

SHOP NO. 16-17, 1ST FLOOR SHOPPING CENTRE, OPP. JLN HOSPITAL, AJMER -305 001 PHONE : 2428948

Patient Name : MANISH

Age / Gender : 32 years / Male

Endo ID : 116392

Organization : Goyal Diagnostics Profile

Referral : MEDIWHEEL



Collected Date & Time : Apr 08, 2023, 02:18 p.m.

Reported Date & Time : Apr 08, 2023, 03:42 p.m.

Sample ID :



230980134

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

LIPID PROFILE

Cholesterol Total Method : ENZYMATIC COLORIMETRIC METHOD CHOD - POD	209.0	mg/dL	130 -250
Triglycerides Method : ENZYMATIC COLORIMETRIC	142.4	mg/dL	60 -170
HDL Cholesterol Method : PHOSPHOTUNGSTIC ACID	46.5	mg/dL	Normal: 40-60 Major Risk for Heart: > 60
VLDL Cholesterol Method : Calculated	28.48	mg/dL	6 - 38
LDL Cholesterol Method : Calculated	134.02	mg/dL	Optimal < 100 Near / Above Optimal 100-129 Borderline High 130-159 High 160-189 Very High >or = 190
CHOL/HDL Ratio Method : Calculated	4.49		2.6-4.9
LDL/HDL Ratio Method : Calculated	2.88		0.5-3.4

END OF REPORT

Dr. Nishi Prasad
M.D. (Patho.)

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IMMUNOLOGY

T3-Triiodothyronine Method : CHEMILUMINOSCECE	0.85	ng/dL	0.60-1.81
T4-Thyroxine Method : CHEMILUMINOSCECE	6.7	ug/dL	4.5 - 10.9
TSH -ULTRA SENSITIVE Method : CHEMILUMINOSCECE	2.70	uIU/mL	0.35 - 5.50

Interpretation:

TSH measurement is useful in screening and diagnosis for euthyroidism, hyperthyroidism and hypothyroidism. TSH levels may be affected by acute illness and drugs like doapmine and glucocorticoids. Low or undetectable TSH is suggestive of graves disease TSH between 5.5 to 15.0 with normal T3 T4 indicates impaired thyroid hormone or subclinical hypothyroidism or normal T3 T4 with slightly low TSH suggests subclinical Hyperthyroidism. TSH suppression does not reflect severity of hyperthyroidism therefore , measurement of FT3 FT4 is important. FreeT3 is first hormone to increase in early Hyperthyroidism. Only TSH level can prove to be misleading in patients on treatment. Therefore FreeT3 , FreeT4 along with TSH should be checked.

****END OF REPORT****

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230980134

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HAEMATOLOGY

HbA1c (GLYCOSYLATED HEMOGLOBIN)

6.8

%

> 8% Action Suggested

BLOOD

7 - 8 % Good Control

Method : Nephelometry Methodology

< 7% Goal

6 - 7 % Near Normal Glycemia

< 6% Normal level

Instrument: Mispa i2

Clinical Information:

Glycated hemoglobin measurement is not appropriate where there has been a change in diet or treatment within 6 weeks. Hence, people with recent blood loss, hemolytic anemia, or genetic differences in the hemoglobin molecule (hemoglobinopathy and Hb variants viz: HbS, HbC, HbE, HbD, elevated HbF, as well as those that have donated blood recently, are not suitable for this test. Conditions associated with false increased HbA1C values: HbF, Uremia, Lead Poisoning, Hypertriglyceridemia, Alcoholism, Opiate addiction, Iron deficiency state, Postsplenectomy, Hyperbilirubinemia, Chronic aspirin therapy. Conditions associated with false low HbA1C values: HbS, HbC, Hemolytic anemia, Pregnancy, Acute or chronic blood loss

AVERAGE BLOOD GLUCOSE

148.46

90 - 120 Very Good Control

121 - 150 Adequate Control

51 - 180 Sub-optimal Control

181 - 210 Poor Control

> 211 Very Poor Control

END OF REPORT

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BIOCHEMISTRY

RENAL FUNCTION TEST

Urea Method : Uricase	34.0	mg/dL	10 - 45
Creatinine Method : Serum, Jaffe	0.94	mg/dL	0.6 - 1.4
Uric Acid Method : Serum, Uricase	8.4	mg/dL	3.0 - 7.0
Calcium Method : ARSENASO with serum	9.33	mg/dl	8.6 - 10.2
Sodium Method : Ion-Selective Electrode with serum	139	mmol/L	135 - 145
Potassium Method : Ion Selective Electrode with serum	4.5	mmol/L	3.50 - 5.00
Chlorides Method : Ion-Selective Electrode with serum	103	mmol/L	98 - 106

