
Sector 11, Ghansoli, Navi Mumbai,
Maharashtra 400701, India
Lat: 19.1192739
Lon: 72.9936418
19/02/2024 09:37:12 AM GMT+05:30



भारत सरकार

Government of India



००

Vijay R

वडील : ००

Father : RAMACHANDRAN S

जन्म तारीख / DOB : 25/04/1994

पुरुष / Male



4719 6735 6116

माझे आधार, माझी ओळख

MEDICAL EXAMINATION FORM

Confidential without Prejudice Report. To Be Filled In Strictly By the Physician/Diagnostic Center

PART I: GENERAL DETAILS

NAME OF THE PATIENT VIJAY R
 D.O.B. 25.04.1994 Age 29 Sex M Phone number 8015416221

PART II: MEDICAL EXAMINATION REPORT (Strictly to be filled by Medical Examiner)

(Kindly tick wherever applicable)

A. PERSONAL HISTORY:

1. Previous history if any:

Disease	Yes/ No	Medicine & Surgery Details	Disease	Yes/ No	Medicine & Surgery Details
Diabetes Mellitus	NO		Cancer	NO	
Hypertension	NO		Tumor/Benign	NO	
IHD	NO		Genital urinary disorder	NO	
Stroke	NO		Rheumatic joint diseases or symptoms	NO	
Surgeries	NO		Asthma	NO	
Tuberculosis	NO		Pulmonary Disease	NO	
Congenital Disease	NO		Anemia	NO	
Arrhythmia	NO		Bleeding disease or Disorder.	NO	
Aids (HIV)	NO		Mental Stress	NO	

2. Habits:

Diet	<u>veg/Non-veg</u>	Alcohol	NO	Tobacco/Smoking	NO	Medicine	NO
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3. Major complaints/Relevant past history if any: NO

4. Previous Illness (Hospitalization Investigation, consultation) NO

5. Family history: Father - DM

B. MEDICAL EXAMINER'S FINDING AND ASSESSMENT: (Please answer each question and where appropriate provide particulars. You are asked not to give any information to the person, assessed, about the results)

1. Anthropometry:

Height	185 cm	Weight	64 kg	BMI	
--------	--------	--------	-------	-----	--

2. Vital Parameters:

(i)

Respiratory Rate	22	Pulse Rate	83 bpm
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(ii) Blood Pressure (Three consecutive Readings):

Systolic	130	120	130
Diastolic	80	80	70
Further readings at 10 minute interval if the first reading exceeds 140/90	mmHg	mmHg	mmHg

3. Skin

Is there is any evidence of:

Chronic Ulcer:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	Eczema:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Swelling:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	Varicose Veins:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Skin Discoloration:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	Psoriasis:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

Any Other skin problem and specific location describe: NO

EXAMINATION FINDINGS DETAILS

4. Cardiovascular System: S1 S2 (A)

5. Genito-Urinary System: NA

6. Respiratory System: ACFT clear

7. Gastro-Entrology System:

(a) Oropharyngeal: NA

(b) Abdomen:

Soft
Non tender



Evidence of Hernia, Hydrocele, Fissure, Fistula & piles.

If yes, please describe NA

8. Nervous System:

conscious & oriented

9. Eye Check-up

10. ENT



12. For Female Clients Only:

1. Is there any disease of breast? _____
2. (I) Is there any evidence of pregnancy? _____
(II) If Pregnant, are any complications to be expected? _____
3. Do you suspect any disease of uterus, cervix of ovaries? _____
4. Any menstrual complaints? _____

C. SUMMARY of the examination findings:

Positive Findings if any: (Please Specify)

Advice:

Conclusion on the fitness of the client:

D. DOCTOR'S DECLARATION:

I confirm that I have examined this CLIENT and the findings stated above are true and correct to the best of my knowledge.

1. Name of the Medical Examiner: _____

Signature of the Medical Examiner: DR. ANAND PRAKASH GAUR

MBBS, CD, FRCM
(Consulting Physician)
MMC Reg. No.
2005/02/0965

Stamp of the Medical Examiner

Registration Number _____

Date of medicals conducted: _____

Place: _____

2. Name of the Client: _____

Signature of the Client: _____

NOTE: NAME AND SIGNATURE OF MEDICAL EXAMINER AND THE CLIENT IS MANDATORY ON THIS FORM

R. Vijay

20.02.2024 7.42.21

Location
Room
Order Number
Indication
Medication 1
Medication 2
Medication 3

75 bpm
- / - mmHg

29 Years

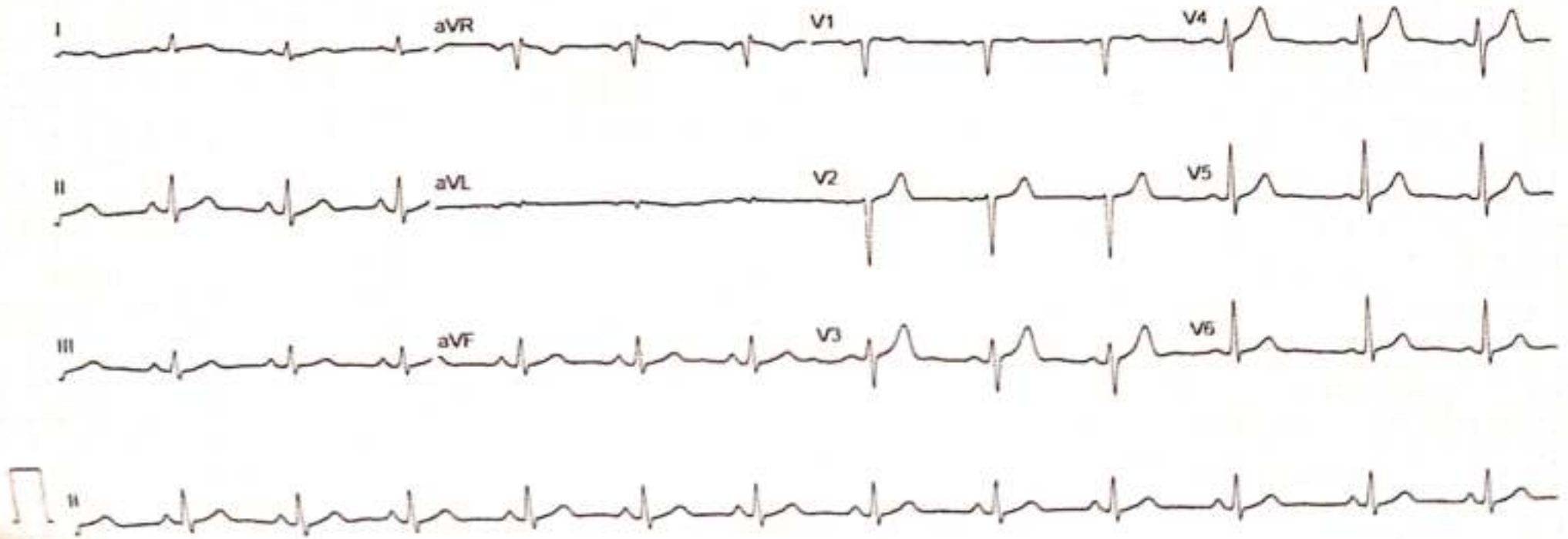
Male

QRS	72 ms
QT / QTcBaz	352 / 393 ms
PR	142 ms
P	92 ms
RR / PP	794 / 800 ms
P / QRS / T	74 / 70 / 72 degrees

