भारत सरकार
Government of India

आधार

Aadhaar no. issued: 01/03/2013

शंकर लाल मीना
Shanker Lal Meena
जन्म तिथि/DOB: 03/08/1984
पुरुष/ MALE

आधार पहचान का प्रमाण है, नागरिकता या जन्मतिथि का नहीं।
इसका उपयोग सत्यापन (ऑनलाइन प्रमाणीकरण, या क्यूआर कोड/ऑफ़लाइन एक्सएमएल की स्कैनिंग) के साथ किया जाना चाहिए।
Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication, or scanning of QR code / offline XML).

9734 1915 0219

मेरा आधार, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

AADHAAR

Details as on: 27/02/2024

पता:
S/O: ननछू राम मीना, जौहड़ा रोड मीना, ग्राम/पोस्ट-गठवाडी तह -जंमवारामगढ, गठ्वारी मीना, गठवाडी, जयपुर, राजस्थान - 303120

Address:
S/O: Nanchhu Ram Meena, johra Road meena, Gram/post-gathwari tah - jamwaramgarh, Gathwari Meena, PO: Gathwadi, DIST: Jaipur, Rajasthan - 303120

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Dr. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No.-037041

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General Physical Examination

Date of Examination: 23/03/2024

Name: Shankar lal Meena Age: 39 DOB: 03/08/1984 Sex: Male

Referred By: Bank of Baroda

Photo ID: Adhar Card ID #: 0219

Ht: 172 (cm) Wt: 59 (Kg)

Chest (Expiration): 80 (cm) Abdomen Circumference: 87 (cm)

Blood Pressure: 120/80 mm Hg PR: 86 / min RR: 18 / min Temp: Afebrile

BMI 19.

Eye Examination: R/E, 6/6, N/6, NCB
L/E 6/6 N/6 NCB

Other: NO

On examination he/she appears physically and mentally fit: Yes / No

Signature Of Examine : ------------------------------------ Name of Examinee: Shankar lal Meena

Signature Medical Examiner : ------------------------------ Name Medical Examiner Dr. Piyush Goyal

Dr. PIYUSH GOYAL
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RMC No. 037041

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Age :-	39 Yrs 7 Mon 20 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Male	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

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HAEMOGARAM

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 MALE			
HAEMOGLOBIN (Hb)	15.0	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	5.08	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	53.0	%	40.0 - 80.0
LYMPHOCYTE	**41.0** H	%	20.0 - 40.0
EOSINOPHIL	2.0	%	1.0 - 6.0
MONOCYTE	4.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	5.08	x10^6/uL	4.50 - 5.50
HEMATOCRIT (HCT)	46.00	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	90.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	29.4	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	32.5	g/dL	31.5 - 34.5
PLATELET COUNT	**126** L	x10^3/uL	150 - 410
RDW-CV	13.6	%	11.6 - 14.0

Technologist

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR) Methord - Westergreen	15	mm in 1st hr	00 - 15

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein.ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis.This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as

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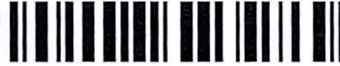

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(CBC): **Methodology**: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and MCH,MCV,MCHC,MENTZER INDEX are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan

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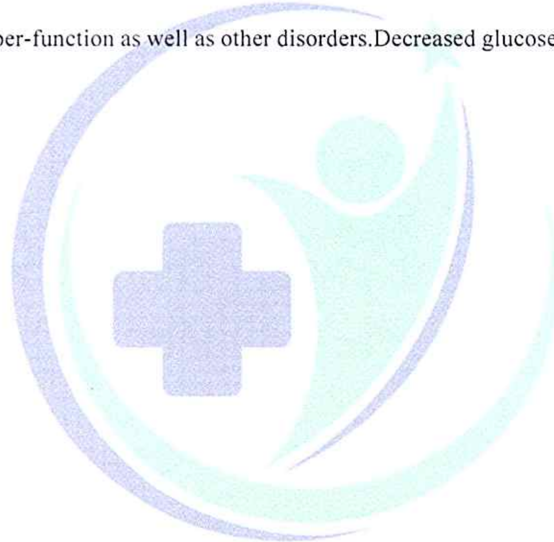
BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Methord - GOD POD	85.3	mg/dl	70.0 - 115.0

Impaired glucose tolerance (IGT)	111 - 125 mg/dL
Diabetes Mellitus (DM)	> 126 mg/dL

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm,
hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin
therapy or various liver diseases .



