

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. Rinkaj Prakash Date: 27/1/24

Age: 38 Sex M F Weight: 61.3 kg Height: 167.2 inc BMI: 21.9

BP: 111/63 mmHg Pulse: 58/m bpm RBS: _____ mg/dl

SpO2: 99%



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF PATHOLOGY

Patient Name : Mr. Pankaj Prakash
Age / Gender : 38 Y(s)/Male
Bill No/ UMR No : BIL2324072417/KH63985
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 27-Jan-24 09:46 am
Report Date : 27-Jan-24 11:06 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	15.2	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		44.2	40.0 - 50.0 %	Calculated
RBC Count		4.90	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		90	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		31.0	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		34.3	31.5 - 35.0 g/l	Calculated
RDW		16.1		Calculated
Platelet count		239	11.5 - 14.0 %	Calculated
WBC Count		5600	150 - 450 10 ³ /cumm	Impedance
<u>DIFFERENTIAL COUNT</u>				
Neutrophils		66.6	4000 - 11000 cells/cumm	Impedance
Lymphocytes		27.6	50 - 70 %	Flow Cytometry/Light microscopy
Eosinophils		1.9	20 - 40 %	Flow Cytometry/Light microscopy
Monocytes		3.9	1 - 6 %	Flow Cytometry/Light microscopy
Basophils		0.0	2 - 10 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		3729.6	0 - 1 %	Flow Cytometry/Light microscopy
			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		1545.6	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		106.4	20 - 500 /cumm	Calculated
Absolute Monocyte Count		218.4	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		
		06	0 - 15 mm/hr	Automated
				Westergren's Method

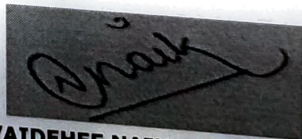
*** End Of Report ***

Suggested Clinical Correlation * If neccessary, Please discuss

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**Dr. VAIDEHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mr. Pankaj Prakash	Age / Gender : 38 Y(s)/Male
Bill No/ UMR No : BIL2324072417/KH63985	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 27-Jan-24 09:46 am	Report Date : 27-Jan-24 11:24 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	95	< 100 mg/dl	GOD/POD,Colorimetric
Post Prandial Plasma Glucose		71	< 140 mg/dl	GOD/POD, Colorimetric

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

HbA1c	4.9	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC
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*** End Of Report ***

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Dr. VAIDEHEE NAIK, MBBS,MD

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Phone: +91 0712 6789100

CIN: U74999MH2018PTC303510



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DEPARTMENT OF BIOCHEMISTRY

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LIPID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	136	Enzymatic(CHE/CHO/POD)
Triglycerides		87	Enzymatic
HDL Cholesterol Direct		37	(Lipase/GK/GPO/POD)
LDL Cholesterol Direct		80.03	Phosphotungstic acid/mgcl-Enzymatic (microslide)
VLDL Cholesterol		17	Enzymatic
Tot Chol/HDL Ratio		4	Calculated
		3 - 5	Calculation

<u>Intiate therapeutic</u>	<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100	>130, optional at 100-129
Multiple major risk factors conferring 10 yrs CHD risk>20%	>130	10 yrs risk 10-20 % >130
Two or more additional major risk factors,10 yrs CHD risk <20%	>160	10 yrs risk <10% >160
No additional major risk or one additional major risk factor		>190,optional at 160-189

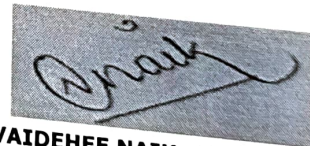
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<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
RFT				
Blood Urea	Serum	16	19.0 - 43.0 mg/dl	Urease with indicator dye
Creatinine		0.68	0.66 - 1.25 mg/dl	Enzymatic (creatinine amidohydrolase)
GFR		122.0	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		144	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.06	3.5 - 5.1 mmol/L	Direct ion selective electrode
THYROID PROFILE				
T3		1.44	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		0.96	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.13	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

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LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.90	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.21	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.69	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric pNPP/AMP buffer
Alkaline Phosphatase		66	38 - 126 U/L	Kinetic with pyridoxal 5 phosphate
SGPT/ALT		18	10 - 40 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		22	15 - 40 U/L	Biuret (Alkaline cupric sulphate)
Serum Total Protein		7.88	6.3 - 8.2 gm/dl	Bromocresol green Dye Binding
Albumin Serum		4.76	3.5 - 5.0 gm/dl	Calculated
Globulin		3.13	2.0 - 4.0 gm/dl	
A/G Ratio		1.52		

*** End Of Report ***

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CLINICAL DIAGNOSTIC LABORATORY DEPARTMENT OF PATHOLOGY

Patient Name : Mr. Pankaj Prakash
Age / Gender : 38 Y(s)/Male
Bill No/ UMR No : BIL2324072417/KH63985
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 27-Jan-24 10:26 am
Report Date : 27-Jan-24 12:31 pm

Parameter	Specimen	Results	Method
URINE MICROSCOPY			
PHYSICAL EXAMINATION			
Volume	Urine	30 ml	
Colour.		Pale yellow	
Appearance		Clear	
CHEMICAL EXAMINATION			
Reaction (pH)	Urine	6.5	4.6 - 8.0
Specific gravity		1.010	1.005 - 1.025
Urine Protein		Negative	Negative
Sugar		Negative	Negative
Bilirubin		Negative	Negative
Ketone Bodies		Negative	Negative
Nitrate		Negative	Negative
Urobilinogen		Negative	Negative
MICROSCOPIC EXAMINATION			
Epithelial Cells	Urine	0-1	0 - 4 /hpf
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		0-1	0 - 4 /hpf
Casts		Absent	Absent
Crystals		Absent	
USF(URINE SUGAR FASTING)			
Urine Glucose	Urine	Negative	

*** End Of Report ***

STRIP

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100909

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**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY**

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BLOOD GROUPING AND RH

Parameter
BLOOD GROUP.

