

Patient Name : Mrs. Nazrana Khan
Age / Gender : 29 Y / Female
Referred By : Dr. Ashwini Bansode
SID No. : 03012051

Reg.Date / Time : 30/03/2023 / 10:45:29
Report Date / Time : 30/03/2023 / 18:27:08
MR No. : 0195399

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Final Test Report

Specimen	Test Name / Method	Result	Units	Biological Reference Interval
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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

HAEMOGLOBIN, RED CELL COUNT & INDICES

HAEMOGLOBIN (Spectrophotometry)	8.9	gm%	12.0-15.0	
PCV (Electrical Impedance)	30.0	%	40 - 50	
MCV (Calculated)	63.2	fL	83-101	
MCH (Calculated)	18.7	pg	27.0 - 32.0	
MCHC (Calculated)	29.7	g/dl	31.5-34.5	
RDW-CV (Calculated)	18	%	11.6-14.0	
RDW-SD (Calculated)	43	fL	36 - 46	
TOTAL RBC COUNT (Electrical Impedance)	4.74	Million/cmm	3.8-4.8	
TOTAL WBC COUNT (Electrical Impedance)	5380	/cumm	4000-10000	
DIFFERENTIAL WBC COUNT				
NEUTROPHILS (Flow cell)	44.3	%	40-80	
LYMPHOCYTES (Flow cell)	44.3	%	20-40	
EOSINOPHILS (Flow cell)	2.1	%	1-6	
MONOCYTES (Flow cell)	7.9	%	2-10	
BASOPHILS (Flow cell)	1.4	%	1-2	
ABSOLUTE WBC COUNT				
ABSOLUTE NEUTROPHIL COUNT (Calculated)	2380	/cumm	2000-7000	
ABSOLUTE LYMPHOCYTE COUNT (Calculated)	2380	/cumm	1000-3000	

Contd ...

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HAEMATOLOGY

ABSOLUTE WBC COUNT

ABSOLUTE EOSINOPHIL COUNT (Calculated)	110	/cumm	200-500
ABSOLUTE MONOCYTE COUNT (Calculated)	420	/cumm	200-1000
ABSOLUTE BASOPHIL COUNT (Calculated)	80	/cumm	0-220
PLATELET COUNT (Electrical Impedance)	378000	/cumm	150000-410000
MPV (Calculated)	10.4	fL	6.78-13.46
PDW (Calculated)	16.6	%	11-18
PCT (Calculated)	0.390	%	0.15-0.50

PERIPHERAL BLOOD SMEAR

COMMENTS
(Microscopic) Hypochromic (+++) Microcytic (+++) Anisocytosis (++)

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Dr.Rahul Jain

MD,PATHOLOGY

Consultant Pathologist

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HAEMATOLOGY

EDTA Blood **ABO BLOOD GROUP***

BLOOD GROUP (Erythrocyte-Magnetized Technology)	O
Rh TYPE (Erythrocyte-Magnetized Technology)	POSITIVE

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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	46	mm / 1 hr	0-20
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Notes : The given result is measured at the end of first hour.

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BIOCHEMISTRY

**COMPREHENSIVE LIVER PROFILE
SERUM**

BILIRUBIN TOTAL (Diazotization)	0.65	mg/dl	0.2 - 1.3
BILIRUBIN DIRECT (Diazotization)	0.15	mg/dl	0.1-0.4
BILIRUBIN INDIRECT (Calculation)	0.5	mg/dl	0.2 - 0.7
ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	22	U/L	<40
ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	16	U/L	<41
ALKALINE PHOSPHATASE (Colorimetric IFCC)	72	U/L	35-104
GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	18	U/L	<40
TOTAL PROTEIN (Colorimetric)	6.70	gm/dl	6.6-8.7
ALBUMIN (Bromocresol Green)	4.70	gm/dl	3.5 - 5.2
GLOBULIN (Calculation)	2.00	gm/dl	2.0-3.5
A/G RATIO (Calculation)	2.3		1-2

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BIOCHEMISTRY

COMPREHENSIVE RENAL PROFILE

SERUM

CREATININE (Jaffe Method)	0.6	mg/dl	0.5 - 1.1
BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	8.5	mg/dl	7-17
BUN/CREATININE RATIO (Calculation)	14.2		10 - 20
URIC ACID (Uricase Enzyme)	4.6	mg/dl	2.5 - 6.2
CALCIUM (Bapta Method)	9.8	mg/dl	8.6-10
PHOSPHORUS (Phosphomolybdate)	3.9	mg/dl	2.5-4.5

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BIOCHEMISTRY

LIPID PROFILE

SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	140	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239
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Notes : Elevated concentrations of free fatty acids and denatured proteins may cause falsely elevated HDL cholesterol results.

Abnormal liver function affects lipid metabolism; consequently, HDL and LDL results are of limited diagnostic value. In some patients with abnormal liver function, the HDL cholesterol result may significantly differ from the DCM (designated comparison method) result due to the presence of lipoproteins with abnormal lipid distribution.

Reference: Dati F, Metzmann E. Proteins Laboratory Testing and Clinical Use, Verlag: DiaSys; 1. Auflage (September 2005), page 242-243; ISBN-10: 3000171665.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	81	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499
SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	36	mg/dl	Low:<40 High:>60
SERUM	LDL CHOLESTEROL (Calculation)	88	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	16	mg/dl	15-40
SERUM	CHOL / HDL RATIO	3.9		3-5
SERUM	LDL /HDL RATIO (Calculation)	2.0		0 - 3.5

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BIOCHEMISTRY

FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	106	mg/dl	70 - 110
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Notes : An early-morning increase in blood sugar (glucose) which occurs to some extent in all individuals, more relevant to people with diabetes can be seen (The dawn phenomenon) . Chronic Somogyi rebound is another explanation of phenomena of elevated blood sugars in the morning. Also called the Somogyi effect and posthypoglycemic hyperglycemia, it is a rebounding high blood sugar that is a response to low blood sugar.

References:

<http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BarbaraDavis/Documents/book-understandingdiabetes/ud06.pdf>, Understanding Diabetes.

FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	134	mg/dl	70 - 140
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EDTA WHOLE BLOOD GLYCOSYLATED HAEMOGLOBIN (HbA1C)

HbA1C (High Performance Liquid Chromatography)	6.0	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	125	mg/dl	

Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations. HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

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BIOCHEMISTRY

SERUM	IRON (Colorimetry assay based on Ferro Zine)	20	µgm/dL	20-162
Urine	URINE GLUCOSE FASTING (Urodip)	ABSENT		
Urine	URINE GLUCOSE POST PRANDIAL (Urodip)	ABSENT		

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IMMUNOLOGY

THYROID PROFILE - TOTAL SERUM

TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.24	ng/ml	0.7-2.04
TOTAL THYROXINE (T4) (ECLIA)	9.24	ug/dl	5.5 - 11
THYROID STIMULATING HORMONE (TSH) (ECLIA)	3.310	uIU/ml	0.27 - 4.20

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IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level. The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)

- Low TSH, Low FT4 - Central hypothyroidism.
- Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
- Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter, Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
- Normal TSH, Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism, Medications.
- Normal TSH, High FT4- Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbuminemic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
- High TSH, Low FT4- Primary hypothyroidism.
- High TSH, Normal FT4- Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
- High TSH, High FT4- TSH mediated hyperthyroidism

Note:

1. Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2. Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3. Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:

1. Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2. "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3. Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4. Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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IMMUNOLOGY

SERUM	FOLIC ACID (ECLIA)	12.12	ng/ml	9.5 - 39.9
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IMMUNOLOGY

SERUM	VITAMIN B12 (ECLIA)	366	pg/ml	200 - 771
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Notes : Vitamin B12 also called Cobalamin, is a water-soluble vitamin which is synthesized by microorganisms. It cannot be synthesized in the human body and is seldom found in products of plant origin. Main sources of vitamin B12 are meat, fish, eggs and dairy products. The uptake in the gastrointestinal tract depends on intrinsic factor, which is synthesized by the gastric parietal cells, and in the distal ileum. The most frequent cause of severe vitamin B12 deficiency is a lack of intrinsic factor due to autoimmune atrophic gastritis. The disease is historically called "pernicious anemia", even though many patients present with mainly neurologic manifestations. Examples of other causes for vitamin B12 deficiency are malabsorption due to gastrectomy, inflammatory bowel disease or dietary deficiency, e.g. in strict vegetarians (vegans). (1)
Vitamin B12 deficiency impacts red blood cell synthesis, resulting in megaloblastic anemia due to abnormal DNA synthesis.³ In addition it impairs neurological function, in particular demyelination of nerves in part due to abnormal methylation, leading to peripheral neuropathy, dementia, poor cognitive performance, and depression.³ Other effects of vitamin B12 deficiency or depletion are increased risk of neural tube defects, osteoporosis, cerebrovascular and cardiovascular diseases. (1)
Cobalamin has extremely low toxicity, and doses as large as 3 mg/day are tolerated without toxic effect. (2)