Normal sinus rhythm with sinus arrhythmia
Normal ECG

Technician
Ordering Ph
Referring Ph
Attending Ph

DR. ANAND PRAKASH GAUR
 MBBS, CCNH, GDM
 (Consultant Physician)
 MM No. 10
 2005/02/0965



MAC2550 1.1

12SL™ V241

25 mm/s 10 mm/mV

ADS 0.56-20 Hz 60 Hz

Unconfirmed
4x2.5x3_25_R1

1/1

Ophthalmology Case Paper

Reg. No. _____ Date 19/2/2024
Patient Name Mr./Mrs: Vijay R.
Age 29 Sex M Address: _____
Mobile No: 8015416221

Systemic Illness:	<u>NAD</u>
Allergies:	<u>no allergies</u>

	Right Eye	Left Eye
Corrected Vision:	<u>6 N</u>	<u>6 N</u>
Distance:	<u>$\frac{6}{6}$ τ glasses</u>	<u>$\frac{6}{6}$ glasses</u>
Near:	<u>N6</u>	<u>N6</u>

DR. ANAND PRAKASH GAUR
MBBS, CCMH, GCEBDM
(Consultant Ophthalmician)
Doc ID: _____ No. _____
2005/0270965

EXERCISE STRESS TEST REPORT

Patient Name: R. VIJAY
Patient ID: 74049
Height:
Weight:

DOB: 25.04.1994
Age: 29yrs
Gender: Male
Race: Asian

Study Date: 19.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: --
Technician: --

Medications:
--

Medical History:
--

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	00:17	0.00	0.00	118	120/80	
	STANDING	00:08	0.00	0.00	120		
	HYPERV.	00:25	0.50	0.00	125		
EXERCISE	STAGE 1	03:00	1.70	10.00	153		
	STAGE 2	03:00	2.50	12.00	181	130/80	
	STAGE 3	00:18	3.40	14.00	184		
RECOVERY		01:36	0.00	0.00	151	130/80	

The patient exercised according to the BRUCE for 6:17 mins, achieving a work level of Max. METS: 7.40. The resting heart rate of 114 bpm rose to a maximal heart rate of 184 bpm. This value represents 96 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 130/80 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: none.
Overall impression: Normal stress test.

Conclusions

TEST IS NEGATIVE FOR EXERCISE INDUCIBLE MYOCARDIAL ISCHEMIA.

DR KUMAR RAJEEV,

MD DNB CARDIOLOGY, DR. PRAMOD GAUR

MBBS, CC

Consultant

Physician

MMC Regd

2005/02/19/0000

Technician

(Signature)

Serial Patient Name Cardiac No.

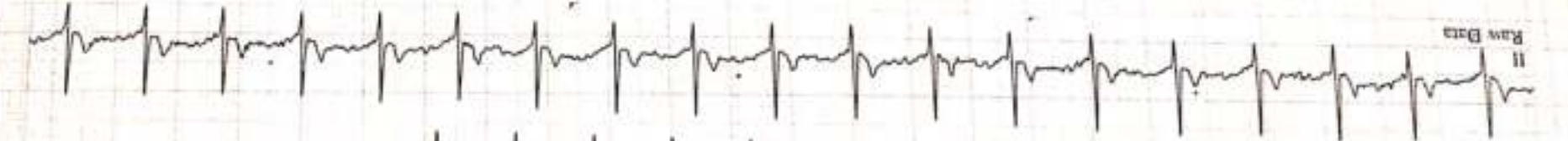
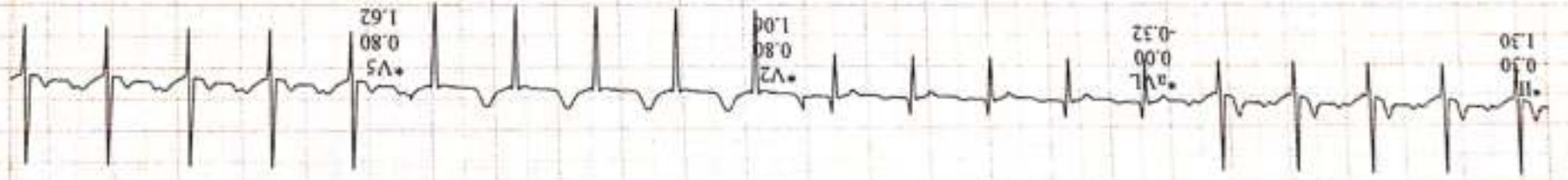
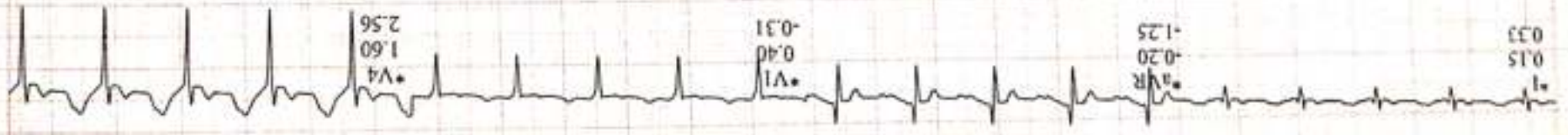
R. VIKAS
Patient ID 74059
19.02.2024
12:04:46pm

115 bpm
120.80 mmHg
PRETEST
SUPINE
00:08
Linked Medians

BRUCE
0.0 mph
0.0 %

-OPCREDEENCE HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)



Cardson V6.73 (2)
10 mm/mV 50Hz 0.01 - 40Hz 5 - HR(V3,V5)
*Computer Synthesized Rhythms
Start of Test: 12:04:35pm