Specimen **Results**

EDTA Whole " B "
Blood &
Plasma/
Serum

Gel Card Method

Rh (D) Typing.

" Positive "(+Ve)

*** End Of Report ***

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PATIENT NAME:	MR. PANKAJ PRAKASH	AGE /SEX:	38 YRS/MALE
UMR NO:	KH63985	BILL NO:	2324072417
REF BY	DR. VIMMI GOEL	DATE:	27/01/2024

USG WHOLE ABDOMEN

LIVER is normal in size, shape and 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.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

No significant abnormality seen.

Suggest clinical correlation / further evaluation.



**DR. R.R. KHANDELWAL
SENIOR CONSULTANT
MD RADIO DIAGNOSIS [MMC-55870]**

38 Years

MR PANKAJ PRAKASH
Male

27-Jan-24 12:23:38 PM

KIMS-KINGSWAY HOSPITALS

PBC DEPT.

Rate 60 . Sinus rhythm.....normal P axis, V-rate 50-99
 . ST elev, probable normal early repol pattern.....ST elevation, age<55
 . Baseline wander in lead(s) V2,V3

PR 136
 QRSd 102
 QT 383
 QTc 383

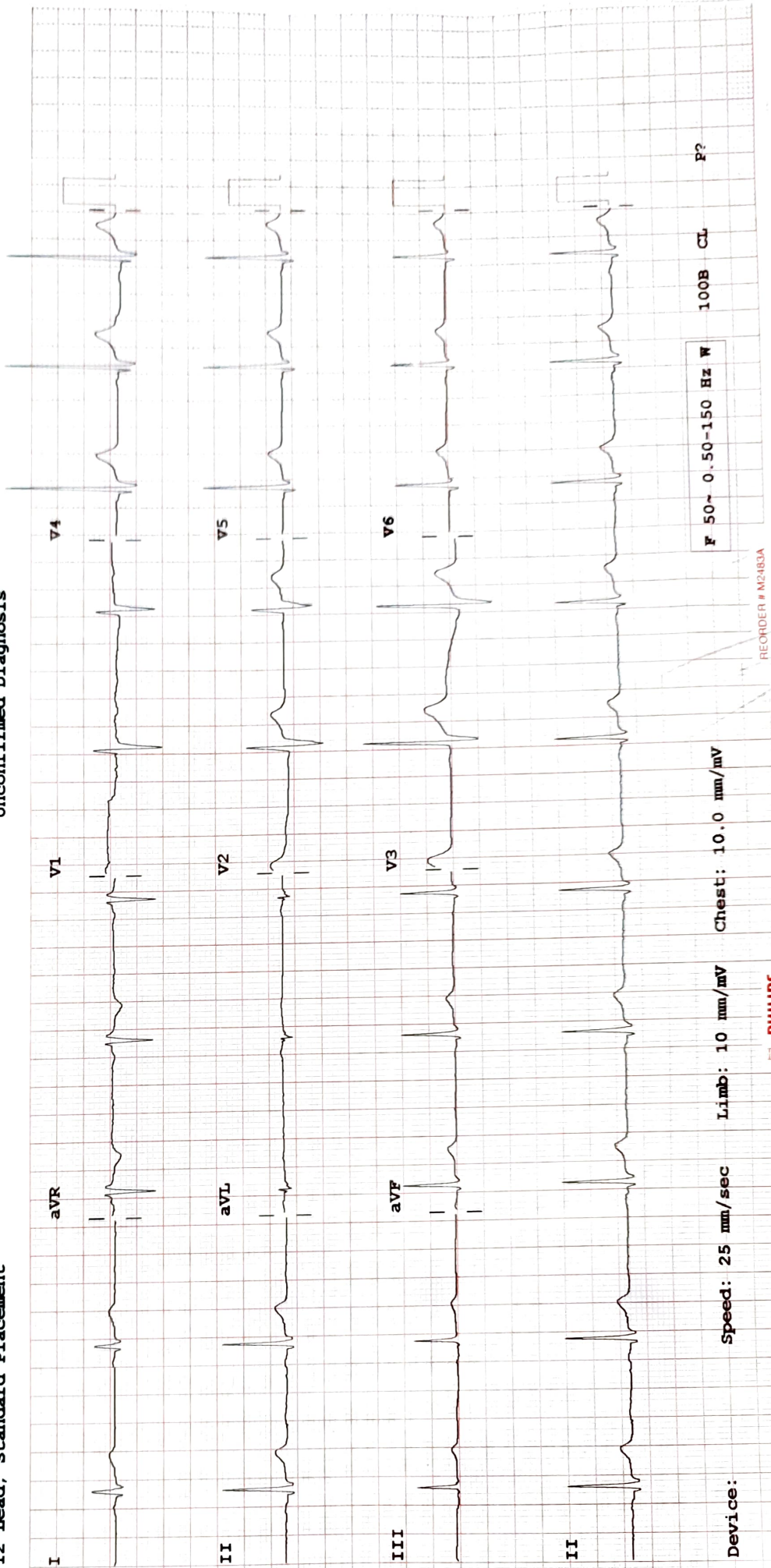
--AXIS--

P -7
 QRS 73
 T 56

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



F 50~ 0.50-1.50 Hz W 100B CL P?

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

REORDER # M2483A