References:

1. Pim-eservices.roche.com. (2018). Roche Diagnostics Customer Self-Service Technical Documentation Portal.
2. Expertconsult.inkling.com. (2018). Expert Consult. Expertconsult.inkling.com. (2018). Expert Consult. Henrys Clinical Diagnosis & Management By Laboratory Methods Mcpherson Pincus -22

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CLINICAL PATHOLOGY

STOOL STOOL ROUTINE EXAMINATION

PHYSICAL EXAMINATION

COLOUR (Visual Examination)	Brown		
CONSISTENCY (Visual Examination)	Semi solid		
MUCUS (Visual Examination)	Absent		
FRANK BLOOD (Visual Examination)	Absent		
ADULT WORM (Microscopy)	Absent		

CHEMICAL EXAMINATION

REACTION (Ph Paper)	Acidic		
BILIRUBIN	Absent		
OCCULT BLOOD (Peroxidase activity)	Absent		

MICROSCOPIC EXAMINATION

PROTOZOA (Microscopy)	Absent		
CYST (Microscopy)	Absent		
OVA (Microscopy)	Absent		
MACROPHAGES (Microscopy)	Absent		
PUS CELLS (Microscopy)	2-3	/hpf	
RED BLOOD CELLS (Microscopy)	Absent	/hpf	
FAT GLOBULES (Microscopy)	Absent		
UNDIGESTED MATERIAL (Microscopy)	Absent		
ANY OTHER FINDINGS	Nil		

Urine URINE ANALYSIS

PHYSICAL EXAMINATION

VOLUME (Volumetric)	30		
COLOR (Visual Examination)	PALE YELLOW		

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CLINICAL PATHOLOGY

Urine URINE ANALYSIS

APPEARANCE CLEAR
(Visual Examination)

CHEMICAL EXAMINATION

SP.GRAVITY 1.010 1.005 - 1.030
(Indicator System)

REACTION(pH) ACIDIC
(Double indicator)

PROTEIN ABSENT
(Protein-error-of-Indicators)

GLUCOSE ABSENT Absent
(GOD-POD)

KETONES ABSENT Absent
(Legal's Test)

OCCULT BLOOD ABSENT Absent
(Peroxidase activity)

BILIRUBIN ABSENT Absent
(Fouchets Test)

UROBILINOGEN NORMAL
(Ehrlich Reaction)

NITRITE ABSENT
(Griess Test)

MICROSCOPIC EXAMINATION

ERYTHROCYTES ABSENT /hpf 0-2
(Microscopy)

PUS CELLS 1-2 /hpf 0-5
(Microscopy)

EPITHELIAL CELLS 2-3 /hpf 0-5
(Microscopy)

CASTS ABSENT

CRYSTALS ABSENT

ANY OTHER FINDINGS NIL

End of the Report

The results given above are end product of controlled technical analysis of the sample submitted. Interpretation with clinical correlation should be done by doctors using these results.

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HEALTHSPRING

TREADMILL STRESS TEST REPORT

DATE: 30/03/2023

NAME:	NAZRANA KHAN	AGE:(years)	29	SEX:	F
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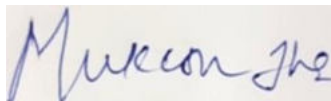
PROTOCOL USED	BRUCE PROTOCOL		
ANGINA SCALE (0 – None, 1 – Non-Limiting, 2 – Limiting)	0	MAXIMUM ST DEPRESSION (mm)	0
WORKLOAD: MAXIMUM METS ACHIEVED (METS)	7	DOUBLE PRODUCT	26550 mm Hg/Min
DUKES SCORE (High Risk Score \leq -11, Low Risk Score \geq 5)	5		

CONCLUSION:

NORMAL INOTROPIC & CHRONOTROPIC RESPONSE
BASELINE ECG SHOWS NO SIGNIFICANT ST-T CHANGES
NO SYMPTOMS SEEN DURING EXERCISE & RECOVERY
NO SIGNIFICANT ST-T CHANGES SEEN DURING EXERCISE & RECOVERY
AVERAGE EFFORT TOLERANCE AND FUNCTIONAL CAPACITY.
TARGET HEART RATE ACHIEVED
STRESS TEST IS **NEGATIVE** FOR INDUCIBLE ISCHEMIA AT GIVEN WORKLOAD

IMPRESSION:

STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA AT GIVEN WORKLOAD
ADVISED- CLINICAL CORRELATION



DR. MUKESH JHA
MD (MEDICINE), DM (CARDIOLOGY)
REG NO- 2010/09/2935

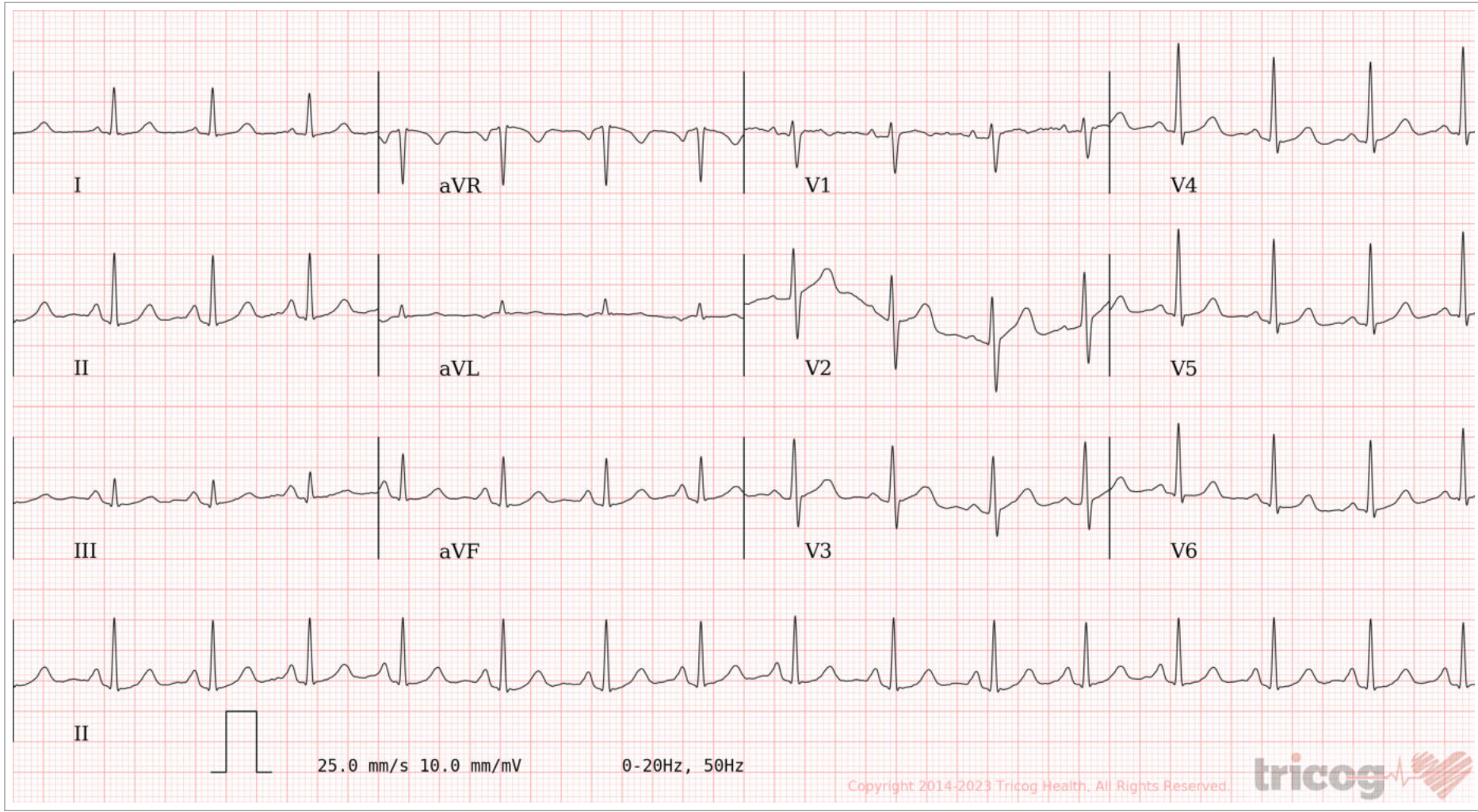
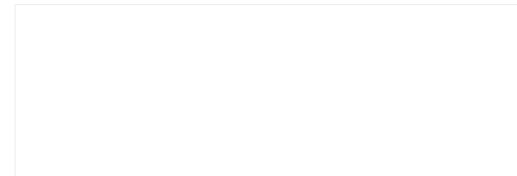
NOTE-

A NEGATIVE STRESS TEST DOES NOT CONCLUSIVELY RULE OUT CORONARY ARTERY DISEASE. A POSITIVE STRESS TEST IS NOT CONCLUSIVE EVIDENCE OF CORONARY ARTERY DISEASE. THERE IS A POSSIBILITY OF THE TEST BEING FALSE POSITIVE OR FALSE NEGATIVE DUE OTHER ASSOCIATED MEDICAL CONDITIONS. THESE REPORTS ARE FOR DOCTORS & PHYSICIANS AND NOT FOR MEDICO-LEGAL PURPOSES. KINDLY CO-RELATE THE REPORT WITH CLINICAL CONDITIONS.