R. VIJAY
Patient ID: 74019
19.02.2024
12:04:54pm

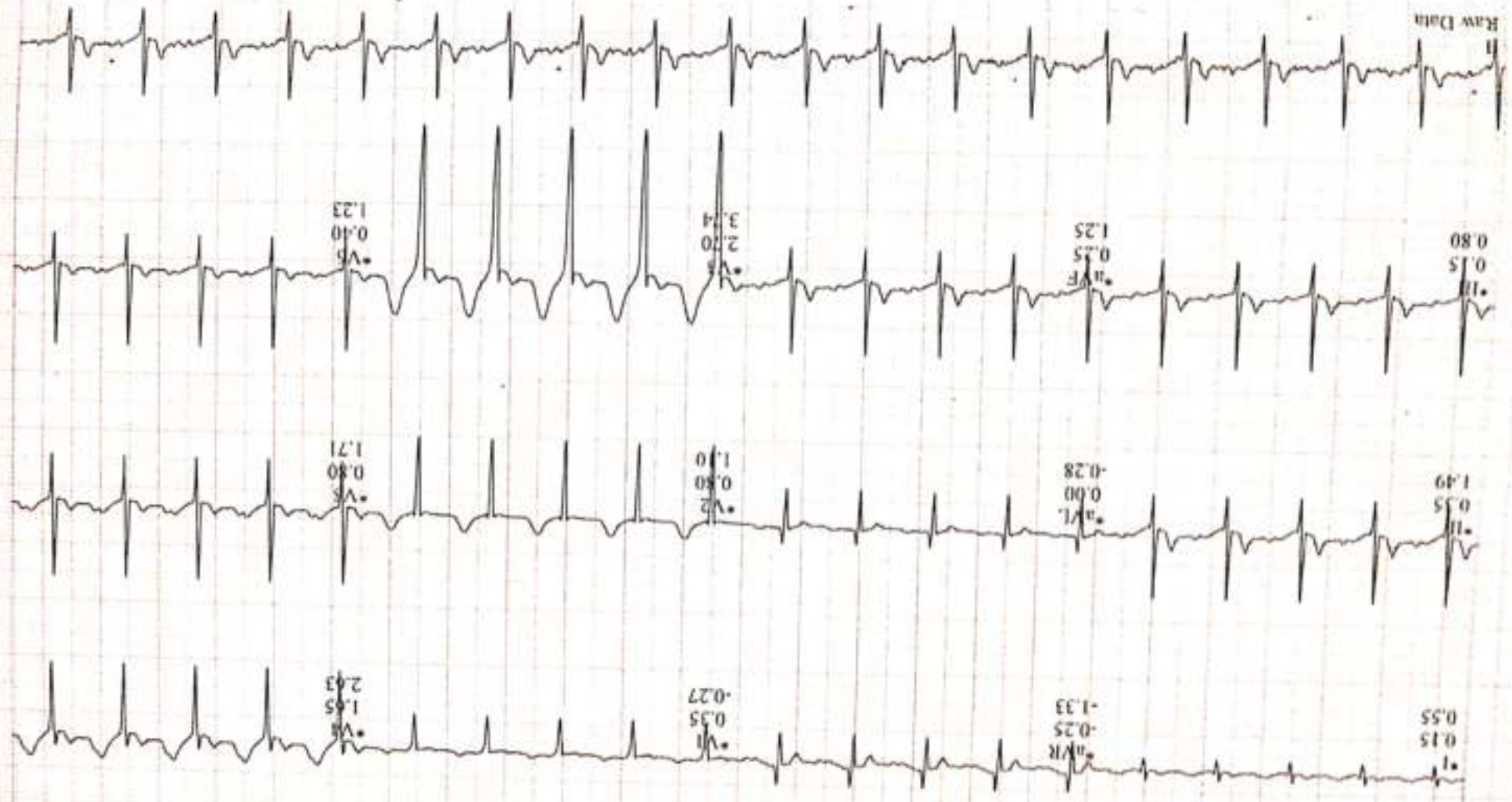
120 bpm
120/80 mmHg

PRETEST
STANDING
00:18

Loaded Medians
BRUCE
10.0 mph
0.0 %

OPCREENCE HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)



*Computer Synthesized Rhythms

Cardiosoft V6.73 (2)
10 mm/mV 50Hz 0.01 - 40Hz S + 1HR(V3,V5)

