

Dr. Vimmi Goel  
MBBS, MD (Internal Medicine)  
Sr. Consultant Non Invasive Cardiology  
Reg. No: MMC- 2014/01/0113

Preventive Health Check up  
KIMS Kingsway Hospital  
Nagpur  
Phone No.: 7499913052

Mediwheel Rlo- Nagpur  
**KIMS-KINGSWAY  
HOSPITALS**

Name: Mr. Anoop Chandrikapure Date: 07/02/24  
Age: 36y Sex (M/F) Weight: 69.2 kg Height: 171 inc BMI: 23.7  
BP: 133/84 mmHg Pulse: 83/min bpm RBS: \_\_\_\_\_ mg/dl  
SpO2: 98%

- Smoker 3 cigs/d
- Alcohol 90ml/d
- Mc Sicale AS pattern
- LDL - 138
- TG - 250
- F1H - Father HT

Mc Lt. AVN - Femoral hip.  
(↓ 7IT)

O/E  
JVP°  
Cv  
W  
P/A / N

Adv.

- T. Atorva 20 (90) A/D
- To see Dr. Tushar Bhure  
(AVN)
- Diet, walking
- R/A 3mm FLP
- Stop Alcohol, Smoking.

Dr. VIMMI GOEL  
MBBS, MD  
Sr. Consultant-Non Invasive Cardiology  
Reg. No.: 2014/01/0113



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mr. Anoop Chandrikapure	<b>Age /Gender</b> : 36 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324075170/KH125031	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:16 am	<b>Report Date</b> : 07-Feb-24 11:49 am

**HAEMOGRAM**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	15.9	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		47.3	40.0 - 50.0 %	Calculated
RBC Count		<b>6.01</b>	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		<b>79</b>	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		<b>26.4</b>	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		33.5	31.5 - 35.0 g/l	Calculated
RDW		<b>18.6</b>	11.5 - 14.0 %	Calculated
Platelet count		341	150 - 450 $10^3$ /cumm	Impedance
WBC Count		5100	4000 - 11000 cells/cumm	Impedance

**DIFFERENTIAL COUNT**

Neutrophils	53.8	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes	36.7	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils	3.3	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes	6.2	2 - 10 %	Flow Cytometry/Light microscopy
Basophils	0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count	2743.8	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		1871.7	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		168.3	20 - 500 /cumm	Calculated
Absolute Monocyte Count		316.2	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
<b><u>PERIPHERAL SMEAR</u></b>				
RBC		Microcytosis +(Few), Hypochromia +(Few), Anisocytosis +(Few)		Light microscopy
WBC		As Above		
Platelets		Adequate		
<b>ESR</b>		05	0 - 15 mm/hr	Automated Westergren's Method
*** End Of Report ***				

Suggested Clinical Correlation \* If necessary, Please discuss

Verified By : : 11100245

Test results related only to the item tested.

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



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mr. Anoop Chandrikapure	<b>Age / Gender</b> : 36 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324075170/KH125031	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:14 am	<b>Report Date</b> : 07-Feb-24 11:56 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	86	< 100 mg/dl	GOD/POD, Colorimetric
Post Prandial Plasma Glucose		105	< 140 mg/dl	GOD/POD, Colorimetric

**GLYCOSYLATED HAEMOGLOBIN (HBA1C)**

<b>HbA1c</b>	5.6	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC
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**COMMENT**

In view of S-window of 36.0% in HbA1c graph, advised HPLC to rule out hemoglobinopathy.  
\*\*\* End Of Report \*\*\*

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**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mr. Anoop Chandrikapure	<b>Age / Gender</b> : 36 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324075170/KH125031	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:16 am	<b>Report Date</b> : 07-Feb-24 12:17 pm