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Test Description	Value(s)	Unit(s)	Reference Range
HAEMATOLOGY			
Hemoglobin (HB)	14.2	gm/dl	13.5 - 18.0
Erythrocyte (RBC) Count	5.04	mil/cu.mm	4.7 - 6.0
Packed Cell Volume (PCV)	42.7	%	42 - 52
Mean Cell Volume (MCV)	84.7	FL	78 - 100
Mean Cell Haemoglobin (MCH)	28.2	Pg	27 - 31
Mean Corpuscular Hb Conc. (MCHC)	33.3	g/dl	32 - 36
Red Cell Distribution Width (RDW)	11.9	%	11.5 - 14.0
Total Leucocytes Count (WBC)	5800	Cell/cu.mm	4000 - 10000
Neutrophils	53	%	40 - 80
Lymphocytes	40	%	20 - 40
Monocytes	04	%	2 - 10
Eosinophils	03	%	1-6
Basophils	00	%	0-1
Mean Platelet Volume (MPV)	9.5	fL	7.2 - 11.7
PCT	0.27	%	0.2 - 0.5
Platelet Count	289	10 ³ /ul	150 - 450

END OF REPORT

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BIOCHEMISTRY

IRON - SERUM	76	ug/dL	65 - 175
TOTAL IRON BINDING CAPACITY(TIBC)	362	ug/dL	228 - 428
FERRITIN	63.8	ng/mL	Male:22-322 Female:10-291
Method : Serum CLIA			
TRANSFERRIN SATURATION %	20.99	%	16 - 50
Method : Calculated			

INTERPRETATION

The serum iron test is used to measure the amount of iron that is in transit in the body – the iron that is bound to transferrin in the blood. Along with other tests, it is used to help detect and diagnose iron deficiency or iron overload. Testing may also be used to help differentiate various causes of anemia. The amount of iron present in the blood will vary throughout the day and from day to day. For this reason, serum iron is almost always measured with other iron tests, including ferritin, transferrin, and calculated total iron-binding capacity (TIBC) and transferrin saturation. Serum ferritin appears to be in equilibrium with tissue ferritin and is a good indicator of storage iron in normal subjects and in most disorders. In patients with some hepatocellular diseases, malignancies and inflammatory diseases, serum ferritin is a disproportionately high estimate of storage iron because serum ferritin is an acute phase reactant. In such disorders iron deficiency anemia may exist with a normal serum ferritin conc. In the presence of inflammation, persons with low serum ferritin are likely to respond to iron therapy.

Increased Levels -

Iron overload – Hemochromatosis, Thalassemia & Sideroblastic anemia

-Malignant conditions - Acute myeloblastic & Lymphoblastic leukemia, Hodgkin's disease & Breast carcinoma

-Inflammatory diseases - Pulmonary infections, Osteomyelitis, Chronic UTI, -Rheumatoid arthritis, SLE, burns, Acute & Chronic hepatocellular disease

Decreased Levels

-Iron deficiency anemia

****END OF REPORT****

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BIOCHEMISTRY

C-Reactive Protein; CRP, SERUM	2.4	mg/L	0.0-6.0
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Interpretation :

1. Measurement of CRP is useful for the detection and evaluation of infection, tissue injury, inflammatory disorders and associated diseases .
2. High sensitivity CRP (hsCRP) measurements may be used as an independent risk marker for the identification of individual at risk for future cardiovascular disease.
3. Increase in CRP values are non-Specific and should not be interpreted without a complete history.

****END OF REPORT****

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BIOCHEMISTRY

LIVER FUNCTION TEST

Bilirubin - Total	0.74	gm/dl	0.0 - 1.20
Bilirubin - Direct	0.21	mg/dL	0.00 - 0.30
Bilirubin - Indirect	0.53	mg/dL	0.1 - 1.0
Method : Calculated			
ASPARTATE AMINO TRANSFERASE (SGOT-AST)	31.9	U/L	5.0-40.0
Method : IFCC with Serum			
ALANINE AMINO TRANSFERASE (SGPT-ALT)	38.2	U/L	5.0 - 40.0
Method : IFCC with POD Serum			
Alkaline Phosphatase	68.0	U/L	MALE & FEMALE
Method : IFCC with Serum			4-19 YEAR: 54-369 U/L
			20-59 YEAR: 42-98 U/L
			>60 YEAR: 53-141 U/L
Total Protein	7.39	g/dL	6.00 - 8.00
Method : Biuret, with Serum			
Albumin	4.51	g/dL	3.40 - 5.50
Method : Tech; BCG with Serum			
Globulin	2.88	g/dL	1.5 - 3.5
Method : Calculated			
A/G Ratio	1.57		1.5 - 2.5
Method : Calculated			