Start of Test: 12:04:35pm

Page 2

R. VIJAY
Patient ID: 74049
19.02.2024
12:05:02pm

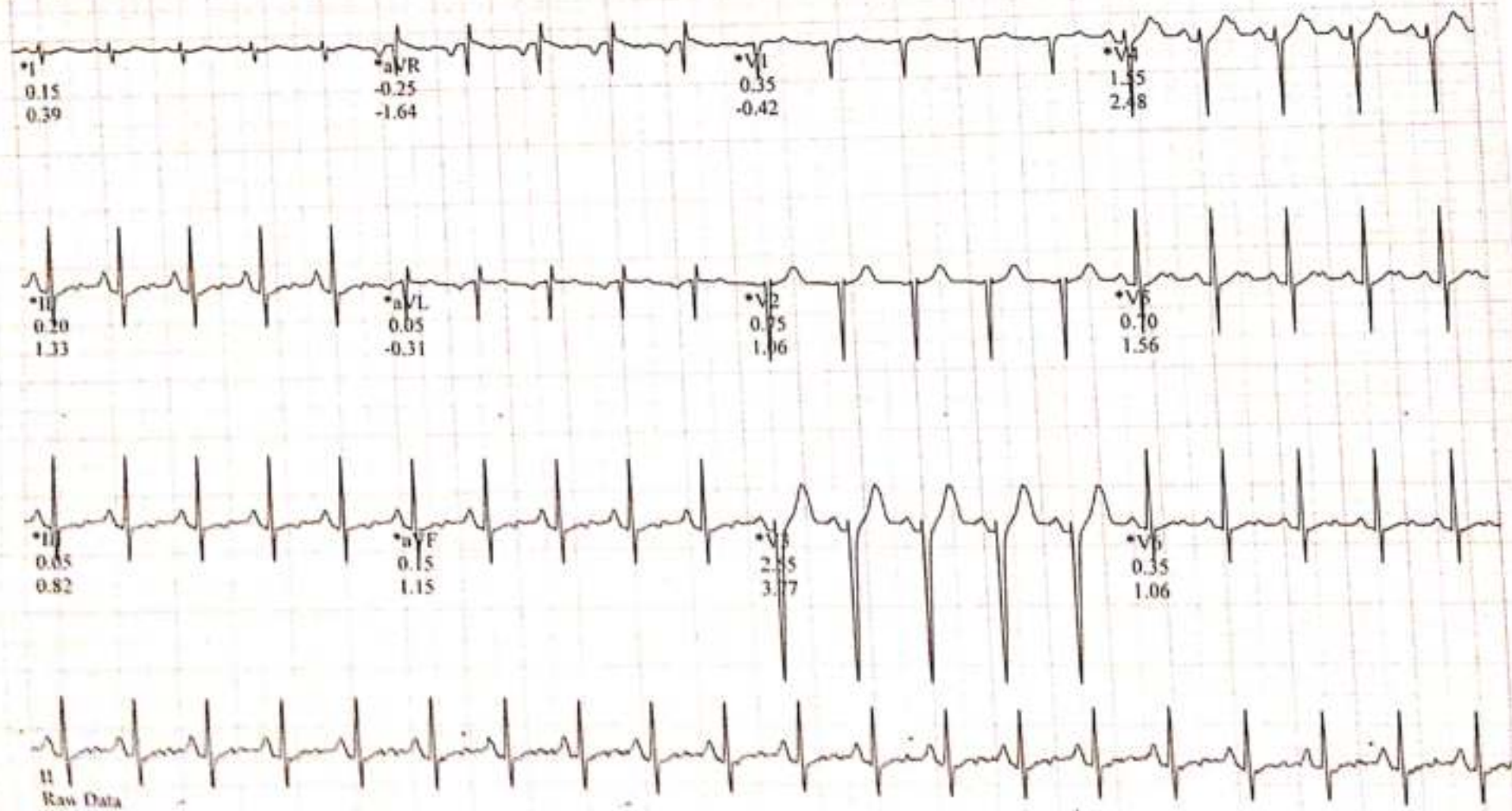
Linked Medians

PRETEST
HYPERV.
00:26

BRUCE
0.0 mph
0.0 %

-0pCREDENCE HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)



Raw Data

*Computer Synthesized Rhythms

MediSoft V6.71 (2)
19 mm/mV 50Hz 0.01-40Hz S+ HR(V3,V5)

Start of Test: 12:04:35pm

Page 1

R. VILAY
Patient ID: 24088
12-02-2024
12:07:11pm

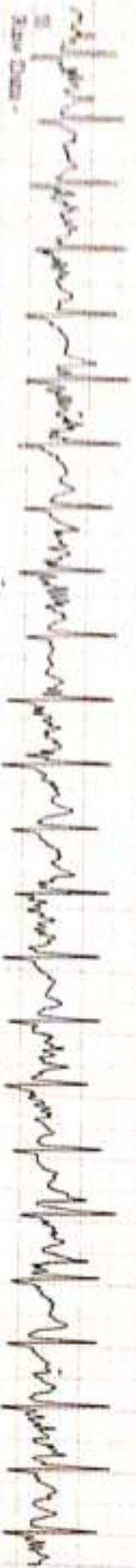
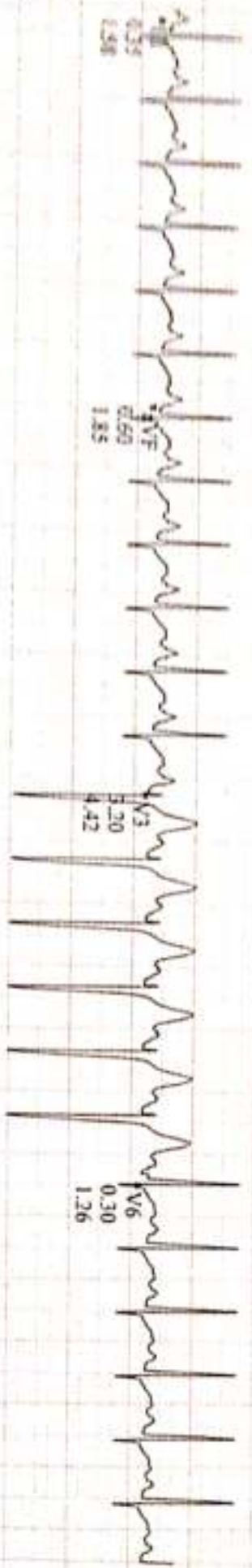
146 bpm

Linked Medians
EXERCISE
STAGE 1
01:47

BRUCE
1.7 mph
10.0 %

-OPCREDDENCE HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

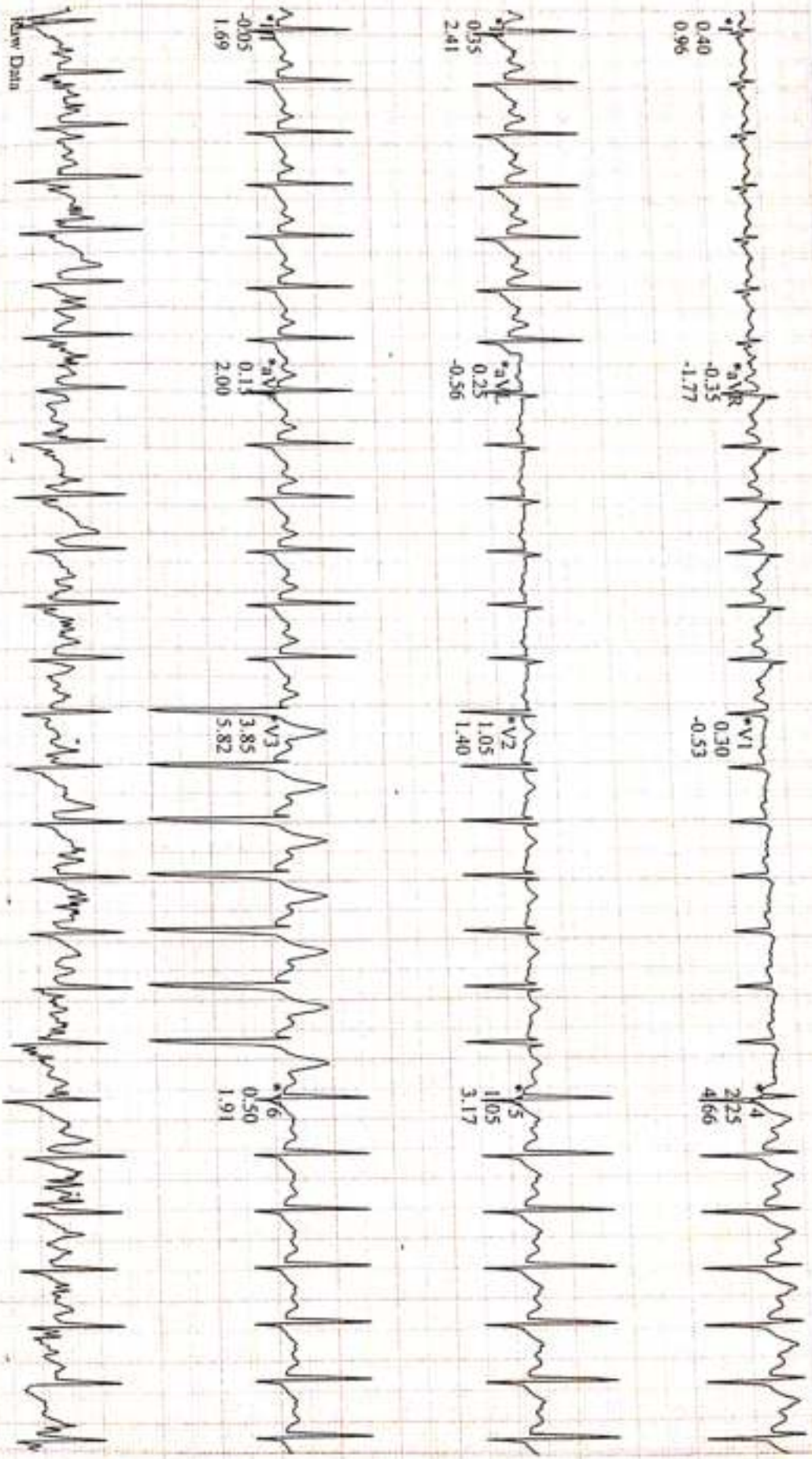


Zero Data

*Computer Synthesized Rhythms

Start of Test: 12:04:35pm

CardiacSoft V6.73 (2)
S 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(V5,V3)