**LIPID PROFILE**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	<b>230</b> < 200 mg/dl	Enzymatic(CHE/CHO/POD)
Triglycerides		<b>250</b> < 150 mg/dl	Enzymatic
HDL Cholesterol Direct		<b>48</b> > 40 mg/dl	(Lipase/GK/GPO/POD)
LDL Cholesterol Direct		<b>138.68</b> < 100 mg/dl	Phosphotungstic acid/mgcl-Enzymatic (microslide)
VLDL Cholesterol		<b>50</b> < 30 mg/dl	Enzymatic
Tot Chol/HDL Ratio		<b>5</b> 3 - 5	Calculated
			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%		<100
Two or more additional major risk factors, 10 yrs CHD risk <20%	>130	10 yrs risk 10-20 % >130 10 yrs risk <10% >160
No additional major risk or one additional major risk factor	>160	>190, optional at 160-189

\*\*\* End Of Report \*\*\*

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**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mr. Anoop Chandrikapure	<b>Age / Gender</b> : 36 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324075170/KH125031	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:16 am	<b>Report Date</b> : 07-Feb-24 12:17 pm

<b>Parameter</b>	<b>Specimen</b>	<b>Result Values</b>	<b>Biological Reference</b>	<b>Method</b>
<b>RFT</b>				
Blood Urea	Serum	27	19.0 - 43.0 mg/dl	Urease with indicator dye
Creatinine		1.0	0.66 - 1.25 mg/dl	Enzymatic ( creatinine amidohydrolase)
GFR		100.0	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		144	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.90	3.5 - 5.1 mmol/L	Direct ion selective electrode
<b>THYROID PROFILE</b>				
<b>T3</b>		1.27	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
<b>Free T4</b>		1.18	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
<b>TSH</b>		1.34	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

\*\*\* End Of Report \*\*\*

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

**CONSULTANT PATHOLOGIST**

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Phone: +91 0712 6789100

CIN: U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mr. Anoop Chandrikapure	<b>Age /Gender</b> : 36 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324075170/KH125031	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:16 am	<b>Report Date</b> : 07-Feb-24 12:17 pm

**LIVER FUNCTION TEST(LFT)**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.63	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.17	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.46	0.1 - 1.1 mg/dl	Dual wavelength spectrophotometric pNPP/AMP buffer
Alkaline Phosphatase		101	38 - 126 U/L	Kinetic with pyridoxal 5 phosphate
SGPT/ALT		<b>41</b>	10 - 40 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		30	15 - 40 U/L	Biuret (Alkaline cupric sulphate)
Serum Total Protein		<b>8.31</b>	6.3 - 8.2 gm/dl	Bromocresol green Dye Binding
Albumin Serum		4.64	3.5 - 5.0 gm/dl	Calculated
Globulin		3.67	2.0 - 4.0 gm/dl	
A/G Ratio		1.3		

\*\*\* End Of Report \*\*\*

Suggested Clinical Correlation \* If neccessary, Please discuss

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**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mr. Anoop Chandrikapure	<b>Age /Gender</b> : 36 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324075170/KH125031	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 11:35 am	<b>Report Date</b> : 07-Feb-24 01:02 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<b>URINE MICROSCOPY</b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
Volume	Urine	20 ml	
Colour.		Pale yellow	
Appearance		Clear	Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
Reaction (pH)	Urine	5.0	4.6 - 8.0
Specific gravity		1.020	1.005 - 1.025
Urine Protein		Negative	Negative
Sugar		Negative	Negative
Bilirubin		Negative	Negative
Ketone Bodies		Negative	Negative
Nitrate		Negative	Negative
Urobilinogen		Normal	Normal
<b><u>MICROSCOPIC EXAMINATION</u></b>			
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	
<b>USF(URINE SUGAR FASTING)</b>			
Urine Glucose	Urine	Negative	STRIP

\*\*\* End Of Report \*\*\*

Suggested Clinical Correlation \* If necessary, Please discuss

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**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF IMMUNO HAEMATOLOGY**