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BIOCHEMISTRY

Gamma GT	22	U/L	8-61
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Method : G-Glutamyl-Carboxy-Nitoanilide

Interpretation

A high GGT level can help rule out bone disease as the cause of an increased ALP level, but if GGT is low or normal, then an increased ALP is more likely due to bone disease. Even small amounts of alcohol within 24 hours of a GGT test may cause a temporary increase in the GGT.

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HAEMATOLOGY

BLOOD GROUP ABO AND RHTYPE

'B' POSITIVE

Method : Gel Technique & Tube Agglutination

Medical Remark :

The blood group done is forward blood group only. In case of any discrepancy kindly contact the lab

END OF REPORT

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CLINICAL PATHOLOGY

General Examination

Colour	Pale yellow		Pale Yellow
Transparency (Appearance)	Clear		Clear
Reaction (pH)	Acidic		4.5 - 7.0
Specific gravity	1.015		1.005 - 1.030

Chemical Examination

Urine Protein (Albumin)	Trace		NIL
Urine Glucose (Sugar)	NIL		NIL

Microscopic Examination

Pus cells (WBCs)	2-3	/hpf	0-9
Epithelial cells	4-5	/hpf	0-4
Red blood cells	NIL	/hpf	0-4
Crystals	Absent		Absent
Cast	Absent		Absent
Amorphous deposits	Absent		Absent
Bacteria	Present		Absent
Yeast cells	Absent		Absent

END OF REPORT

Dr. Nishi Prasad
M.D. (Patho.)

Consultant Radiologist & Sonologist

Dr. Roopa Goyal

MD (Radio-Diagnosis)

GOYAL
DIAGNOSTICS
4-D ULTRASOUND • COLOUR DOPPLER

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BIOCHEMISTRY

Glucose fasting	92.30	mg/dL	70.0-110.0
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Method : Fluoride Plasma-F, Hexokinase

END OF REPORT

Dr. Nishi Prasad
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BIOCHEMISTRY

Blood Glucose-Post Prandial

105.30

mg/dL

70 - 140

Method : Hexokinase

END OF REPORT

Dr. Nishi Prasad

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DIAGNOSTICS
4-D ULTRASOUND • COLOUR DOPPLER

SHOP NO. 16-17, 1ST FLOOR SHOPPING CENTRE, OPP. JLN HOSPITAL, AJMER -305 001 PHONE : 2428948

NAME- Manish Kumar AGE- 32 yrs DATE - 8-04-2023

REF.BY -

SKIAGRAM CHEST PA VIEW

**Both cp angles are clear.
Cardiac size is within normal limits.
Both lungs fields are clear.**

NAD IN HEART AND LUNGS.

Dr. ROOPA GOYAL (M.B.B.S., M.D.)
Consultant Radiologist & Sonologist
RMC No. - 004507/15600

भ्रूण लिंग परिक्षण करवाना जघन्य अपराध है। इसकी शिकायत 104 टोल फ्री सेवा पर की जा सकती है।

USG ABDOMEN-PELVIS

NAME - Manish

AGE - 32 yrs

Date - 08-04-2023

REF BY -

LIVER: is Enlarged and bright 14.7 cm and shows homogeneous echotexture. No evidence of intrahepatic biliary radicles dilatation / focal space occupying lesion. The portal vein and common bile duct show normal caliber.

GALL BLADDER: distended and shows smooth walls. Wall thickness appears normal. No evidence of sludge/ calculus. No evidence of pericholecystic collection.

SPLEEN: normal in size and shows normal echopattern.

PANCREAS: Normal in size, shape and position. Parenchyma is homogenous.

KIDNEYS: Both the kidneys are normal in size, shape and location. Both show normal cortico-medullary differentiation. No evidence of hydronephrosis or calculus.

Right kidney - measures :- 10.2 x 5.1 cm
Left kidney - measures :- 10.0 x 4.7 cm

URINARY BLADDER: is distended with smooth walls. No evidence of diverticulum or calculus.