THIS TMT/ ECG IS REPORTED ONLINE WITHOUT INTERACTING WITH PATIENTS AND THE RESULT SHOULD BE CLINICALLY CO-RELATED AND INDEPENDENTLY REVIEWED BY THE PATIENT'S CONSULTANT DOCTOR. THE PATIENT WAS NOT SEEN BY DOCTORS PERSONALLY AND THE ABOVE REPORT HAS BEEN REVIEWED BY THE DOCTOR BASED ON THE TMT/ECG RESULT AS PROVIDED TO THE DOCTOR.

Age / Gender: 29/Female
Patient ID: 0195399
Patient Name: Nazrana Khan

Date and Time: 30th Mar 23 11:04 AM



AR: NA VR: 94bpm QRSD: 84ms QT: 338ms QTc: 422ms PRI: 134ms P-R-T: 73° NA 58°

ECG Within Normal Limits: Sinus Rhythm. Please correlate clinically.

AUTHORIZED BY



Dr. Charit
MD, DM: Cardiology

63382

REPORTED BY



Dr. Bharati R

72470

SHIPL Hospital

Patient Details**Date:** 30-Mar-23**Time:** 11:15:50 AM**Name:** NAZRANA KHAN ID: 76**Age:** 29 y**Sex:** F**Height:** 151 cms.**Weight:** 59 Kg.

Interpretation

The patient exercised according to the Bruce protocol for 5 m 6 s achieving a work level of Max. METS : 7.00. Resting heart rate initially 103 bpm, rose to a max. heart rate of 177 (93% of Pr.MHR) bpm. Resting blood Pressure 110 / 70 mmHg, rose to a maximum blood pressure of 150 / 90 mmHg.

Ref. Doctor: -----

Doctor: -----*(Summary Report edited by user)*

SHIPL Hospital

Patient Details **Date:** 30-Mar-23 **Time:** 11:15:50 AM
Name: NAZRANA KHAN ID: 76
Age: 29 y **Sex:** F **Height:** 151 cms. **Weight:** 59 Kg.
Clinical History: Routine Test

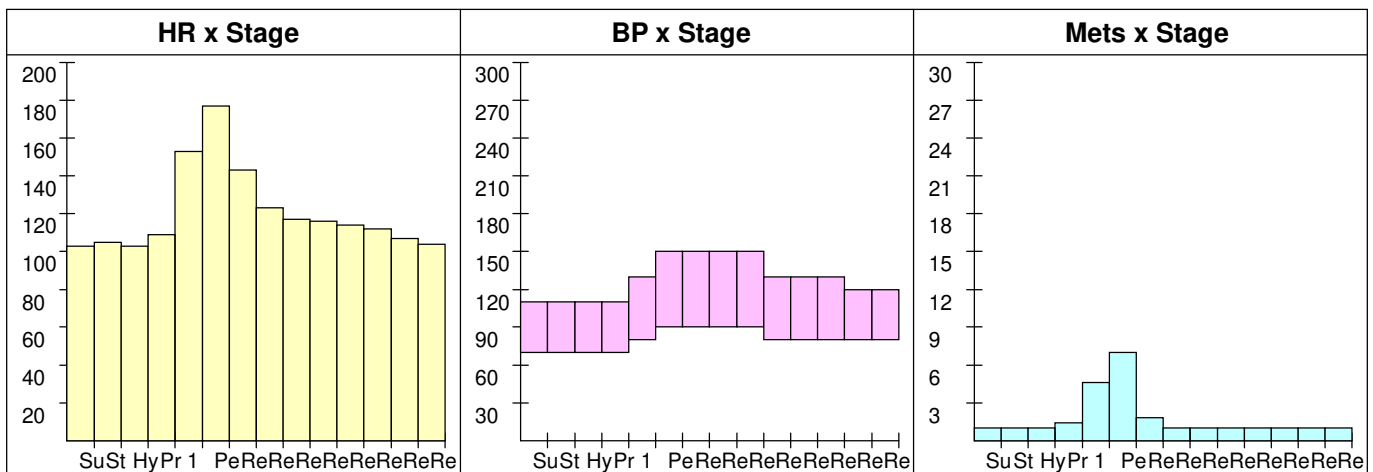
Medications: NIL

Test Details

Protocol: Bruce **Pr.MHR:** 191 bpm **THR:** 171 (90 % of Pr.MHR) bpm
Total Exec. Time: 5 m 6 s **Max. HR:** 177 (93% of Pr.MHR)bpm **Max. Mets:** 7.00
Max. BP: 150 / 90 mmHg **Max. BP x HR:** 26550 mmHg/min **Min. BP x HR:** 7210 mmHg/min
Test Termination Criteria: Target HR attained

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	1 : 23	1.0	0	0	103	110 / 70	-0.85 aVR	1.42 II
Standing	0 : 10	1.0	0	0	105	110 / 70	-0.42 aVR	1.06 II
Hyperventilation	0 : 6	1.0	0	0	103	110 / 70	-0.64 aVR	1.06 II
1	3 : 0	4.6	1.7	10	153	130 / 80	-0.85 III	2.83 II
Peak Ex	2 : 6	7.0	2.5	12	177	150 / 90	-1.27 II	3.89 II
Recovery(1)	1 : 0	1.8	1	0	143	150 / 90	-1.06 aVR	4.60 V2
Recovery(2)	1 : 0	1.0	0	0	123	150 / 90	-1.06 aVR	3.54 II
Recovery(3)	1 : 0	1.0	0	0	117	150 / 90	-0.42 aVR	2.48 II
Recovery(4)	1 : 0	1.0	0	0	116	130 / 80	-1.06 aVR	1.77 II
Recovery(5)	1 : 0	1.0	0	0	114	130 / 80	-0.42 aVR	1.77 II
Recovery(6)	1 : 0	1.0	0	0	112	130 / 80	-0.64 aVR	1.77 II
Recovery(7)	1 : 0	1.0	0	0	107	120 / 80	-0.42 aVR	1.42 II
Recovery(8)	0 : 29	1.0	0	0	104	120 / 80	-0.42 aVR	1.42 II



SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 110 / 70

Protocol: Bruce

Stage: Supine

Speed: 0 mph

Grade: 0 %

Exec Time : 0 m 0 s

Stage Time : 1 m 17 s

HR: 105 bpm

(THR: 171 bpm)

