

Patient:

Amelal Kumar

HR 73/min

Axis: P 51°
QRS 63°
T 48°

SINUS RHYTHM
NORMAL ECG

5.62

UNCONFIRMED REPORT

Intervals:
RR 821 ms
P 124 ms
PR 156 ms
QRS 80 ms
QT 362 ms
QTc 402 ms

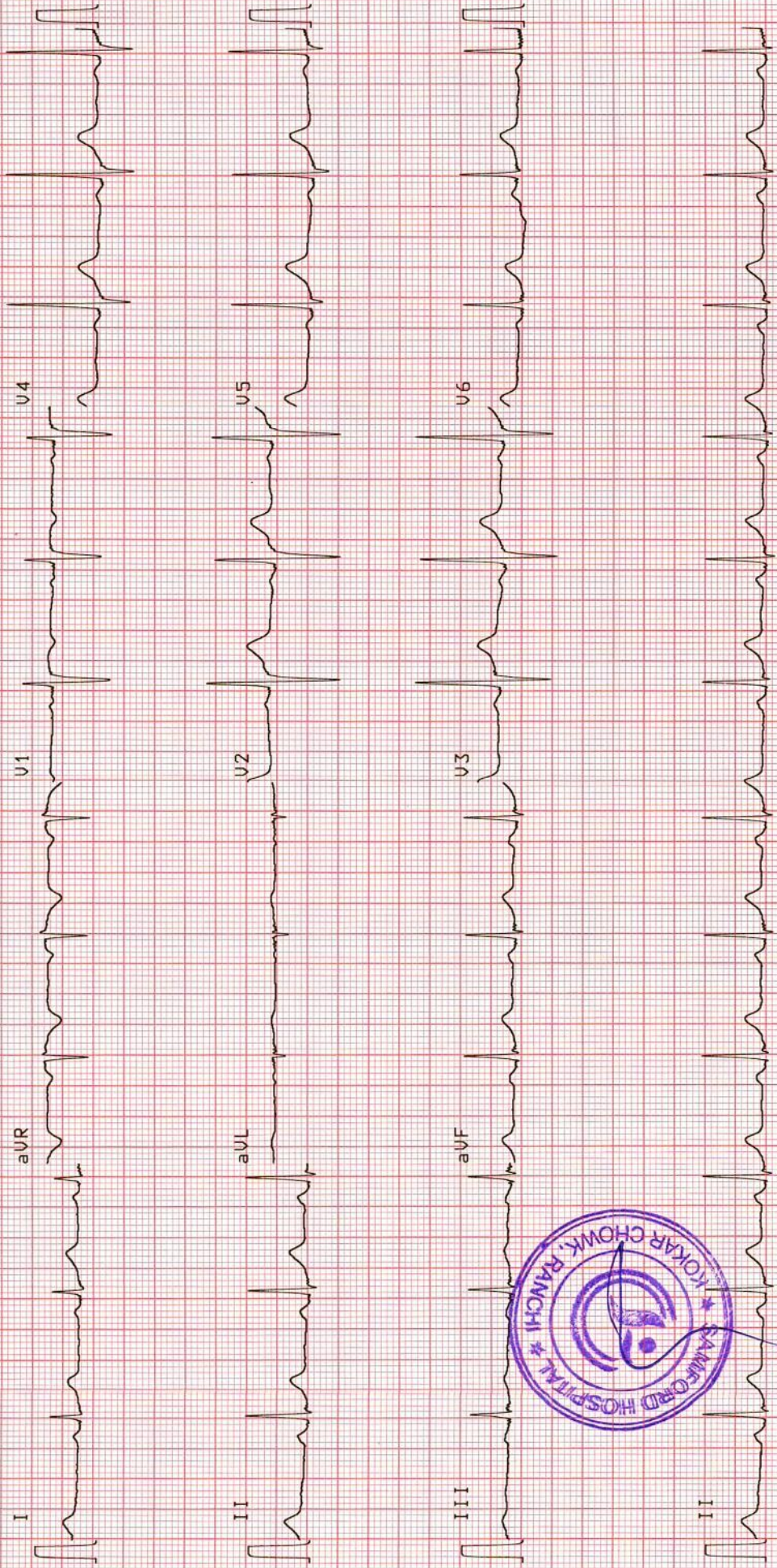
P (II) 0.14 mV
S (V1) -0.98 mV
R (V5) 1.55 mV
Sokol. 2.87 mV

Age: 31y M / F

..... cm / kg

10 mm/mV

10 mm/mV



Patient Name	ANCHAL KUMARI	Requested By	HEALTH CHECKUP
MRN	202410441	Procedure Date	14.09.2024
Age/Sex	31 Y/F	Reporting Date	14.09.2024

USG WHOLE ABDOMEN

Liver: The liver is normal in size and outline. It shows a uniform echopattern. No obvious focal or diffuse pathology is seen. The intra and extra hepatic biliary passage are not dilated. The portal vein is normal in calibre at the porta hepatis.