<b>Patient Name</b> : Mr. Anoop Chandrikapure	<b>Age /Gender</b> : 36 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324075170/KH125031	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 07-Feb-24 10:16 am	<b>Report Date</b> : 07-Feb-24 12:09 pm

**BLOOD GROUPING AND RH**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
<b>BLOOD GROUP.</b>	EDTA Whole Blood & Plasma/Serum	" B "	Gel Card Method
<b>Rh (D) Typing.</b>		" Positive "(+Ve)	
		*** End Of Report ***	

Suggested Clinical Correlation \* If necessary, Please discuss

Verified By : : 11100499

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

**DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE**

NAME	Anoop Chandrikapure	STUDY DATE	07-02-2024 10:47:11
AGE/ SEX	1Y 2M 20D / M	HOSPITAL NO.	KH125031
ACCESSION NO.	BIL2324075170-9	MODALITY	DX
REPORTED ON	07-02-2024 11:09	REFERRED BY	Dr. Vimmi Goel

**X-RAY CHEST PA VIEW**

Both the lung fields are clear.

Heart and Aorta are normal.

Both hilar shadows appear normal.

Diaphragm domes and CP angles are clear.

Bony cage is normal.

**IMPRESSION:**

No pleuro-parenchymal abnormality seen.



**DR R.R KHANDELWAL**

**SENIOR CONSULTANT**

**MD, RADIODIAGNOSIS [MMC-55870]**

N.B: This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations. Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

PATIENT NAME:	MR. ANOOP CHANDRIKAPURE	AGE /SEX:	36 YRS/MALE
UMR NO:	KH1258031	BILL NO:	2324075170
REF BY	DR. VIMMI GOEL	DATE:	07/02/2024

**USG WHOLE ABDOMEN**

LIVER is normal in size, shape and echotexture.

No evidence of any focal lesion seen. Intrahepatic billiary 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. Wt – 19.9 gms.

There is no free fluid or abdominal lymphadenopathy seen.

**IMPRESSION:**

No significant abnormality seen.

Suggest clinical correlation / further evaluation.



**DR NAVEEN PUGALIA**  
**MBBS, MD [076125]**  
**SENIOR CONSULTANT RADIOLOGIST**

Kingsway Hospitals  
44 Kingsway, Mohan Nagar,  
Near Kasturchand Park, Nagpur

Station  
Telephone:

## EXERCISE STRESS TEST REPORT

Patient Name: Mr. Anoop, Chandrikapure  
Patient ID: 125031  
Height:  
Weight:  
Study Date: 07.02.2024  
Test Type: Treadmill Stress Test  
Protocol: BRUCE

DOB: 31.01.1988  
Age: 36yrs  
Gender: Male  
Race: Indian  
Referring Physician: Mediwheel HCU  
Attending Physician: Dr. Vimmi Goel  
Technician: --

### Medications:

--

### Medical History:

NIL

### Reason for Exercise Test:

Screening for CAD

### Exercise Test Summary:

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	01:42	0.00	0.00	90	120/80	
	HYPERV.	00:01	0.00	0.00	90		
	WARM-UP	00:18	0.00	0.00	99		
EXERCISE	STAGE 1	03:00	1.70	10.00	112	120/80	
	STAGE 2	03:00	2.50	12.00	126	130/80	
	STAGE 3	02:59	3.40	14.00	148	130/80	
RECOVERY		01:00	0.00	0.00	121	140/80	
		02:00	0.00	0.00	102	140/80	
		00:17	0.00	0.00			

The patient exercised according to the BRUCE for 8:58 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 90 bpm rose to a maximal heart rate of 150 bpm. This value represents 81 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 140/80 mmHg. The exercise test was stopped due to Fatigue.

### Interpretation:

Summary: Resting ECG: normal.

Functional Capacity: normal.

● Response to Exercise: THR not achieved.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: none.

Overall impression: Normal stress test.

### Conclusions:

TMT is negative for inducible ischemia.