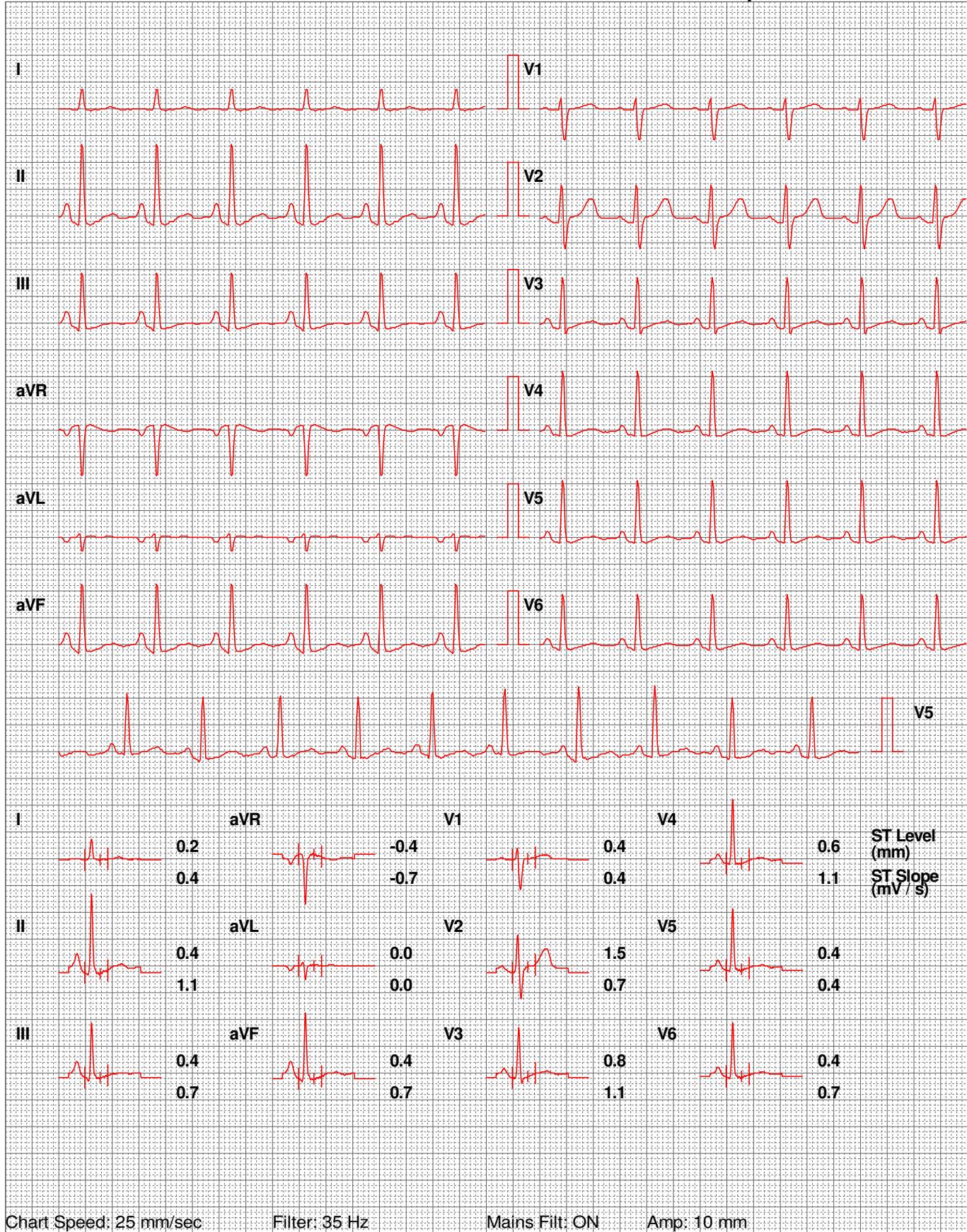


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 110 / 70

Protocol: Bruce

Stage: Standing

Speed: 0 mph

Grade: 0 %

Exec Time : 0 m 0 s

Stage Time : 0 m 4 s

HR: 101 bpm (THR: 171 bpm)

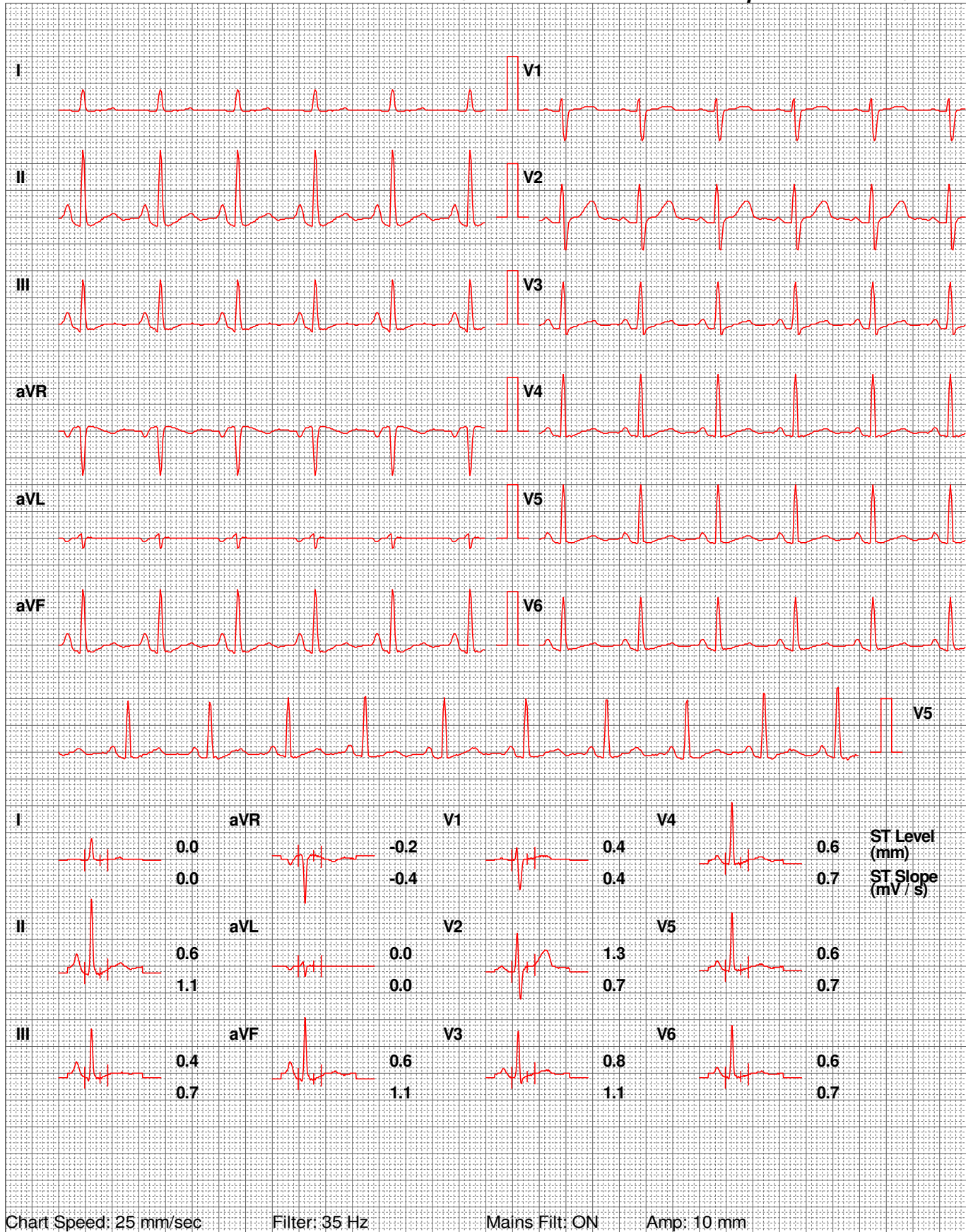


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 110 / 70

Protocol: Bruce

Stage: Hyperventilation

Speed: 0 mph

Grade: 0 %

Exec Time : 0 m 0 s

Stage Time : 0 m 0 s

HR: 97 bpm

(THR: 171 bpm)



Lead	ST Level (mm)	ST Slope (mV/s)
I	0.2	0.4
aVR	-0.2	-0.7
V1	0.2	0.4
V4	0.6	0.7
II	0.6	1.1
aVL	0.0	0.0
V2	1.3	0.4
V5	0.6	0.7
III	0.4	0.4
aVF	0.6	0.7
V3	0.8	0.7
V6	0.4	0.7

Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 130 / 80

Protocol: Bruce

Stage: 1

Speed: 1.7 mph

Grade: 10 %

Exec Time : 2 m 54 s

Stage Time : 2 m 54 s

HR: 154 bpm

(THR: 171 bpm)