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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
GLYCOSYLATED HEMOGLOBIN (HbA1C) Methord:- CAPILLARY with EDTA	5.5	%	Non-diabetic: < 5.7 Pre-diabetics: 5.7-6.4 Diabetics: = 6.5 or higher ADA Target: 7.0 Action suggested: > 6.5
MEAN PLASMA GLUCOSE Methord - Calculated Parameter	108	mg/dL	68 - 125

INTERPRETATION
AS PER AMERICAN DIABETES ASSOCIATION (ADA)
Reference Group HbA1c in %
Non diabetic adults >=18 years < 5.7
At risk (Prediabetes) 5.7 - 6.4
Diagnosing Diabetes >= 6.5

CLINICAL NOTES
In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia.The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings.
Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al]

1. Erythropoiesis
- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c.

3. Glycation
- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

4. Erythrocyte destruction
- Increased HbA1c: increased erythrocyte life span: Splenectomy
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

5. Others
- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use,chronic renal failure
- Decreased HbA1c: hypertriglyceridemia,reticulocytosis, chronic liver disease, aspirin, vitamin C and E,splenomegaly, rheumatoid arthritis or drugs

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HAEMATOLOGY

BLOOD GROUP ABO Methord:- Haemagglutination reaction	"A" POSITIVE

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Methord:- CHOD-PAP methodology	188.00	mg/dl	Desirable <200 Borderline 200-239 High> 240

InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.

Test Name	Value	Unit	Biological Ref Interval
TRIGLYCERIDES Methord:- GPO-PAP	125.00	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500

InstrumentName: Randox Rx Imola **Interpretation** : Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.

Test Name	Value	Unit	Biological Ref Interval
DIRECT HDL CHOLESTEROL Methord:- Direct clearance Method	46.20	mg/dl	MALE- 30-70 FEMALE - 30-85

Instrument Name: Rx Daytona plus **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies.Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.

Test Name	Value	Unit	Biological Ref Interval
LDL CHOLESTEROL Methord:- Calculated Method	120.97	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Methord:- Calculated	25.00	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Methord:- Calculated	4.07		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Methord:- Calculated	2.62		0.00 - 3.50
TOTAL LIPID Methord:- CALCULATED	569.20	mg/dl	400.00 - 1000.00

1. Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol
2. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status.Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is

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BIOCHEMISTRY

recommended

3 Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated fromperipheral tissues

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BIOCHEMISTRY

LIVER PROFILE WITH GGT

Test	Result	Unit	Reference Range
SERUM BILIRUBIN (TOTAL) Methord:- DMSO/Diazo	0.78	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Methord:- DMSO/Diazo	0.25	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Methord:- Calculated	0.53	mg/dl	0.30-0.70
SGOT Methord:- IFCC	35.6	U/L	0.0 - 40.0
SGPT Methord:- IFCC	39.3	U/L	0.0 - 40.0
SERUM ALKALINE PHOSPHATASE Methord:- DGKC - SCE	96.30	U/L	80.00 - 306.00

InstrumentName:MISPA PLUS **Interpretation**:Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobilary disease and in bone disease associated with increased osteoblastic activity. Alkaline phosphatase is also used in the diagnosis of parathyroid and intestinal disease.

Test	Result	Unit	Reference Range
SERUM GAMMA GT Methord:- Szasz methodology Instrument Name Randox Rx Imola	32.20	U/L	10.00 - 45.00

Interpretation Elevations in GGT levels areseen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal)are observed with infectious hepatitis.

Test	Result	Unit	Reference Range
SERUM TOTAL PROTEIN Methord:- Direct Biuret Reagent	6.58	g/dl	6.00 - 8.40
SERUM ALBUMIN Methord:- Bromocresol Green	4.30	g/dl	3.50 - 5.50
SERUM GLOBULIN Methord:- CALCULATION	2.28	gm/dl	2.20 - 3.50
A/G RATIO	1.89		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc.Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

Test	Result	Unit	Reference Range
SERUM UREA Methord - Urease/GLDH	33.60	mg/dl	10.00 - 50.00

InstrumentName: HORIBA CA 60 **Interpretation** : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

Test	Result	Unit	Reference Range
SERUM CREATININE Methord:- Jaffe's Method	1.37	mg/dl	Males : 0.6-1.50 mg/dl Females : 0.6 -1.40 mg/dl

Interpretation :
Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

Test	Result	Unit	Reference Range
SERUM URIC ACID	5.69	mg/dl	2.40 - 7.00

InstrumentName:HORIBA YUMIZEN CA60 Daytona plus **Interpretation**: **Elevated Urate**:High purine diet,Alcohol• Renal insufficiency,Drugs , Polycythaemia vera, Malignancies,Hypothyroidism,Rare enzyme defects ,Downs syndrome,Metabolic syndrome, Pregnancy,Gout.