*Computer Synthesized Rhythms

Start of Test: 12:04:35pm

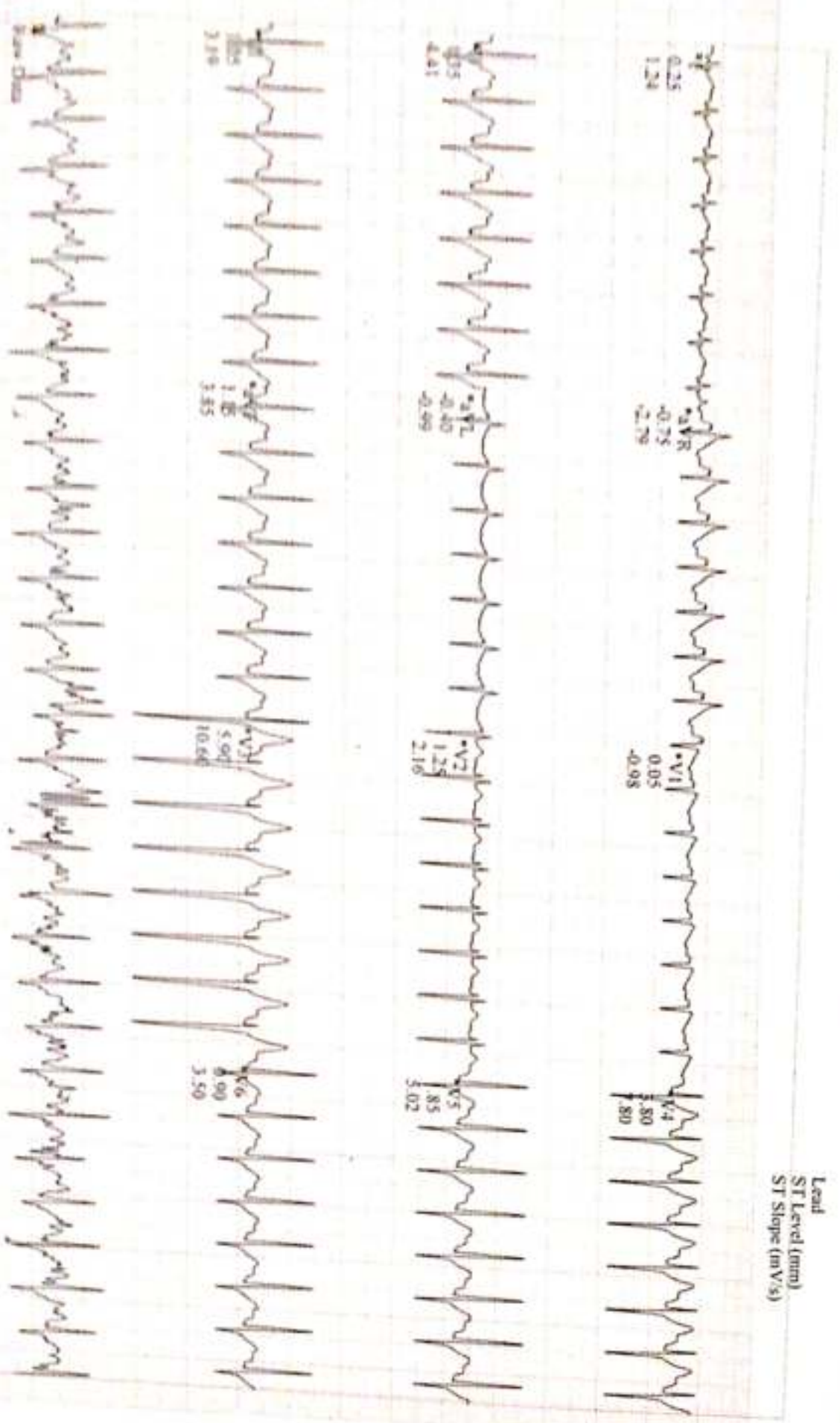
Page 5

R. VIJAY
Patient ID: 24049
19.02.2024
12:11:54pm

Linked Medians
EXERCISE
STAGE 3
06:10

BRUICE
3.4 mph
14.0 %

APCREDDENCE HOSPITAL



Computer Synthesized Rhythms

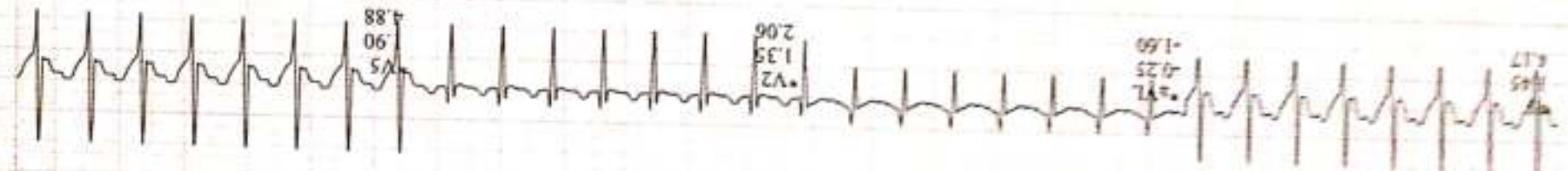
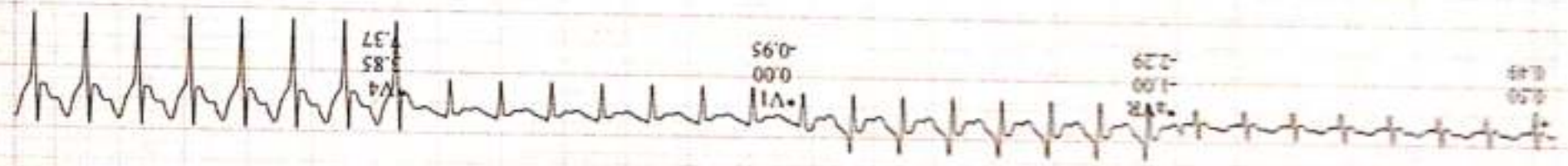
Start of Test: 12:04:35pm

OPCREDESCENCE HOSPITAL

BRUCE EXERCISE STAGE 3 06:18 3.4 mph 14.0 %

12-04-35pm

Lead ST Level (mm) ST Slope (mV/s)