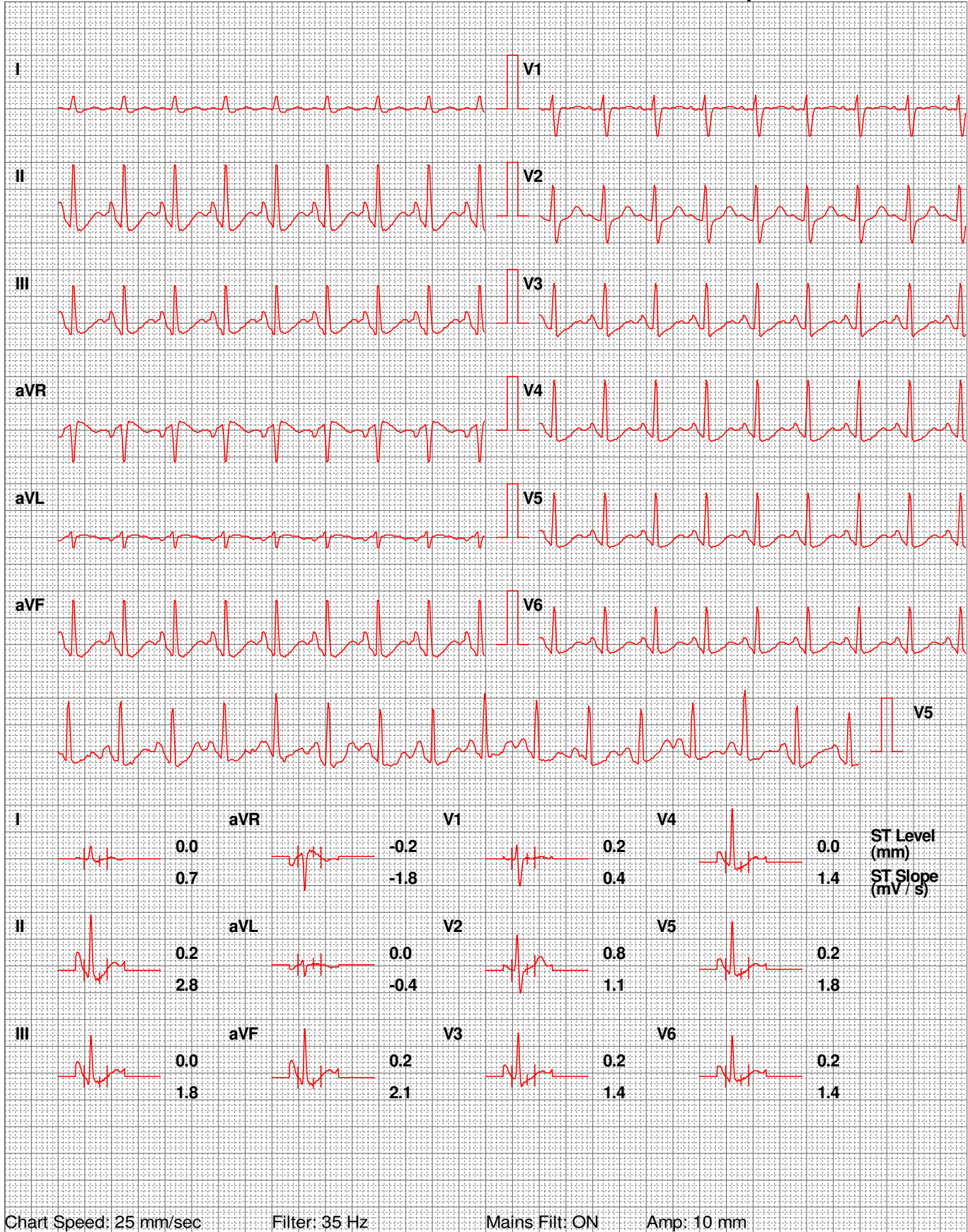


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 150 / 90

Protocol: Bruce

Stage: Peak Ex

Speed: 2.5 mph

Grade: 12 %

Exec Time : 5 m 0 s

Stage Time : 2 m 0 s

HR: 177 bpm

(THR: 171 bpm)

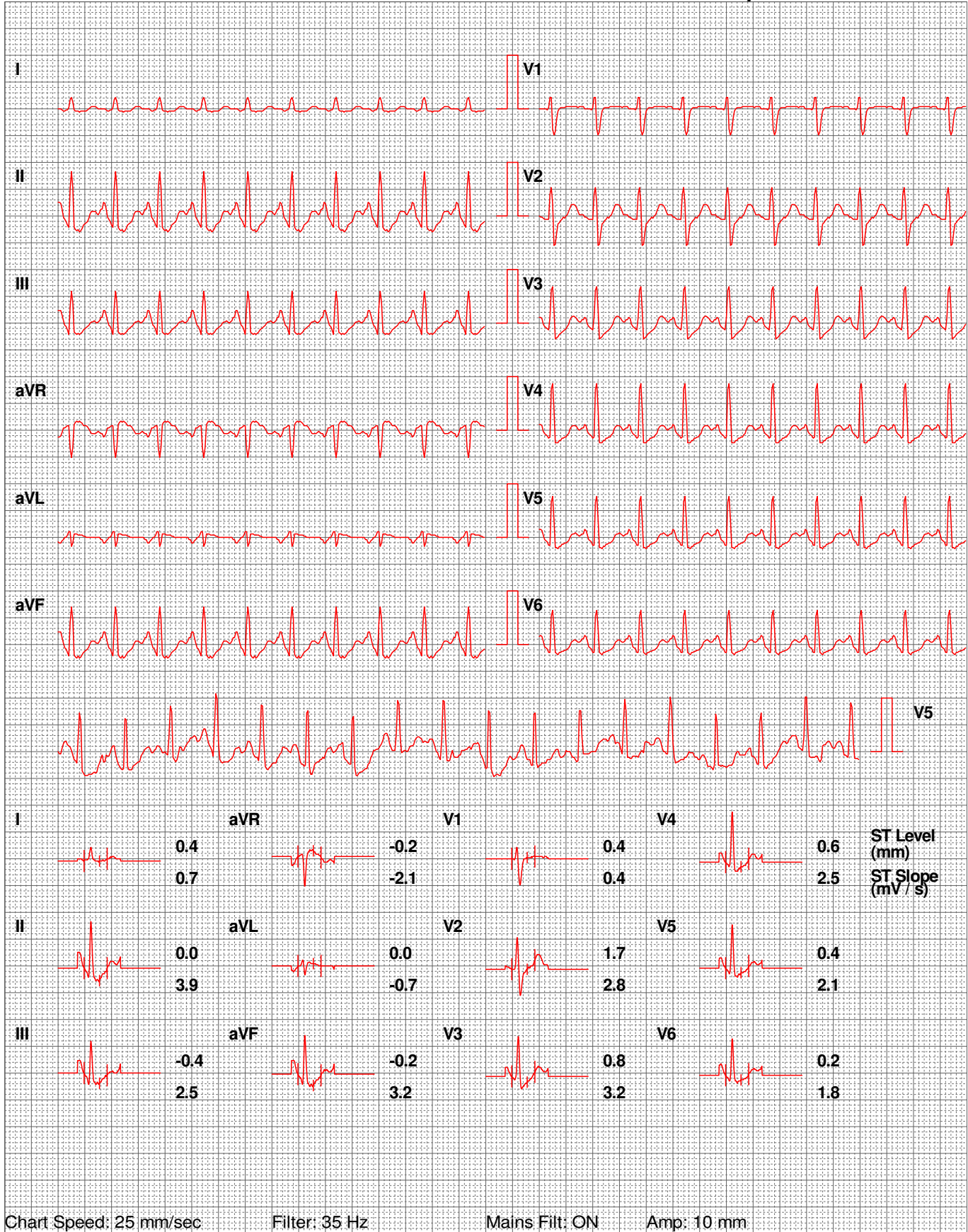


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

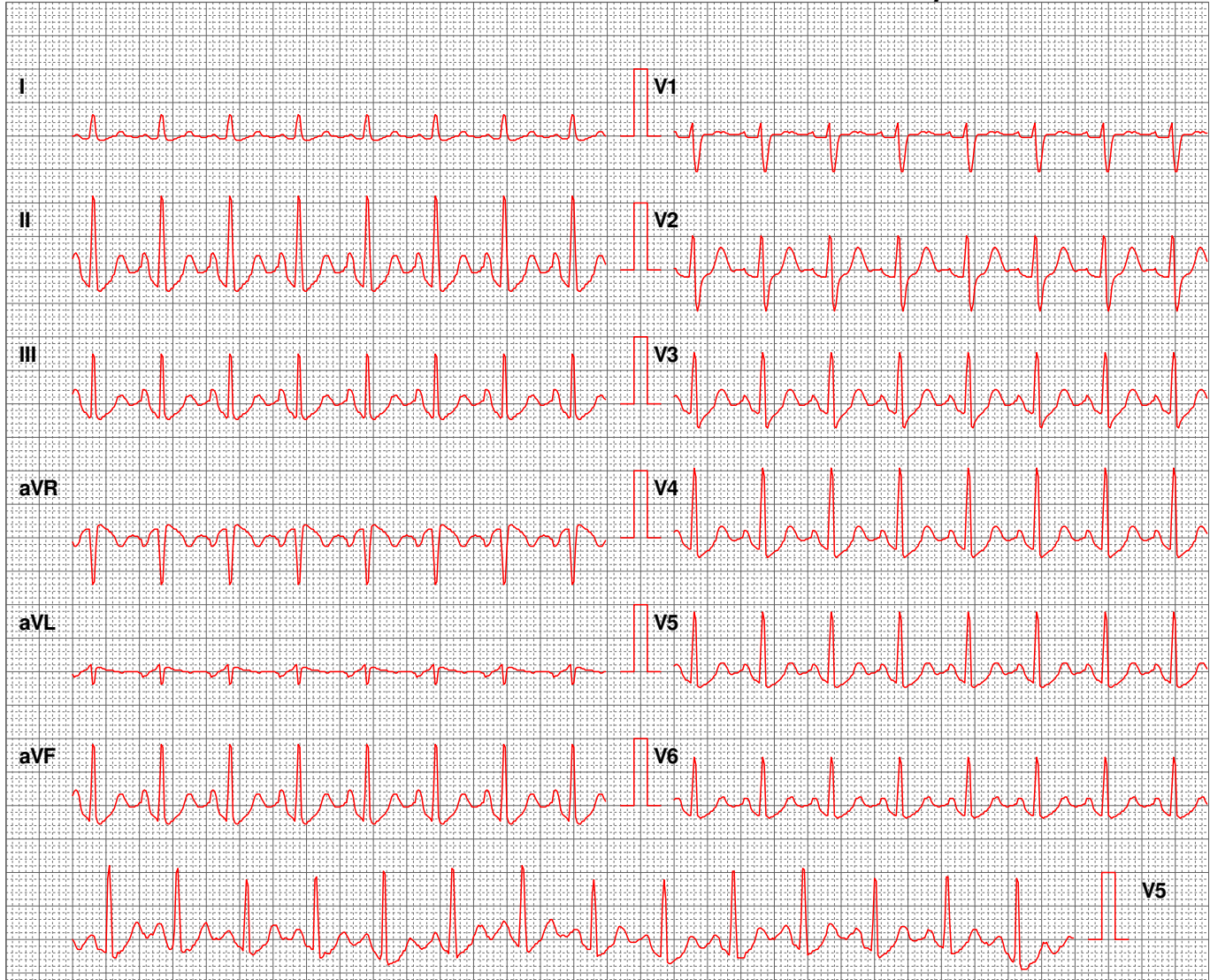
Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median