PROSTATE: is normal in size and shows normal homogeneous echotexture. No evidence of ascites / pleural effusion.

IMPRESSION:-

Enlarged Fatty Liver

Rest of the abdominal organs are within normal limits.

(Adv- clinical correlation, further evaluation)

RMC No.: 004250/15000
Consultant Radiologist
And Sonologist

ध्रूण लिंग परिक्षण करवाना जघन्य अपराध है। इसकी शिकायत 104 टोल फ्री सेवा पर की जा सकती है।

HOLTER TMT ECHOCARDIOGRAPHY SPIROMETRY DIGITAL X-RAY BMD OPG MAMMOGRAPHY CLINICAL LAB. PAP SMEAR FNAC
THE DIAGNOSIS, FINDING SHOULD ALWAYS BE CORRELATED WITH CLINICAL HISTORY

GOYAL DIAGNOSTICS

5 Seconds ECG Report

Patient Name: Mr. MANISH KUMAR 32/M

HR : 66 bpm BP : 0 / 0 mmHg

April 08, 2023

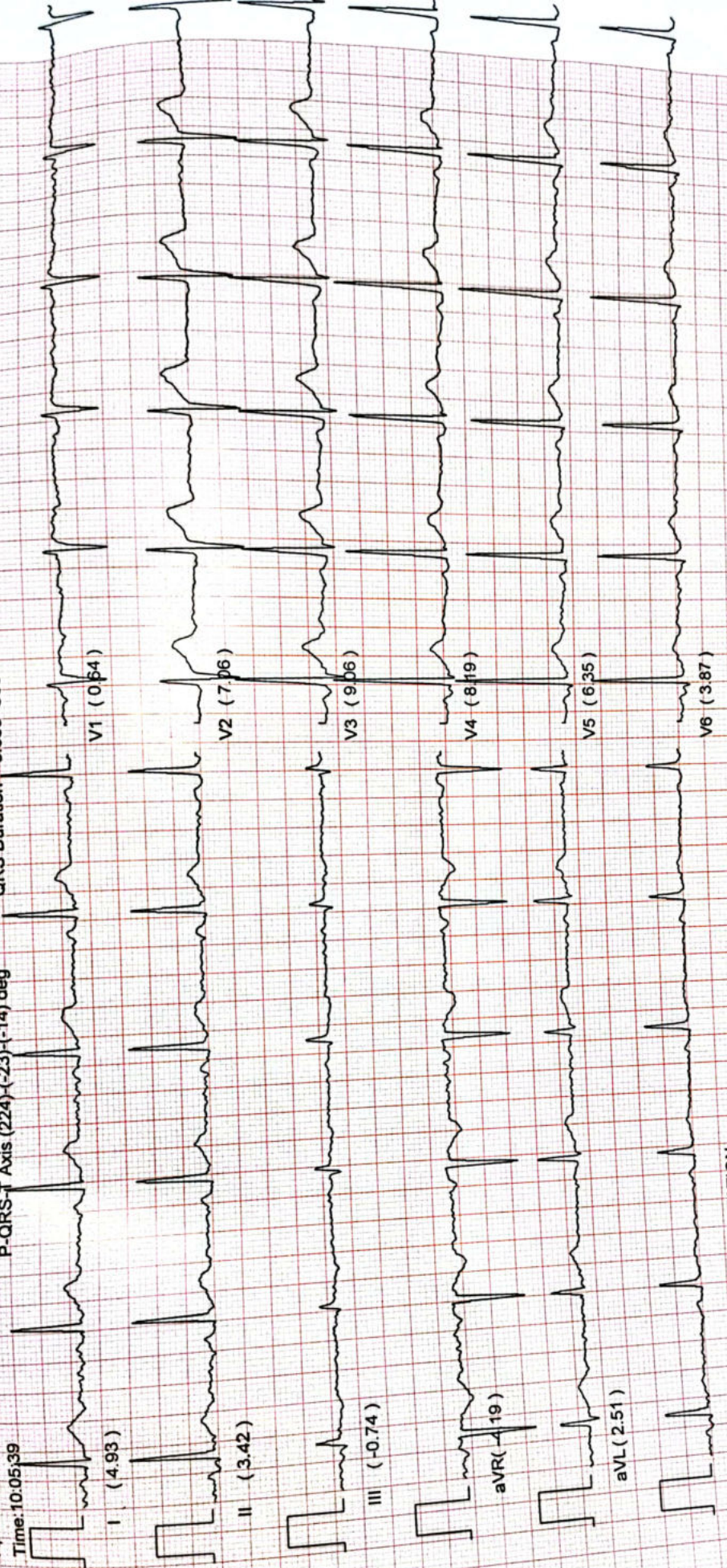
Time: 10:05:39

RR Interval: 0.90 sec

PR Interval: 0.20 sec

QRS Duration: 0.036 Sec

P-QRS-T Axis (224) (-23) (-14) deg



INTERPRETATION

aVF (0.58)
PR is normal, Normal QRS Width, Normal QT interval,
Junctional/NonSinus Rhythm suspected. Left axis deviation, T wave inversion in Lead III, aVF.
ECG not normal

DR
MD

10mm/mv, 25mm/sec NASAN Simul-G BL U 4.6/1.13

*Unconfirmed Reporting, Refer to Clinician

NAME	: MR . MANISH	DATE	: 08-04-2023
AGE	: 32 YRS	REF BY	:
SEX	: MALE		

INTERPRETATION SUMMARY

NORMAL CHAMBER DIMENSIONS
 INTACT IAS/ IVS
 ALL VALVES ARE NORMAL.
 MILD TR
 RVSP 30 MM HG
 NO RWMA : LVEF 65 %
 NO CLOT, VEGITATION.
 NO PERICARDIAL EFFUSION
 NORMAL PERICARDIUM

M.MODE/2D MEASUREMENTS (MM) & CALCULATIONS (ML)

LVID d	48.1	LVEDV	
LVID s	30.7	LVESV	
RVID(d)	---	SV	-
IVS d	10.9	F.S	35%
IVS s	14.9	EF	65%
LVPW d	9.9	C.O	-
LVPWS	13.6	MITRAL VALVE	-