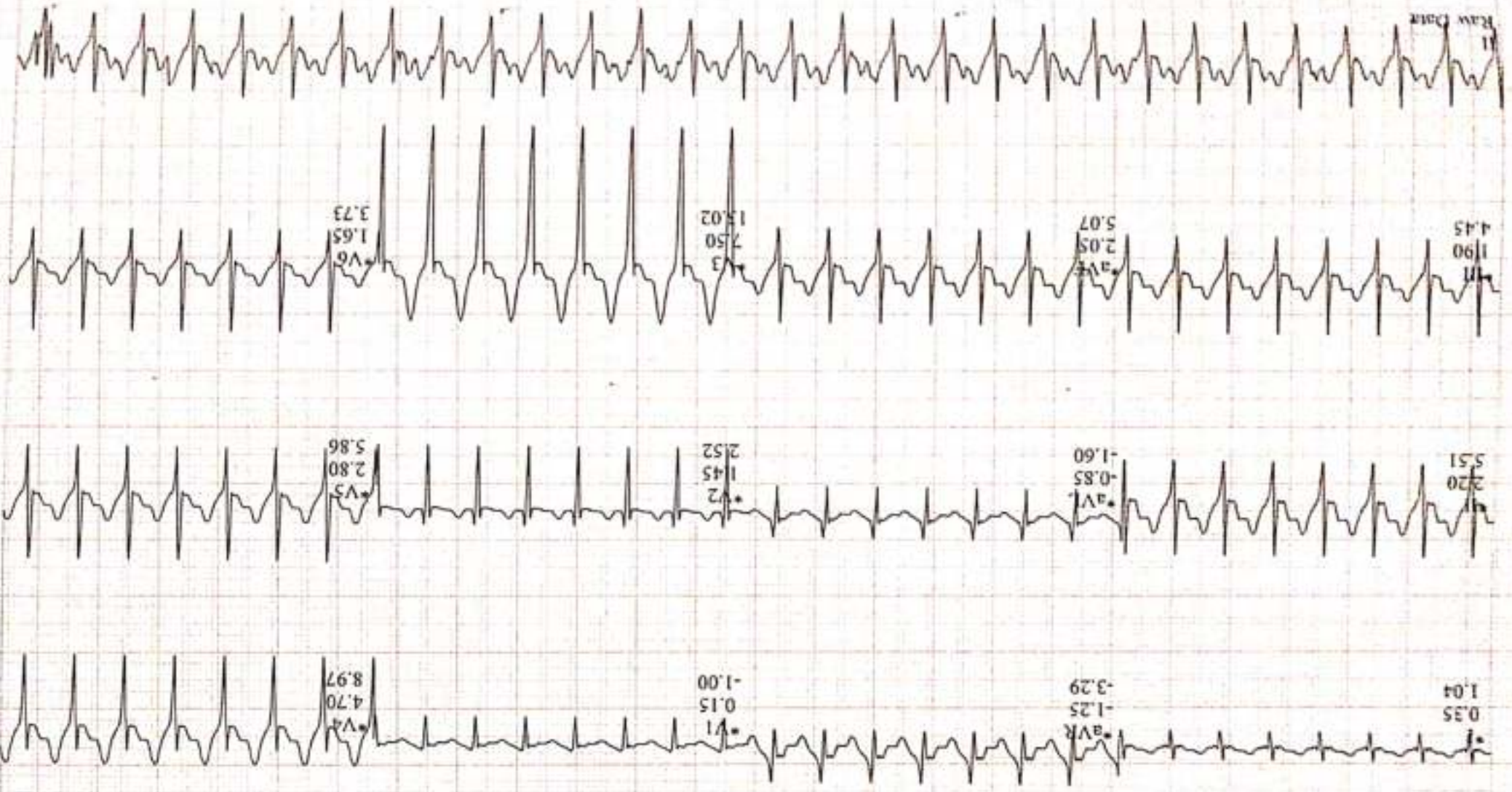


Computer Synthesized Rhythms

Start of Test: 12-04-35pm

12-04-35pm 50Hz 0.01 - 40Hz 5+ HRV5.V3

*Computer Synthesized Rhythms



AMOUNT 12.200g
12/12/2004
12:12:29pm

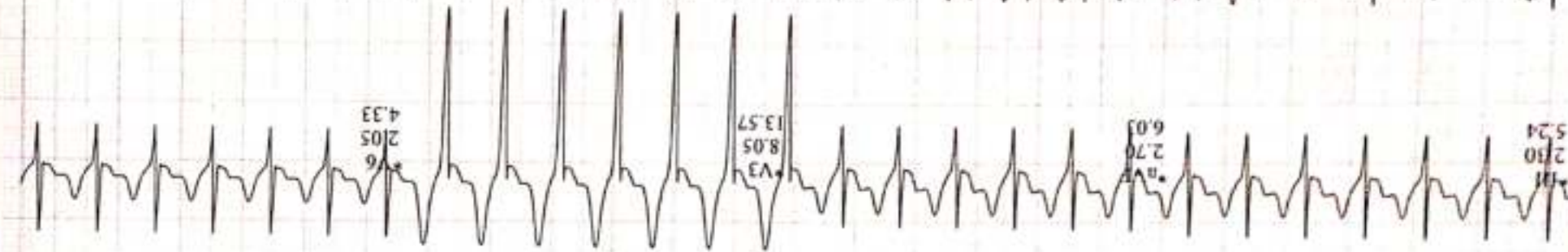
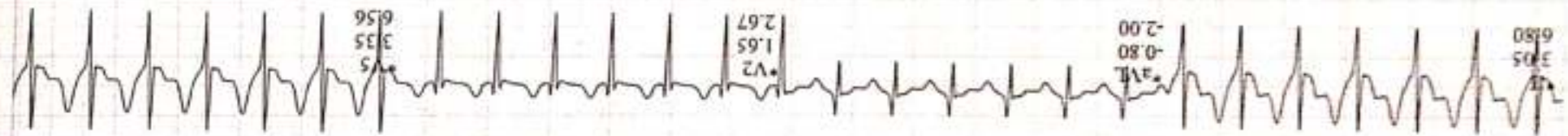
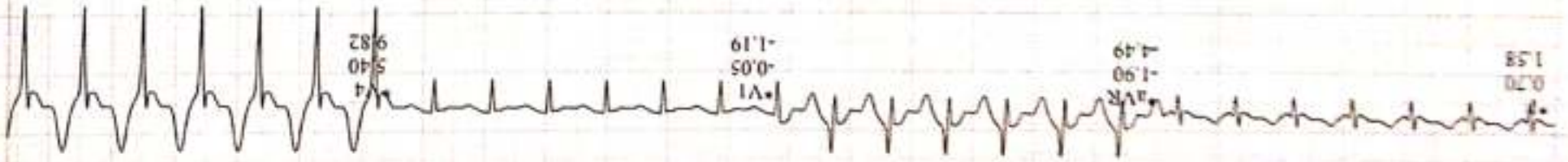
102 bpm
130/80 mmHg

Label Mediums
RECOVERY
#1
01:18

BRUCE
0.0 mph
0.0%

OPCRIDENCE HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)



*Computer Synthesized Rhythms

AD 1000V V6.73 (2) 50Hz 0.01 - 40Hz S+ HR(V5,V3)

Start of Test: 12:04:35pm



Credence
Care Hospital Pvt. Ltd.



