MEDICAL EXAMINATION FORM

NAME OF EXAMINEE: NAVDEEP SINGH DATE OF BIRTH: 14/03/1991

NAME OF COMPANY: BOB

FAMILY HISTORY :] Not Significant

PAST HISTORY :

GENERAL PHYSICAL EXAMINATION

BUILT: well Built PALLOR: Not Seen

HEIGHT: 175 Cms WEIGHT: 73 Kgs BMI: 23.8 (Normal)

	1st Reading	2nd Reading	3rd Reading
BLOOD PREESURE	124/80		
PULSE	90/min		
RESPIRATION	19/min		

SYSTEMATIC EXAMINATION

RESPIRATORY SYSTEM :
CARDIOVASCULAR SYSTEM:] WNL
GENITOURINARY SYSTEM :

LIVER :
SPLEEN :] Not Palpable
LYMPH NODES :

SKIN :
VARICOSE VEINS:] WNL
ENT :

EYES : B/E Visim N6
Dvisim 6/6
Colour visim Normal

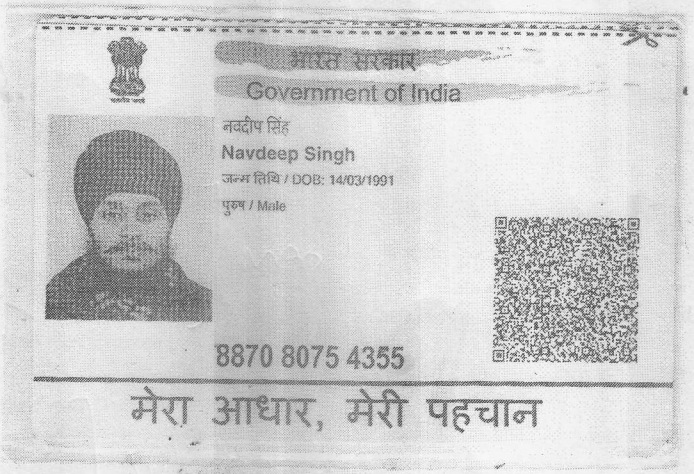
REMARKS BY MEDICAL EXAMINER:

No Adverse Remarks

DR.SIGNATURE:

Dr. PRIYA MAHAJAN
DNB Pathology
Regd. No. 61896

PAN HEALTH
S.C.O. 56, 1st Floor
Sec. 47-D, Chandigarh



Nagar

85914-93699

NAVDEEP.SINGH3@ Bank of Baroda.ac.in

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Regd. No. 31896

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ISO: 9001:2000

Dr. Priya Mahajan
MBBS, DNB (Pathology)
+91 99884-63931

SCO 56, Ist Floor, Sector 47-D, Chandigarh
Ph. : 0172-5006756, E-mail : panhealth35@gmail.com

Patient Name	:- Mr Navdeep Singh	**Guardian**	:-	**Reg. No.**	:- 22022215
Receipt Date	:- 22 Feb 2022	**Receipt No.**	:- 11220005876	**Age/Sex**	:- 32 Y / M
Address	:- BOB,Chandigarh			**Mobile No.**	:- 1111111111

Final Report

Investigations	Observations	Biological Reference Interval	Unit
COMPLETE BLOOD COUNTS (CBC) *Method: SPECTROPHOTOMETER/AUTOMATED CELL COUNTER*			
HAEMOGLOBIN *Method : Spectrophotometer /Automated cell counter*	14.7	11.00 - 16.00	mg/dl
TLC	7800	4000-11000	/cmm
DLC DIFFERENTIAL LEUCOCYTE COUNT *Method : Microscopy*			
NEUTROPHILS	63	40-75	%
LYMPHOCYTES	24	20-40	%
EOSINOPHILS	05	1-6	%
MONOCYTES	08	2-10	%
BASOPHILS	00	<0-1	%
RBCS (RED BLOOD CELLS) *Method : Impedance/Automated cell counter*	4.61	4.50 - 5.50	millions/cumm
PCV *Method : Calculation/Automated cell counter*	40.6	40.00 - 50.00	%
MCV(MEAN CELL VOLUME) *Method : Calculation/Automated cell counter*	88.1	80.00 - 100.00	fl
MCH(MEAN CELL HAEMOGLOBIN) *Method : Calculation/Automated cell counter*	31.9	27.00 - 32.00	pg
MCHC *Method : Calculation/Automated cell counter*	**36.2**	31.50 - 34.50	g/dL
PLATELET COUNT *Method : Impedance/Automated cell counter*	1.92	1.50 - 4.50	Lakhs/cmm
RDW	13.4	10.00 - 15.00	%
PDW	**20.7**	9.00 - 17.00	fL
MPV	13.0	9.00 - 13.00	fL
P-LCR	**47.1**	13.00 - 43.00	%
ERYTHROCYTE SEDIMENTATION RATE (ESR). *Method: WESTERGREN*	09	0.00 -10.00	MM/1st hr