Gall bladder: The gall bladder is normal in size, has normal wall thickness with no evidence of calculi. **Small GB sludge is seen.**

CBD: The CBD is of normal calibre.

Pancreas: The pancreas is normal in size and echogenicity with distinct outline. No obvious focal lesion is seen.

Kidneys: Both kidneys were normal in position and measured as follows:

Right kidney measures 9.2 cm.

Left kidney measures 9.1 cm.

Small concretion of size 3 mm is seen in left kidney.

The renal cortical thickness and corticomedullary differentiation were adequate on both sides. No evidence of renal calculus is seen on right side. No hydronephrosis seen on either side.

Spleen: The spleen is normal in size and echogenicity.

Urinary bladder: The urinary bladder is normal in size. Its walls show a smooth outline. There is no evidence of any intraluminal or perivesical abnormality.

Uterus: The uterus is normal in size measuring 6.4 x 3.2 cm. Its outline is smooth. It shows normal and endometrial echoes with no evidence of any mass lesion. No evidence of free fluid in the pouch of Douglas. Endometrium measures 5 mm.

Left ovary is enlarged in size measures 11 cc and show multiple peripherally arranged follicles in both ovary.

Right ovary is normal in size and measures 5 cc. There is no evidence of any mass lesion arising from or within right ovary.

No evidence of ascites or lymphadenopathy seen.

No pleural effusion seen.

IMPRESSION:

- Left renal concretion.
- PCOD changes in left ovary.



DR. ZIAUR RAHMAN, M.D
Sr. Consultant Radiologist.

Note: - We regret typographical errors if any. Please contact us for correction.

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X-RAY CHEST PA VIEW

Result:

Both lung fields are clear.

Both hila are normal.

Both CP angles are normal.

Cardiac contour and size are within normal limits.

The bony rib cage is normal.

Soft tissues are normal.

IMPRESSION: NORMAL STUDY.


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Laboratory Report
dsfsdasadas

Patient	Ms. Anchal Kumari	UHID	202410441	Age/sex	31 yr 8 mo 15 D / F
Refer By	Samford Hospital	Order Date	14/09/2024	Done Date	14/09/2024
Date	16/09/2024				

Biochemistry

<u>Test</u>	<u>Result</u>	<u>Unit</u>	<u>Bio. Ref. Interval</u>
Blood Sugar (post parandial)(1465) - 14/09/2024	90	mg/dL	70-140
Blood Sugar (Fasting)(1465) - 14/09/2024	87	mg/dl	70-110
Creatinine(1447) (Modified Jaffe Kinetic) - 14/09/2024	0.7	mg/dl	0.6-1.5
Blood Urea Nitrogen (BUN) (1446) - 14/09/2024	9.8	mg/dl	5-25
Uric Acid(1455) - 14/09/2024	5.1	mg/dl	3.6 - 7.2
LFT (Liver Function Test)(1513) - 14/09/2024			
Serum Bilirubin (Total) (1456)	0.6	mg/dL	0.1-1.2
Serum Bilirubin (Direct)	0.2	mg/dL	0.0-0.3
Serum Bilirubin (InDirect)	0.4	mg/dL	0.2-0.8
SGPT (1475)	21	U/L	0-45
SGOT (1476)	20	U/L	5-40
Alkaline Phosphatase (ALP) (1494)	74	U/L	41-137
Total Protein	8.0	g/dl	6.0 - 8.0
Albumin (1461)	4.3	g/dl	3.7-5.3
Globulin	3.7	g/dl	2.3-3.6
A/G Ratio	1.1		1.2-1.8
GGT	23	U/L	1-94
Lipid Profile - 14/09/2024			
(CHOD-POD)			
Cholesterol(1463)	200	mg/dl	< 200
Triglycerides (1487)	100	mg/dl	< 150
HDL Cholesterol	49	mg/dl	40 - 60
LDL	131	mg/dl	60-130
VLDL Cholesterol	20	mg/dL	< 30