RAMAN CT SCAN &
DIAGNOSTIC CENTER

Name: Mr. Vijay R.

Age/Sex: 29Y/Male

Date: 19/02/2024

2 D Echocardiography & color Doppler Study

FINDINGS:

- No left ventricle regional wall motion abnormality.
- No left ventricle diastolic dysfunction.
- No left ventricle wall hypertrophy. No LV dilation.
- Normal left ventricle systolic function. LVEF appr \approx -60%.
- No mitral regurgitation.
- No aortic regurgitation.
- No TR. No pulmonary hypertension.
- Cardiac valves are structurally normal.
- Normal size of cardiac chambers.
- Intact IAS & IVS.
- No LV clot/vegetation/pericardial effusion.
- Normal RV systolic function. No hepatic congestion.

Conclusion:

Normal 2D echo & color Doppler Study.

DR. KUMAR RAJEEV
M.D.(Med),DNB(Cardiology)





Credence
Care Hospital Pvt. Ltd.



RAMAN CT SCAN &
DIAGNOSTIC CENTER

Name: Mr. Vijay R.

Age/Sex: 29Y/Male

Date: 19/02/2024

2D Measurements:

LA	35 mm
AORTIC ROOT	28 mm
EF SLOPE	90 mm/sec
LVIDD	40 mm
LVIDS	29 mm
IVS(D)	09 mm
PW(D)	09 mm
RVID	28 mm
LVEF	60%

Doppler study:

AV max -	1.1 m/sec	E vel	0.9 m/sec
PV max -	0.9 m/sec	A vel	0.7 m/sec
PASP		E/A	1.3





Credence
Care Hospital Pvt. Ltd.



**RAMAN CT SCAN &
DIAGNOSTIC CENTER**

PATIENT'S NAME	MR. VIJAY R	AGE :- 29 y/M
REFERRED BY	CREDENCE CARE HOSPITAL	DATE :19/02/2024

USG WHOLE ABDOMEN

LIVER is normal in size, normal in 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.

Urinary Bladder is minimally distended; no e/o wall thickening or mass or calculi seen.

PROSTATE is normal in size, shape and echotexture.

Visualised 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 CORRELATION BEFORE ANY APPLICATION.

DR SAGAR GARGE
CONSULTANT RADIOLOGIST

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/  511

Reporting Date : 19/02/2024 05:47 PM

Complete Blood Count (CBC)

Test Description	Value(s)	Unit	Reference Range
Hemoglobin	15.0	gms/dl	13 - 16
RBC Count	4.69	mil./cmm	4.5 - 6.5
Haematocrit (HCT)	45.6	%	40 - 54
RBC Indices			
MCV	97.23	fL	80 - 100
MCH	31.98	pg	27 - 34
MCHC	32.89	gm/dl	32 - 36
RDW-CV	13.0	%	11 - 16
Total WBC Count	9100	/uL	4000 - 10000
DIFFERENTIAL COUNT			
Neutrophil	61	%	40 - 70
Lymphocytes	35	%	20 - 40
Eosinophil	02	%	1 - 6
Monocytes	02	%	2 - 8
Basophils	00	%	0 - 1
Platelet Indices			
Platelet Count	233000	/cmm.	150000 - 450000
RBC Morphology	Normocytic Normochromic		
WBC Morphology	Within Normal Limits		
Platelet	Adequate on smear		

Done on fully Automated cell counter-ERBA H360



Checked By

Authenticity Check

Dr. Harshal Thorat

MD (Path)


Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/ 
511

Reporting Date : 19/02/2024 05:47 PM

ESR (ERYTHROCYTE SEDIMENTATION RATE)

Test Description	Value(s)	Unit	Reference Range
Erythrocyte Sedimentation Rate Wintrobe method	09	mm/hr	< 15

Interpretation: It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

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Authenticity Check

Dr. Harshal Thorat

MD (Path)


Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/ 
511

Reporting Date : 19/02/2024 05:47 PM

BLOOD GROUP (BG)

Test Description	Value(s)	Unit	Reference Range
------------------	----------	------	-----------------

Sample Type : WHOLE BLOOD EDTA

Blood Group : A Rh Positive

METHOD : Monoclonal blood grouping (Agglutination test) by slide method

KIT : Span diagnostics.

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Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/ 
511

Reporting Date : 19/02/2024 05:47 PM

BLOOD GLUCOSE LEVEL (FASTING & POST PRANDIAL)

Test Description	Value(s)	Unit	Reference Range
Glucose Fasting (Plasma)	90.0	mg/dl	70 - 110
Glucose PP (Plasma)	101.0	mg/dl	90 - 150

Interpretation : Fasting Blood Sugar more than 126 mg/dl on more than one occasion can indicate Diabetes Mellitus.

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Authenticity Check



Dr. Harshal Thorat

MD (Path)


Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/ 
511


Reporting Date : 19/02/2024 05:47 PM

LIPID PROFILE

Test Description	Value(s)	Unit	Reference Range
Total Cholesterol	151.0	mg/dl	Low < 125 Desirable : < 200 Borderline High : 201 - 240 High : > 240
Triglycerides	141.0	mg/dl	Low < 25 Normal : < 150 Borderline High : 151 - 199 High : > 200
HDL Cholesterol	42.0	mg/dl	<35 Low >80 High
Non HDL Cholesterol	109.00	mg/dl	Desirable : < 130 Boderline high : 130 - 159 High : > 160
LDL Cholesterol	80.80	mg/dl	Low < 85 Optimal : <100 Near/Above Optimal : 101 - 129 Borderline High : 130 - 159 High : >160
VLDL Cholesterol	28.20	mg/dl	Below 40
TOTAL CHOL/HDL Ratio	3.60	-	Desirable/Low Risk : 3.3 - 4.4 Borderline/Middle Risk : 4.5 - 7.1 Elevated/High Risk : 7.2 - 11.0
LDL/HDL Ratio	1.92	-	Desirable/Low Risk : 0.5 - 3.0 Borderline/Middle Risk : 3.1 - 6.0 Elevated/High Risk : >6.1
Appearance of Serum	Clear		

Checked By





Dr. Harshal Thorat
MD (Path)
Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/  511

Reporting Date : 19/02/2024 05:47 PM

LIVER FUNCTION TEST (LFT)