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<<::END OF REPORT::>>

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Biochemistry | Microbiology | Hematology | Clinical Pathology | Histopathology | Immunology

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Receipt Date	:- 22 Feb 2022	**Receipt No.**	:- 11220005876	**Age/Sex**	:- 32 Y / M
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Final Report

Investigations	Observations	Biological Reference Interval	Unit
THYROID PROFILE (T3,T4,TSH)			
T3	0.99	0.70 - 2.04	ng/mL
T4 *Method : CLIA*	7.9	5.00 - 12.60	µg/dL
TSH *Method : CLIA*	2.42	0.35 - 5.50	µIU/mL
GAMMA GT (GGT)	36.9	11.00-73.00	U / L
URIC ACID *Method: URICASE - POD*	4.94	3.60 -7.20	mg/dl
BLOOD UREA NITROGEN (BUN)	13.7	6.00 -21.00	mg/dl
CREATININE *Method: JAFFES METHOD*	0.72	0.70-1.40	mg/dl
BLOOD GROUP (ABO &RH TYPING) *Method: SLIDE METHOD*			
BLOOD GROUP (ABO RH) *Method : SLIDE METHOD*	B		
RH	POSITIVE		
HBA1C (GLYCOSYLATED HAEMOGLOBIN) *Method: BORONATE AFFINITY ASSAY*	5.3	4.00 Estimated Average Gl-6.00	%
GLUCOSE (FASTING) *Method: GOD POD*	102.1	70.00 -110.00	mg/dl
GLUCOSE (PP) *Method: GOD POD*	126.3	70.00 -140.00	mg/dl

<<::END OF REPORT::>>

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Patient Name	:- Mr Navdeep Singh	**Guardian**	:-	**Reg. No.**	:- 22022215
Receipt Date	:- 25 Feb 2022	**Receipt No.**	:- 11220005911	**Age/Sex**	:- 32 Y / M
Address	:- BOB,Chandigarh			**Mobile No.**	:- 1111111111

Final Report

Investigations	Observations	Biological Reference Interval	Unit
LIVER FUNCTION TESTS (LFT)			
TOTAL BILIRUBIN *Method : Diazo Method*	0.96	0.00 - 2.00	mg/dl
DIRECT BILIRUBIN *Method : Diazo Method*	0.33	0.00 - 0.40	mg/dl
INDIRECT BILIRUBIN *Method : Calculated*	0.63	0.20 - 0.80	mg/dl
SGOT *Method : IFCC KINETIC METHOD*	24.7	7.00 - 35.00	U/L
SGPT(ALT) *Method : IFCC KINETIC METHOD*	38.9	5.00 - 42.00	U/L
ALKALINE PHOSPHATASE *Method : PNPP*	79.3	42.00 - 369.00	U/L
TOTAL PROTIENS *Method : Biuret reaction end point*	7.2	4.60 - 7.80	g/dl
ALBUMIN *Method : Method: Bormocresol green*	3.6	3.50 - 5.00	g/dl
GLOBULIN *Method : Calculated*	3.60	2.30 - 3.60	gm/dl
A/G RATIO *Method : Calculated*	1.00	1.00 - 2.00	RATIO

<<::END OF REPORT::>>

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Patient Name	:- Mr Navdeep Singh	**Guardian**	:-	**Reg. No.**	:- 22022215
Receipt Date	:- 22 Feb 2022	**Receipt No.**	:- 11220005876	**Age/Sex**	:- 32 Y / M
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Final Report

Investigations	Observations	Biological Reference Interval	Unit
LIPID PROFILE			
TOTAL CHOLESTROL *Method : Cholesterol oxidase & peroxidase*	**231.8**	125.00 - 200.00	mg/dl
TRIGLYCERIDES *Method : GPO Method*	166.5	upto 150	mg/dl
HDL CHOLESTROL *Method : DIRECT HDL*	64.2	35.30 - 79.50	mg/dl
LDL CHOLESTROL *Method : Calculated*	134.30	<130	mg/dl
VLDL *Method : Calculated*	33.30	7.00 - 35.00	mg/dl
CHOL/HDL RATIO *Method : Calculated*	**3.61**	0.00 - 3.50	RATIO
LDL/HDL RATIO *Method : Calculated*	1.73	<3	ratio