Clinical Pathology

1. This report is related to the item tested.
2. This is a professional opinion and cannot be used for medicolegal purpose.
3. Laboratory result should be interpreted with clinico radiological corelation.
4. In case of unexpected/abnormal result contact the laboratory immediatelv





Laboratory Report
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Patient	Ms. Anchal Kumari	UHID	202410441	Age/sex	31 yr 8 mo 15 D / F
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Date	16/09/2024				

<u>Test</u>	<u>Result</u>	<u>Unit</u>	<u>Bio. Ref. Interval</u>
Urine Routine Examination(1383) (Strip / Microscopy) - 14/09/2024			
TEST NAME	RESULT	UNIT	REFERENCE RANGE
VOLUME	20 ml		
COLOUR	Straw		
APPEARANCE	Slightly Hazy		
SP GRAVITY	1.015		1.003 - 1.035
PH	6.5		4.7 - 7.5
PROTEIN	NOT DETECTED		NOT DETECTED
GLUCOSE	NOT DETECTED		NOT DETECTED
KETONE BODIES	NOT DETECTED		NOT DETECTED
BLOOD	NOT DETECTED		NOT DETECTED
BILIRUBIN	NOT DETECTED		NOT DETECTED
UROBILINOGEN	NOT DETECTED		NOT DETECTED
NITRITE	NOT DETECTED		NOT DETECTED
PUS CELLS	18 - 20	/HPF	0-5
EPITHELIAL CELLS	12 - 15	/HPF	0-5
RBC	NOT DETECTED	/HPF	NOT DETECTED
CAST	NOT DETECTED		NOT DETECTED
CRYSTAL	NOT DETECTED		NOT DETECTED
BACTERIA	NOT DETECTED		NOT DETECTED

Immunology

<u>Test</u>	<u>Result</u>	<u>Unit</u>	<u>Bio. Ref. Interval</u>
THYROID PROFILE(1559) - 14/09/2024			
(Chemiluminescence Assay(C.L.I.A))			
T3	1.20	ng/mL	0.58 - 1.59
T4 (1561)	132.1	nmol/l	60 - 120
TSH (1562)	1.74	uIU/ml	0.50 - 5.50

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Laboratory Report

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Refer By	Samford Hospital	Order Date	14/09/2024	Done Date	14/09/2024
Date	16/09/2024				

Haematology

<u>Test</u>	<u>Result</u>	<u>Unit</u>	<u>Bio. Ref. Interval</u>
Complete Blood Count(CBC)(1394) - 14/09/2024 (Hematology analyzer and microscopy)			
RBC Count	4.93	million/cumm	4.5-5.5
Hb Haemoglobin (1389)	14.1	gm/dl	12.0-15.0
HCT	42.2	%	40-50
MCV	85.5	Fl	80-100
MCH	28.6	Pg	27-32
MCHC	33.4	g/dl	32-36
Platelet Count (1395)	3.88	lac/cumm	1.50-4.50
RDW	<u>14.7</u>	%	11-14
TLC (Total Leucocyte Count)(1390)	8200	/cumm	4000 - 11000
DLC (Differential Leucocyte Count)(1391)			
Neutrophils	63	%	45-75
Lymphocytes	30	%	20-45
Eosinophils	03	%	1-6
Monocytes	04	%	2-10
Basophils	00	%	0-1

Blood Grouping & RH Typing(1418) - 14/09/2024

TEST NAME	RESULT
ABO	'AB'
RH	POSITIVE

HbA1C(Glycosylated Haemoglobin)(1510) (HPLC) - 14/09/2024

Test Name	Result	Unit	Reference Range
HbA1c	5.3		4.5-6.5
Mean Plasma Glucose*	105.4	mg/dL	
Calculated			

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Mean Plasma Glucose is based on estimated Average Glucose (eAG) value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

Reference Range (HBA1c)

Good control	: 4.5 - 6.4 %
Fair control	: 6.5 - 7.4 %
Poor control	: Above - 7.5 %

Note: Anaemia can lead to erroneous increase or decrease in HbA1C reading to misinterpretation of the disease condition, hence it might not be a reliable indicator to assist the glycaemic index.

Advice: Fructosamine test.