Test Description	Value(s)	Unit	Reference Range
Bilirubin Total	0.84	mg/dL	0.3 - 1.5
Bilirubin Direct	0.31	mg/dL	0.0 - 0.5
Bilirubin Indirect	0.53	mg/dL	0.2 - 0.9
SGOT (AST)	23.0	U/L	0 - 45
SGPT (ALT)	29.0	U/L	0 - 45
Alkaline Phosphatase	174.0	U/L	80 - 306
Protein Total	6.9	g/dL	6 - 8
Albumin	3.8	g/dL	3.2 - 5.0
Globulin	3.1	g/dL	2.5 - 3.3
A/G Ratio	1.23	-	1.0 - 2.1

Checked By



Authenticity Check

Dr. Harshal Thorat

MD (Path)

Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/  511

Reporting Date : 19/02/2024 05:47 PM

GAMMA GT

Test Description	Value(s)	Unit	Reference Range
Gamma Glutaryl Trans Peptidase	25.0	U/L	5 - 40

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Authenticity Check

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MD (Path)


Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/  511

Reporting Date : 19/02/2024 05:47 PM

BLOOD UREA NITROGEN

Test Description	Value(s)	Unit	Reference Range
BUN* Serum,Calculated	9.0	mg/dL	7 - 18.0

Checked By



Authenticity Check

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MD (Path)


Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/  511

Reporting Date : 19/02/2024 05:47 PM

CREATININE

Test Description	Value(s)	Unit	Reference Range
CREATININE Jaffe IDMS	0.8	mg/dl	0.7 - 1.4

Checked By



Authenticity Check

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MD (Path)

Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/  511

Reporting Date : 19/02/2024 05:47 PM

URIC ACID

Test Description	Value(s)	Unit	Reference Range
Uric Acid	5.62	mg/dl	3.5 - 7.2

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Authenticity Check

Dr. Harshal Thorat

MD (Path)


Reg No. 2014/10/4438

Patient Name : MR. VIJAY R

Age / Gender : 29 Years / Male

Referral Doctor: CREDENCE CARE HOSPITAL

Collection Date : 19/02/2024 11:25 AM

Pt.Type / ID : OPD/  511

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GLYCOSYLATED HAEMOGLOBIN (GHB / HBA1c)

Test Description	Value(s)	Unit	Reference Range
HbA1c H.P.L.C	5.4	%	Below 6.0% - Normal Value 6.0% - 7.0% - Good Control 7.0% - 8.0% - Fair Control 8.0% - 10% - Unsatisfactory Control Above 10% - Poor Control

Interpretation: Glycosylated Haemoglobin is accurate and true index of the * Mean Blood Glucose Level in the body for the previous 2-3 months. HbA1c is an indicator of glycemic control. HbA1c represent average glycemia over the past six to eight weeks. Glycation of hemoglobin occurs the entire 120 days life span of the red blood cell, but with in this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months 2-4.

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THYROID FUNCTION TEST (TFT)

Test Description	Value(s)	Unit	Reference Range
TOTAL TRIIODOTHYRONINE (T3) Competitive Chemi Luminescent Immuno Assay	142.3	ng/dl	60 - 181
TOTAL THYROXINE (T4) Competitive Chemi Luminescent Immuno Assay	6.53	µg/dL	4.5 - 12.6
THYROID STIMULATING HORMONE (TSH) SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY	1.99	uIU/mL	0.3 - 5.5

SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY

Reference range for < 18 years

TEST	1 - 3 D	4 - 30 D	31 - 60 D	61 D - 12 M	1 - 5 Y	6 - 10 Y	11 - 14 Y	15 - 18 Y
TSH	0.1-9.2	0.2-8.5	0.2-7.8	0.30-5.9	0.4-4.8	0.5-4.7	0.5-4.6	0.6-4.5
T3	41.7-272.1	48.2-272.1	54.7-272.1	76.8-272.1	89.2-246.7	87.2-218.1	86.6-199.8	85.3-188.8
T4	4.9-15.8	5-15.3	5.2-14.8	5.7-13.3	5.7-11.7	5.4-10.7	5.2-10	5.1-9.6
FT3	1.5-5.3	1.6-5.2	1.6-5.1	1.8-4.8	2-4.5	2.1-4.4	2.3-4.4	2.3-4.3
FT4	0.84-2.08	0.85-1.98	0.85-1.89	0.89-1.62	0.89-1.48	0.85-1.46	0.84-1.45	0.84-1.45

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URINE ROUTINE REPORT

Test Description	Value(s)	Unit	Reference Range
Physical Examination			
Quantity	10	ml	-
Colour	Pale Yellow		Pale yellow/Yellow
Appearance	Slightly Hazy		Clear
Specific Gravity	1.020		1.005-1.030
pH	Acidic		Acidic
Deposit	Absent		Absent
Chemical Examination			
Protein	Absent		Absent
Sugar	Absent		Absent
Ketones	Absent		Absent
Bile Salt	Absent		Absent
Bile Pigment	Absent		Absent
Urobilinogen	Normal		Normal
Microscopic Examination (/hpf)			
Pus Cell	Occasional		Upto 5
Epithelial Cells	1-2		Upto 5
Red Blood Cells	Absent		Absent
Casts	Absent		Absent
Crystals	Absent		Absent
Bacteria	Absent		Absent

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STOOL ANALYSIS REPORT

Test Description	Value(s)	Unit	Reference Range
Physical Examination			
Colour	Brown		Brown
Mucus	Absent		Absent
Frank Blood	Absent		Absent
Consistency	Semi solid		Semi solid
Parasite	Absent		Absent
Reaction	Acidic		Acidic
Occult Blood	Negative		Negative
Microscopic Examination (/hpf)			
Ova of Parasites	Absent		Absent
RBC	Absent		Absent
Pus cells	2-3		Absent
Macrophages	Absent		Absent
Fat Globules	Absent		Absent
Veg. Matter	Absent		Absent
Vegetative Forms	Absent		Absent
Cysts	Absent		Absent
Epithelial cells	2-4		Absent

END OF REPORT

Checked By




Dr. Harshal Thorat
MD (Path)
Reg No. 2014/10/4438



Patient Name : VIKAY R

Patient ID:4781

Age /Gender : 29 yrs/MALE

Date : 20/02/2024

X-RAY CHEST PA

Plain P.A. Radiograph of chest shows :-

The hilar shadows are normal in size, position and density.

Both Cardiophrenic and Costophrenic angles are clear.

The Cardiac silhouette is within normal limits.

Aortic shadow is normal.

Rest of the visualized mediastinum shadows are normal.

Both domes of diaphragms are normal.

The visualised bony thorax is normal.

CONCLUSION :

NO SIGNIFICANT ABNORMALITY DETECTED

DR. Nikunj Kothia

MBBS, DMRD Reg-2009093218