<<::END OF REPORT::>>

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Final Report

Investigations	Observations	Biological Reference Interval	Unit
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION			
URINE GLUCOSE	NIL	NIL	
URINE SPECIFIC GRAVITY	1.010	1.01 - 1.03	
URINE PH	5.0	4.8-7.6	
URINE PROTEIN	NIL	NIL	
MICROSCOPIC EXAMINATION			
URINE PUS CELLS	01-02	2.00 - 3.00	/HPF
URINE RBC	ABSENT	Absent	/HPF
EPITHELIAL CELLS	01-02	0-5	/HPF
CASTS	NOT SEEN		
CRYSTALS	NOT SEEN		
OTHERS	NIL		

<<::END OF REPORT::>>

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DNB Pathology
Regd. No. 31896

tricity
HEALTHCARE
— DIAGNOSTIC CENTRE —
the pathology & radiology specialist

SCO 41, Level I, Sector 47-D,
CHANDIGARH - 160 047

Ph. 0172-2633141 M : 98767 00150
Email : tricityhealthcare47@gmail.com

PATIENT NAME :	**Mr. NAVDEEP SINGH**	**AGE**	**: 32 YRS / MALE**
REFERRED BY :	**PAN HEALTH LAB**	**VISIT DATE**	**: 24-FEB-2022**
VISIT NO.	**: 01**		

CLINICAL PROFILE: MEDICAL CHECK-UP.

X-RAY CHEST (PA View)

OBSERVATIONS

Both lungs appear clear with no obvious parenchymal lesions.

Bilateral hila appear unremarkable.

CP angles appear normal.

Cardiac size appears normal.

Domes of diaphragm appear unremarkable.

No free air seen under the domes of diaphragm.

Bony thoracic cage & soft tissues under view appear unremarkable.

IMPRESSION: NORMAL STUDY.

Please correlate clinically and with findings of other relevant investigations.

PAN HEALTH
S.C.O. 56, 1st Floor
Sec. 47-D, Chandigarh

Dr. Aman Deepak
Consultant Radiologist
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Consultant Radiologist
Regd. No. 011131

tricity
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PATIENT NAME : Mr. NAVDEEP SINGH	**AGE : 32 YRS / MALE**
REFERRED BY : PAN HEALTH LAB	**VISIT DATE : 24-FEB-2022**
VISIT NO. : 01	

CLINICAL PROFILE: MEDICAL CHECK-UP.

USG WHOLE ABDOMEN

IMPRESSION

- **Normal size & echotexture of bilateral kidneys.**
- **No evidence of significant renal calculus noted in bilateral kidneys.**

Please correlate clinically and with findings of other relevant investigations.

OBSERVATIONS ARE AS BELOW

LIVER: is normal in size, shape, & outline and homogeneous echotexture. No obvious focal lesion noted in both lobes of liver. Intrahepatic & extrahepatic billiary radicals are not dilated. Hepatic veins are normal.

PORTA: Portal vein is normal in caliber. No periportal collaterals noted. CBD is normal in course and calibre in traceable portion.

GALL BLADDER: is partially distended and shows no wall thickening. No intraluminal echogenic foci/ sludge noted. No pericholecystic collection noted.

PANCREAS: It is normal in size, shape, outline & echotexture. No peripancreatic collection noted.

SPLEEN: It is normal in size & echotexture. No focal lesion noted. Splenic vein calibre at the hilum is within normal limits. No collaterals observed at the splenic hilum.

RETROPERITONEUM: No e/o significant lymphadenopathy noted. Aorta & IVC appears normal.

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RIGHT KIDNEY: is normal in size and measures 10.2 x 4.2 cm, shape and echotexture. Cortical echogenicity is normal. Cortico-medullary differentiation is maintained. No pelvicalyceal system dilatation noted. No calculus noted.

LEFT KIDNEY: is normal in size and measures 10.4 x 4.0 cm, shape and echotexture. Cortical echogenicity is normal. Cortico-medullary differentiation is maintained. No pelvicalyceal system dilatation noted. No calculus noted.

URINARY BLADDER: Well distended. Wall thickness is normal. No calculi /debris noted. No fluid/fluid level noted.

PROSTATE: is normal in size, shape, outline and echotexture. It is well confined in it's capsule. No e/o capsular breach. Periprostatic region is normal.

SEMINAL VESICLES: Both side seminal vesicles are normal / symmetrical with no e/o enlargement/ inhomogeneosity.

No free fluid or obvious abnormality in visualized bowel loops. Gut loops show normal peristalsis.

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Regd. No. 0111

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