Lead	ST Level (mm)	ST Slope (mV/s)
I	0.2	0.7
II	1.5	3.5
III	0.8	2.1
aVR	-1.1	-2.5
aVL	-0.2	-0.7
aVF	1.3	2.8
V1	0.8	1.1
V2	2.3	3.5
V3	1.5	3.5
V4	1.3	3.2
V5	1.1	2.8
V6	1.1	2.1

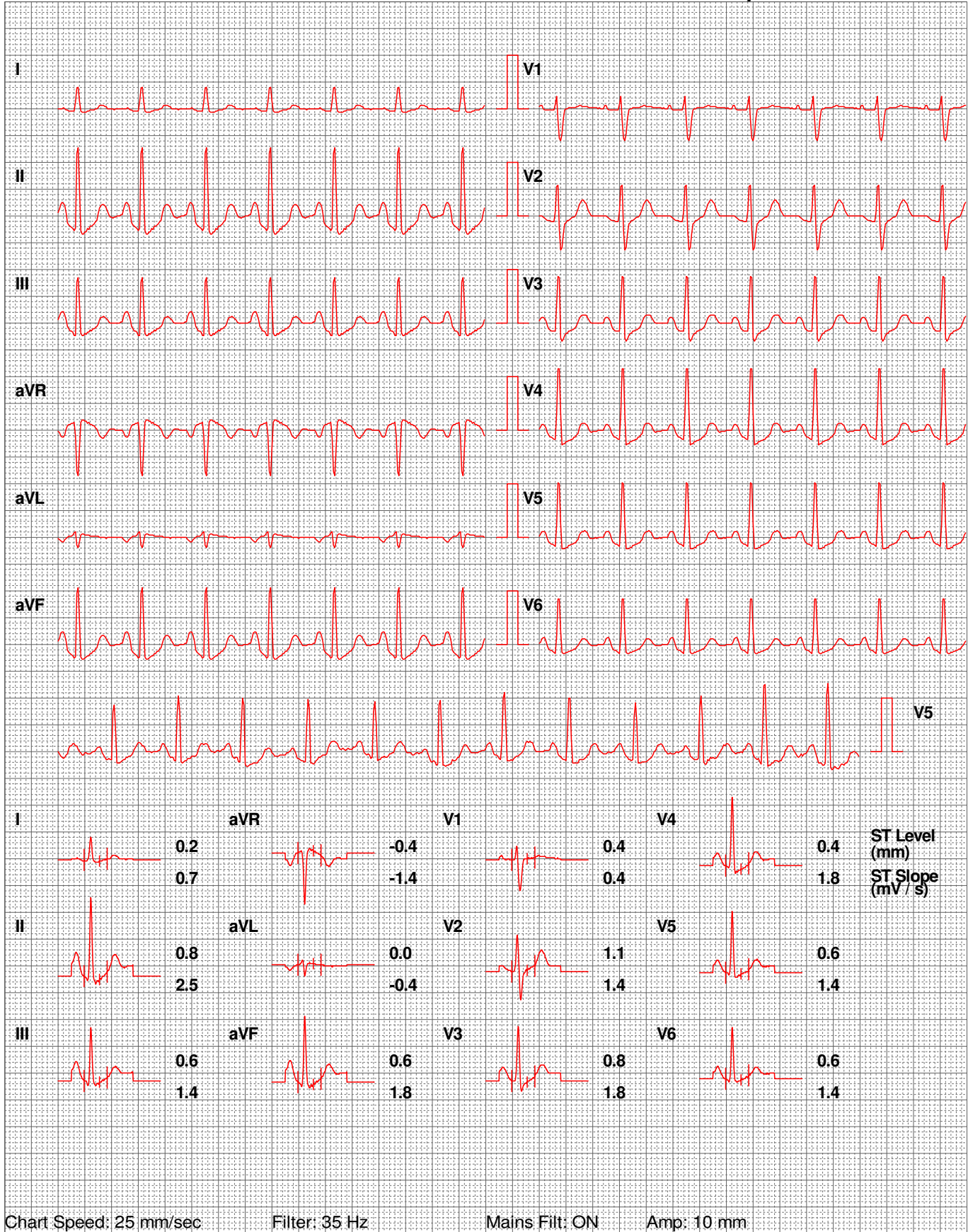


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 150 / 90

Protocol: Bruce

Stage: Recovery(3)

Speed: 0 mph

Grade: 0 %

Exec Time : 5 m 6 s

Stage Time : 0 m 54 s

HR: 119 bpm

(THR: 171 bpm)

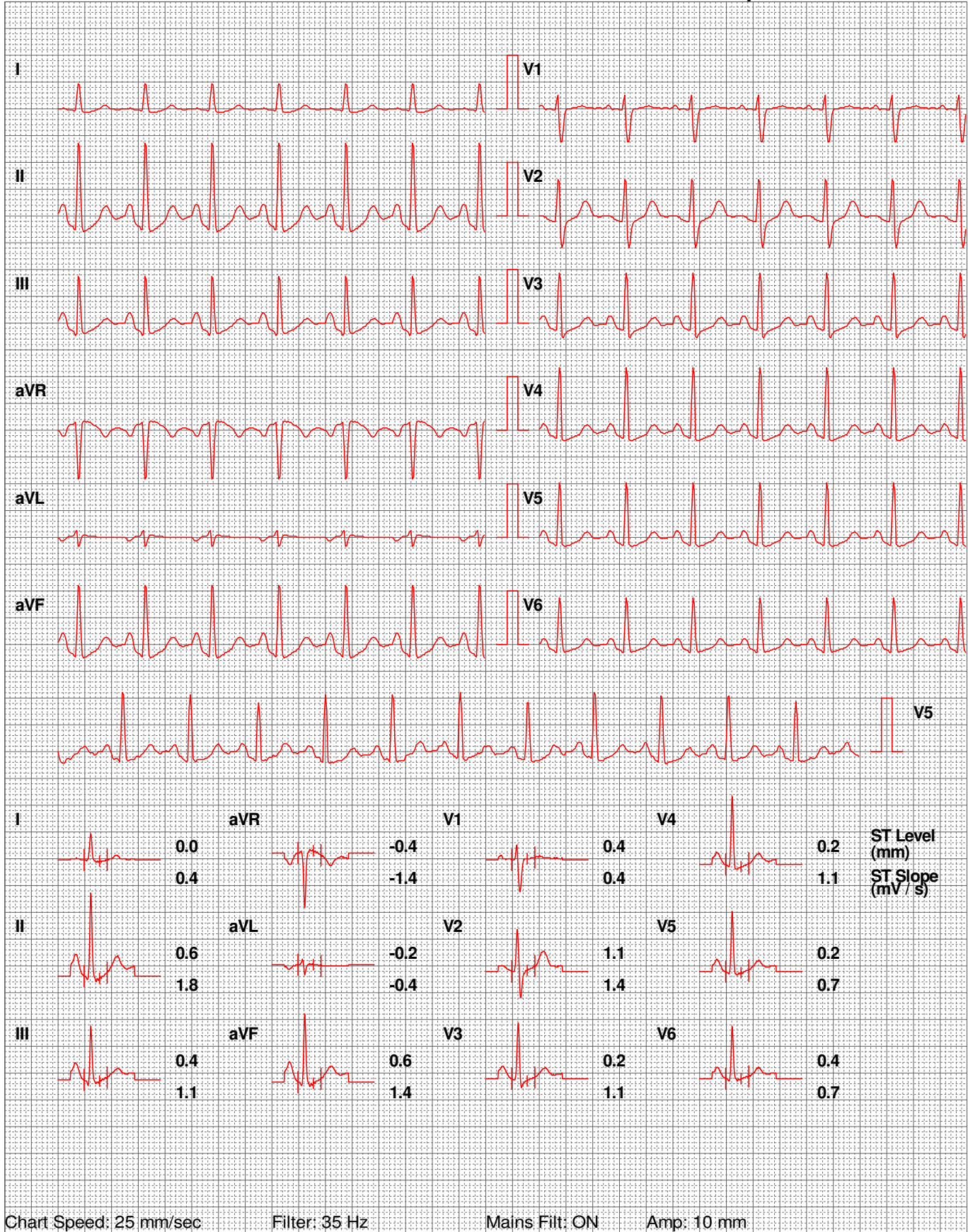


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 130 / 80

Protocol: Bruce

Stage: Recovery(4)