ESR(ERYTHROCYTE SEDIMENTATION RATE)(1392) (Westergren) - 14/09/2024	<u>55</u>	mm at 1st hr	0-20
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Result Entered By

Mr. Akash Ghosh

Ms. Madhu Kumari

Dr. Anubhuti Choudhary
(Consultant Pathologist)



**This is computer generated report, Hence does not require signature.

Patient Demographics

ANCHAL KUMARI 31Y/F

Study Date: 14/09/2024

Patient ID: 202410441

Accession #:

Alt ID:

DOB:

Age:

Gender: F

Ht:

Wt:

BSA:

Institution: Samford Hospital

Referring Physician:

Physician of Record:

Performed By: DR.MD.FARHAN SHIKOH

Comments:

Adult Echo: Measurements and Calculations

2D

LVIDd (2D)	4.4 cm	EF (2D-Teich)	66.2 %	IVSd (2D)	0.9 cm
LVPWd (2D)	0.8 cm	EDV (2D-Cubed)	85.2 ml	RVIDd/LVIDd	0.591
LVIDs (2D)	2.8 cm	ESV (2D-Cubed)	22.0 ml	RVIDd (2D)	2.6 cm
EDV (2D-Teich)	87.7 ml	SV (2D-Cubed)	63.2 ml	LA Dimen (2D)	2.6 cm
ESV (2D-Teich)	29.6 ml	FS (2D-Cubed)	36.4 %	LA/Ao (2D)	1.00
SV (2D-Teich)	58.1 ml	EF (2D-Cubed)	74.2 %	AoR Diam (2D)	2.6 cm
FS (2D-Teich)	36.4 %	IVS/LVPW (2D)	1.13		

Doppler

AV Vmax		MV Peak A Vel		PV Vmax	
Max PG	4 mmHg	Vel	55.3 cm/s	Max PG	4 mmHg
Vmax	103 cm/s	PG	1 mmHg	Vmax	93.7 cm/s
MV Peak E Vel		MV E/A	1.4		
Vel	76.2 cm/s				
PG	2 mmHg				

Comments

NORMAL SIZED CHAMBERS
NORMAL VALVE ECHO
TRIVIAL MR
NORMAL LV SYSTOLIC FUNCTION
NO RWMA
LVEF=55%
NO CLOT/VEG/PE

DR. MD. FARHAN SHIKOH
MBBS, MD MEDICINE, DM CARDIOLOGY





202410441 / ANCHAL KUMARI / 31 Yrs / F / 155 Cms / 59 Kg Date: 14-Sep-2024 Technician : ROHINI KUMARI Examined By:

Stage	Time	Duration	Speed(mph)	Elevation	METs	Rate	%THR	BP	RPP	PVC	Comments
Standing	00:03	0:03	00.0	00.0	01.0	110	58 %	110/80	121	00	
Warm Up	00:16	0:13	00.0	00.0	01.0	108	57 %	110/80	118	00	
ExStart	00:54	0:38	01.0	00.0	01.0	117	62 %	110/80	128	00	
BRUCE Stage 1	03:54	3:00	01.7	10.0	04.7	148	78 %	110/80	162	00	
PeakEx	04:55	1:01	02.5	12.0	05.5	161	85 %	120/80	193	00	
Recovery	05:55	1:00	01.1	00.0	01.0	143	76 %	120/80	171	00	
Recovery	06:55	2:00	00.0	00.0	01.0	100	53 %	120/80	120	00	
Recovery	07:55	3:00	00.0	00.0	01.0	108	57 %	120/80	129	00	
Recovery	08:55	4:00	00.0	00.0	01.0	108	57 %	120/80	129	00	
Recovery	09:55	5:00	00.0	00.0	01.0	100	53 %	120/80	120	00	
Recovery	10:07	5:12	00.0	00.0	01.0	097	51 %	120/80	116	00	

REPORT

Sample Name: Stress Test Graded Exercise Treadmill

Description: To rule out to CAD

INDICATIONS: To rule out to CAD

PROCEDURE DONE: Graded exercise treadmill stress test.

STRESS ECG RESULTS: The patient was stressed by continuous graded treadmill testing for Exercise Time 4:02 Mins. of the standard Bruce protocol. The initial HR was recorded as 110 bpm, and the maximum predicted Target Heart Rate 189.

The Test was completed because of **TARGET HEART RATE ACHIEVED**

CONCLUSIONS:

1. Stress test is **NEGATIVE** for ischemia.
2. Good functional capacity
3. Blood pressure response to exercise is normal.



Doctor : DR. MD.FARHAN SHIKOH