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Reg. No. 2014/01/01119

36 Years

Rate 83 Sinus rhythm.....normal P axis, V-rate 50- 99  
 PR 126 RSR' in V1 or V2, right VCD or RVH.....  
 QRS 100 Baseline wander in lead(s) V6  
 QT 365  
 QTc 429

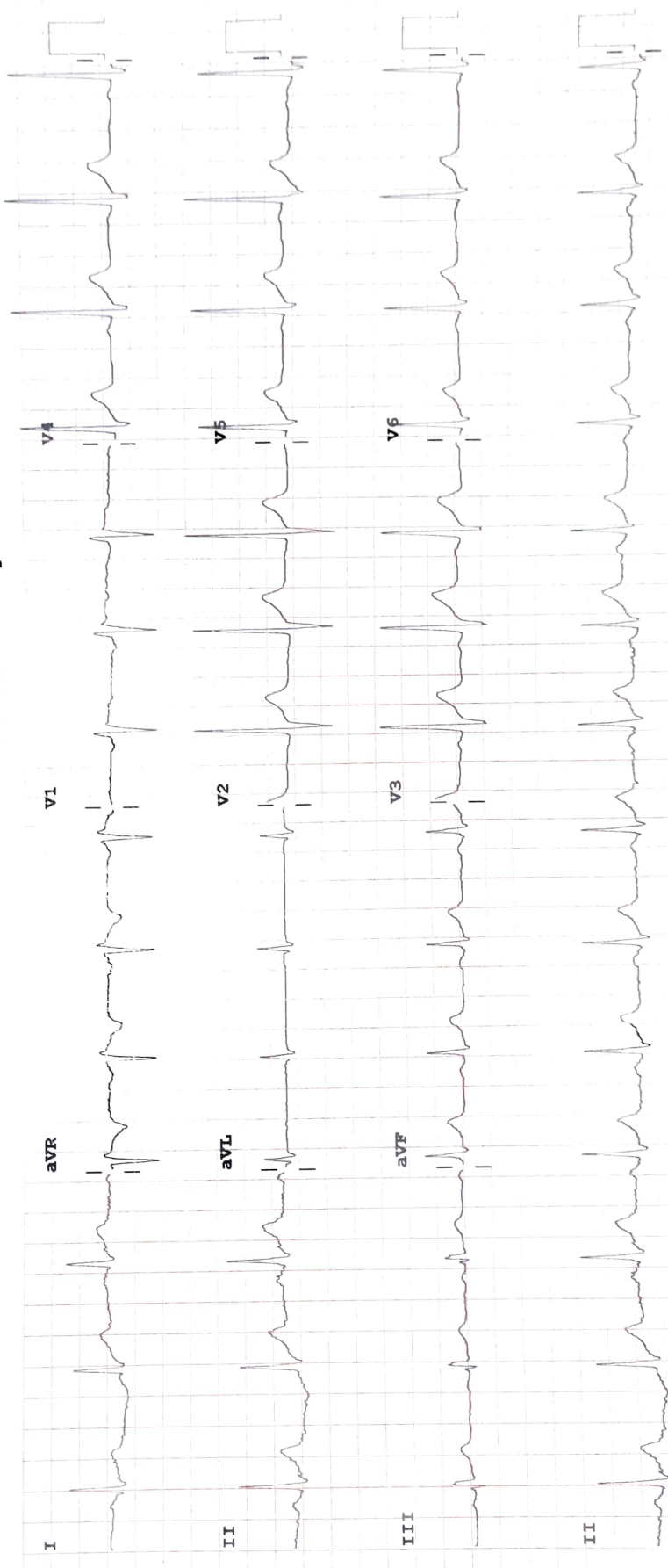
--AXIS--

P 49  
 QRS 52  
 T 56

12 Lead; Standard Placement

- OTHERWISE NORMAL ECG -

Unconfirmed Diagnosis



F 50~ 0.50-150 Hz W 100B CL P?

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

Device:

PHILIPS

RECORDITY