AORTIC ROOT	28.1	EF SLOPE	-
LEFT ATRIUM	32.1	OPENING AMPLITUDE	-
AORTIC CUSP OPENING	-	E.P.S.S	-

DOPPLER MEASUREMENTS & CALCULATIONS:



STRUCTURE	MORPHOLOGY	VELOCITY(cm/sec.)	GRADIENT P/M	REGURGITATION
MITRAL VALVE	NORMAL	E- 121 A-78	-	NIL
TRICUSPID VALVE	NORMAL	229	-	MILD
PUL VALVE	NORMAL	108	-	NIL
AORTIC VALVE	NORMAL	155	-	NIL

PULMONARY ARTERY	MITRAL VALVE AREA (BY P 1/2 T)
PEAK ACCELERATION TIME	PRESSURE HALF TIME
SYSTOLIC PRESSURE 30 MM HG	MVA


Dr. DEVENDRA GOYAL (M.D.)
 RMC No.: 004250/15000
 Consultant Radiologist
 And Sonologist

भ्रूण लिंग परिक्षण करवाना जघन्य अपराध है। इसकी शिकायत 104 टोल फ्री सेवा पर की जा सकती है।

HOLTER TMT ECHOCARDIOGRAPHY SPIROMETRY DIGITAL X-RAY BMD OPG MAMMOGRAPHY CLINICAL LAB. PAP SMEAR FNAC
 THE DIAGNOSIS, FINDING SHOULD BE... WHERE APPLICABLE THIS REPORT IS NOT MEANT FOR MEDICO-LEGAL PURPOSE

 **भारत सरकार**
Government of India 



Issue Date: 30/10/2011



मनीष कुमार राठोरिया
Manish Kumar Rathoria
जन्म तिथि/DOB: 22/11/1989
पुरुष/ MALE

6617 8528 8079
VID : 9159 8504 6194 2324

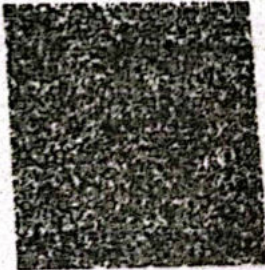
मेरा आधार, मेरी पहचान

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Unique Identification Authority of India 

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S/O भवानी शंकर राठोरिया, 1085/45 शान्ति गुलाबंगन,
संस्कार कॉलोनी, कल्याणी पुरा रोड, गुलाब बार्डी, अजमेर,
अजमेर,
राजस्थान - 305001

Download Date: 28/11/2022

Address:
S/O Bhawani Shankar Rathoria, 1085/45
SHANTI GULABANGAN, sanskaar colony,
kalyani pura road, gulab bari, Ajmer, Ajmer,
Rajasthan - 305001



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