Speed: 0 mph

Grade: 0 %

Exec Time : 5 m 6 s

Stage Time : 0 m 54 s

HR: 115 bpm

(THR: 171 bpm)



Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 130 / 80

Protocol: Bruce

Stage: Recovery(5)

Speed: 0 mph

Grade: 0 %

Exec Time : 5 m 6 s

Stage Time : 0 m 54 s

HR: 115 bpm

(THR: 171 bpm)

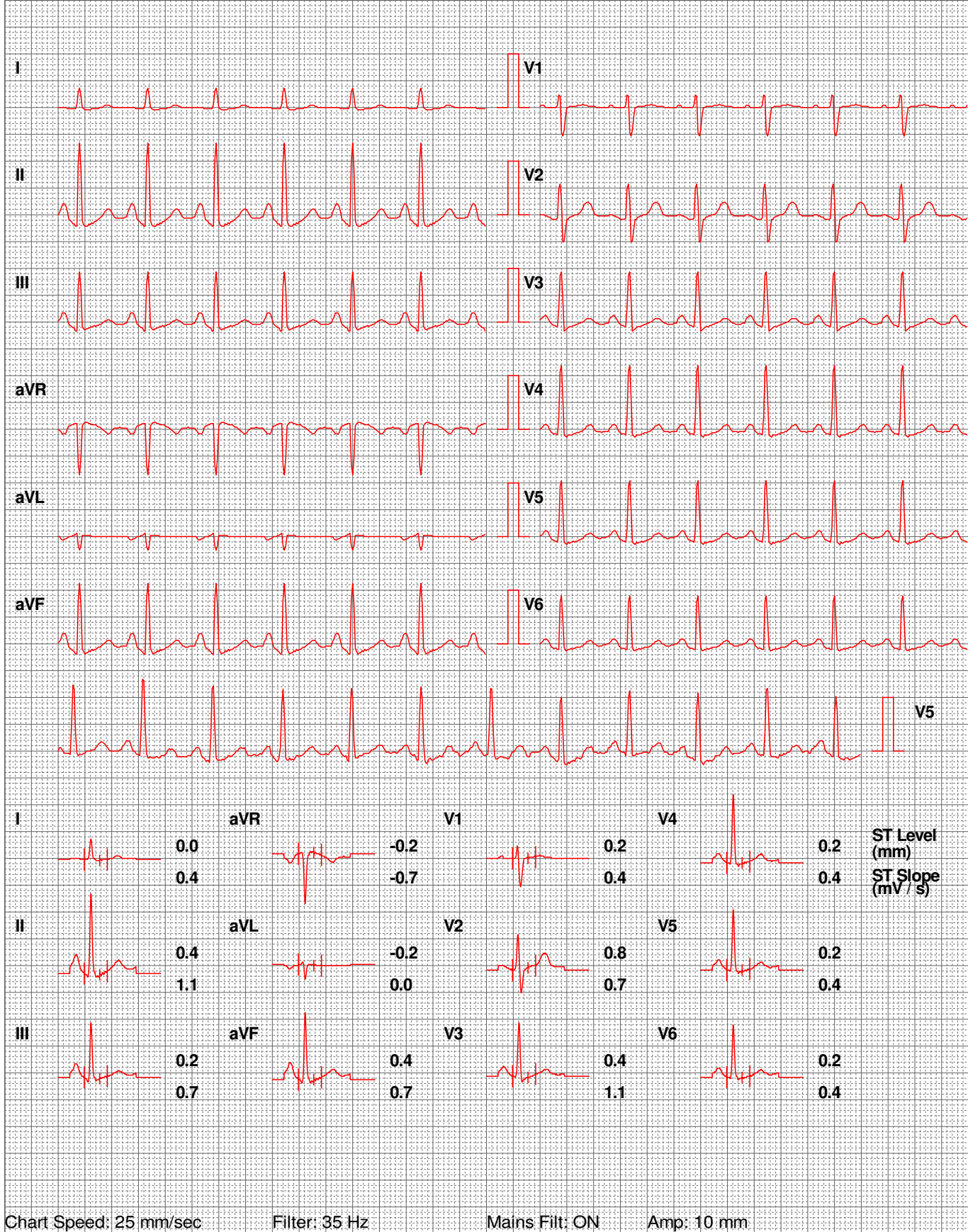


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

SHIPL Hospital

NAZRANA KHAN (29 F)

ID: 76

Date: 30-Mar-23

B.P: 130 / 80

Protocol: Bruce

Stage: Recovery(6)

Speed: 0 mph

Grade: 0 %

Exec Time : 5 m 6 s

Stage Time : 0 m 54 s

HR: 112 bpm

(THR: 171 bpm)



Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

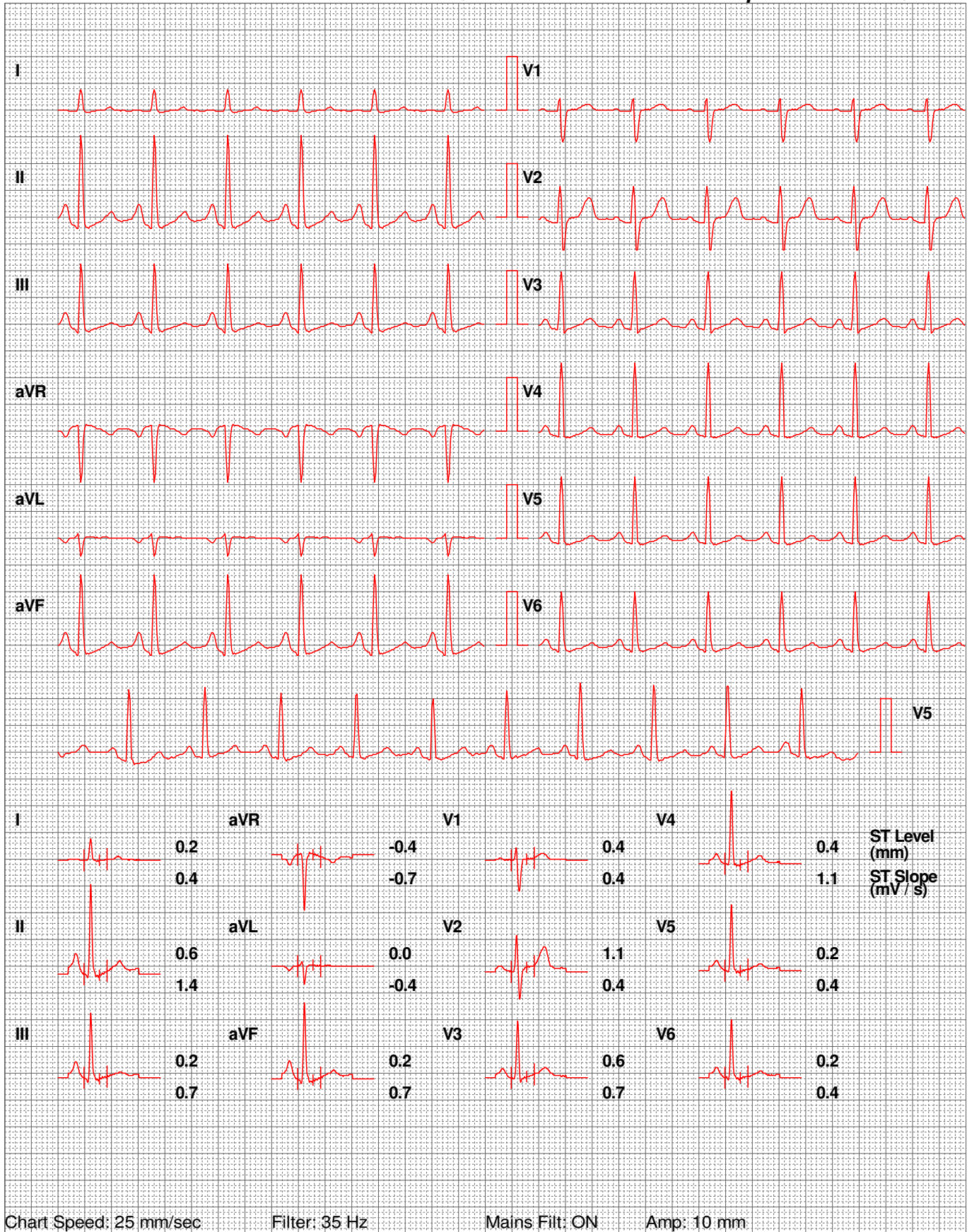


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

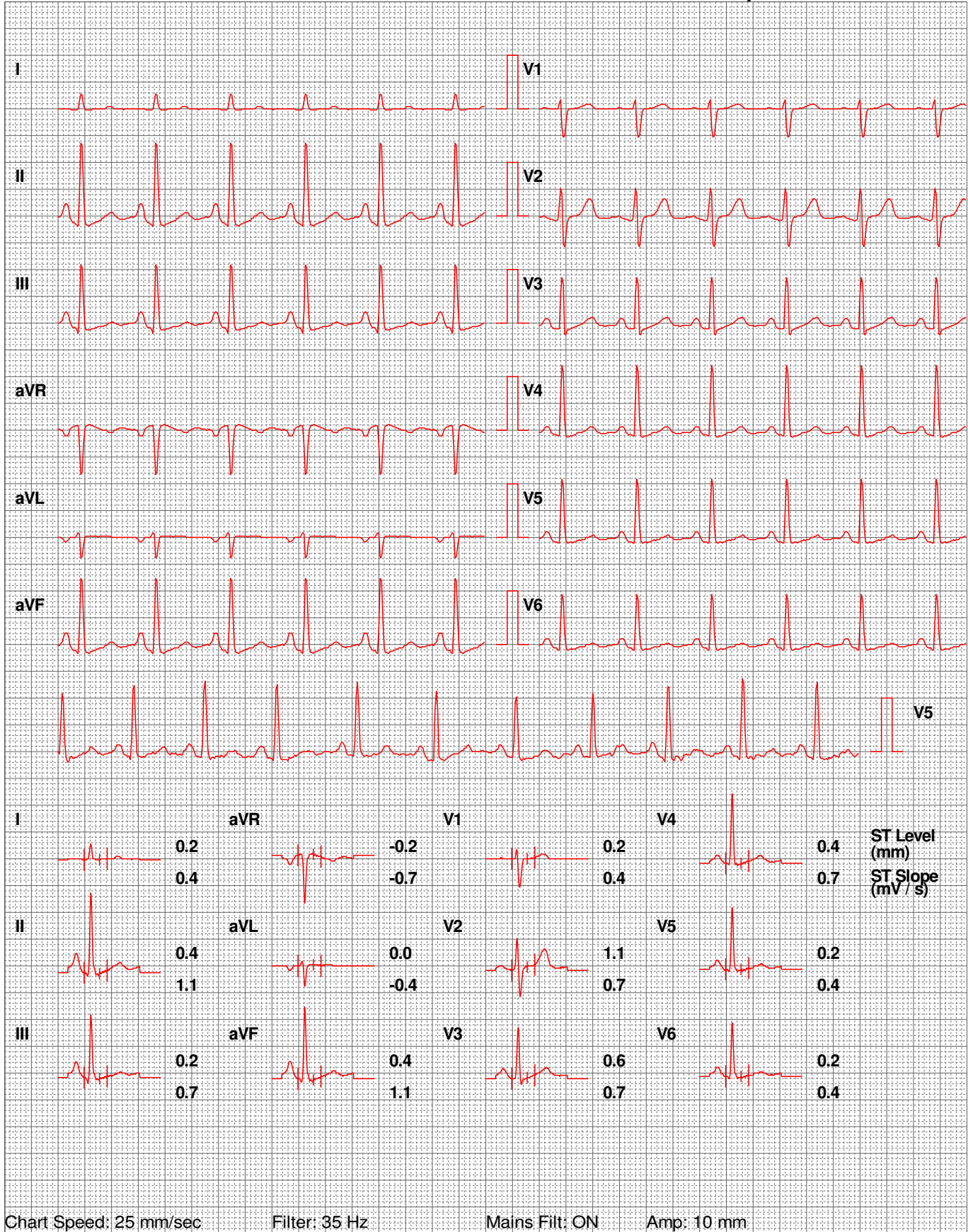


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Schiller Spandan V 4.7

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

NAME	: MRS NAZRANA KHAN	DATE	: 30/03/2023
REF BY	: -	AGE / SEX	: 29YRS/ F

USG WHOLE ABDOMEN

LIVER:

The liver is normal in size shape and smooth margins. It shows normal parenchymal echo pattern. The intra hepatic biliary and portal radical appear normal. No evidence of any intra hepatic cystic or solid lesion seen. The main portal vein and CBD appears normal.

GALL BLADDER:

The gall bladder is partially distended and normal.

PANCREAS:

The pancreas is well visualised and normal. No evidence of solid or cystic mass lesion.

KIDNEYS:

Both the kidneys are normal in size and reveal normal cortical echogenicity. No evidence of any calculus, hydronephrosis or mass lesion seen. Right kidney measures 10.4 x 3.6 cm. Left kidney measures 12.1 x 3.8 cm.

SPLEEN:

The spleen is normal in size and echotexture. No evidence of focal lesion is noted. There is no evidence of any lymphadenopathy or ascites.

URINARY BLADDER:

The urinary bladder is normal.

PELVIS:

The uterus and ovaries appear grossly normal. IUCD is seen in situ.

IMPRESSION:

No significant abnormality is seen.

DR SHRIKANT BODKE

CONSULTANT RADIOLOGIST

Note: Investigations have their limitations. Solitary radiological investigations never confirm the final diagnosis. They only help in diagnosing the disease in correlation to clinical symptoms and other related tests. USG is known to have inter-observer variations. Further / Follow-up imaging may be needed in some cases for confirmation / exclusion of diagnosis. Patient was explained in detail verbally about the USG findings, USG measurements and its limitations. In case of any typographical error in the report, patient is requested to immediately contact the center for rectification within 7 days post which the center will not be responsible for any rectification. Please interpret accordingly.

----End of Report----



*Members only



PATIENT'S NAME- Nazrana Khan

DATE - 30/03/23

AGE/SEX -

DOCTOR'S NAME - Dr Ashwini Bansode

VISION SCREENING

	RE	RE	LE	LE
	Glasses	UNAIDED	Glasses	UNAIDED
DISTANT		6/6		6/6
NEAR		N6		N6
COLOUR		normal		normal

VITALS

Pulse - 62/min	B.P- 120/80	SpO2- 98%
Height- 151 cm	Weight - 59 kg	BMI - 25.8
Waist - 85 cm	Hip - 97 cm	Waist/Hip Ratio- 0.8
Chest -	Inspiration-	Expiration-

CENTRE NAME - HEALTHSPRING GOREGAON



SIGN & STAMP- Dr Ashwini Bansode

(Family Physician - Goregaon centre)



FROST AND SULLIVAN AWARD OF BEST PRIMARY CARE PRACTICE IN SOUTH EAST ASIA 2017

BUSINESS MODEL INNOVATION AWARDS BEST BUILDING OF A BRAND



NAME : NAZRANA KHAN	Age :29/ YRS
Gender : FEMALE	Date : 30/03/2023

X-RAY CHEST PA VIEW

X-ray of the chest in P.A. projection reveals that the bony thorax is normal.

Lung fields and pleural spaces are clear on both sides.

The silhouettes of the heart and aorta are normal in size and configuration.

Both domes of the diaphragm are normal in position, contour and outline.

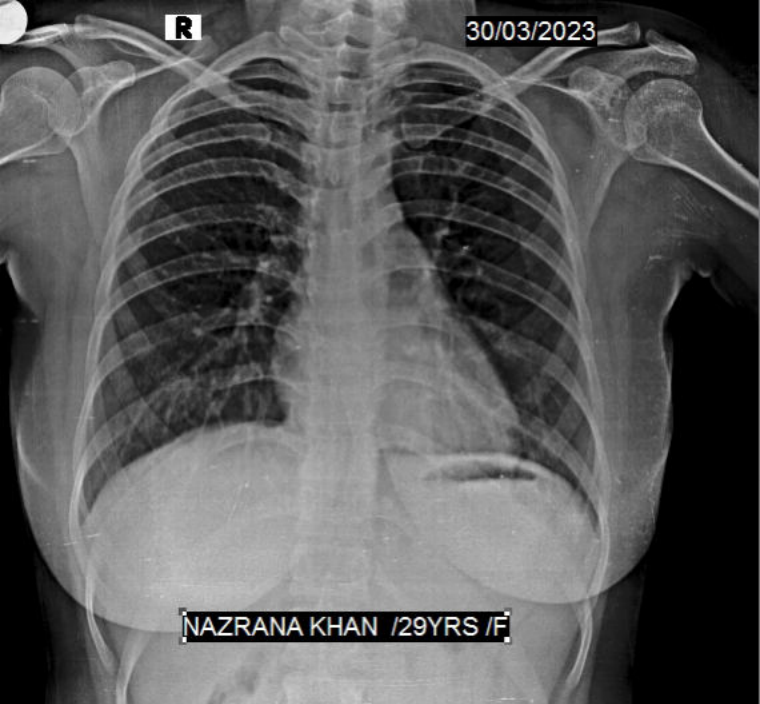
IMPRESSION:NO SIGNIFICANT ABNORMALITY SEEN .

Dr. Nitish Kotwal
MBBS, DMRD (Bom)
Consulting Radiologist

Online reporting done hence no signature

R

30/03/2023



NAZRANA KHAN /29YRS /F