Test	Result	Unit	Reference Range
SODIUM Methord - ISE	137.0	mmol/L	135.0 - 150.0
POTASSIUM Methord - ISE	4.48	mmol/L	3.50 - 5.50
CHLORIDE Methord - ISE	100.4	mmol/L	94.0 - 110.0
SERUM CALCIUM Methord:- Arsenazo III Method	9.65	mg/dL	8.80 - 10.20

InstrumentName:MISPA PLUS **Interpretation**: Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia .Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

Test	Result	Unit	Reference Range
SERUM TOTAL PROTEIN Methord:- Direct Biuret Reagent	6.58	g/dl	6.00 - 8.40
SERUM ALBUMIN Methord:- Bromocresol Green	4.30	g/dl	3.50 - 5.50
SERUM GLOBULIN Methord:- CALCULATION	2.28	gm/dl	2.20 - 3.50
A/G RATIO	1.89		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of dis[illegible] liver, kidney and

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bone marrow as well as other metabolic or nutritional disorders.

INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR. in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare; they almost always reflect low muscle mass

Apart from renal failure Blood Urea can increase in dehydration and GI bleed

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CLINICAL PATHOLOGY

URINE SUGAR (FASTING)	Nil	Nil

Collected Sample Received

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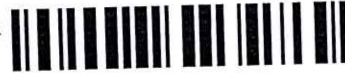

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Age :-	39 Yrs 7 Mon 20 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Male	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 24/03/2024 13:09:44

TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
THYROID-TRIIODOTHYRONINE T3 Methord:- ECLIA	1.01	ng/mL	0.70 - 2.04
THYROID - THYROXINE (T4) Methord:- ECLIA	8.24	ug/dl	5.10 - 14.10
TSH Methord:- ECLIA	3.132	µIU/mL	0.350 - 5.500

4th Generation Assay,Reference ranges vary between laboratories

PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)
1st Trimester : 0.10-2.50 uIU/mL
2nd Trimester : 0.20-3.00 uIU/mL
3rd Trimester : 0.30-3.00 uIU/mL
The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.
NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result.

INTERPRETATION
1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
2.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
3.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
4.Normal or↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
5.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism

. **COMMENTS**: Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test.

Disclaimer-TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly

. **Reference ranges are from Teitz fundamental of clinical chemistry 8th ed (2018**
Test performed by Instrument : Beckman coulter Dxi 800

Note The result obtained relate only to the sample given/ received & tested. A single test result is not always indicative of a disease, it has to be correlated with clinical data for interpretation.

****** End of Report *****

Technologist
MGR

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226

This Report Is Not Valid For Medico Legal Purpose

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(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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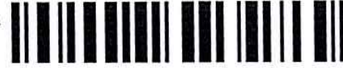

NAME :-	**Mr. SHANKER LAL MEENA**	Patient ID :-12234958	Date :- 23/03/2024 09:30:39
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Sex :-	Male	Lab/Hosp :-	
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Final Authentication : 24/03/2024 13:09:44

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION(PH)	5.0		5.0 - 7.5
SPECIFIC GRAVITY	1.030		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
MICROSCOPY EXAMINATION			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		

Technologist
MGR

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MR. SHANKAR LAL MEENA	39 Y/M
Registration Date: 23/03/2024	Ref. by: BANK OF BARODA

CHEST-X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

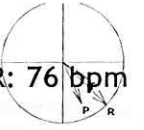
IMPRESSION: No significant abnormality is detected.

Shalini

DR.SHALINI GOEL
M.B.B.S, D.N.B (Radiodiagnosis)
RMC no.: 21954

ıems (P) Ltd
ŦP3 HEALTH SOLUTIONS LLP B-14, Vidhyadhar nahar , Jaipur
ı28541925461239/Mr Shankar Lal Meena 39Yrs-11Months/Male Kgs/31 Cms BP: ___/___ mmHg **HR: 76 bpm**
ʀef.: BANK OF BARODA Test Date: 23-Mar-2024(10:42:18) Notch: 50Hz 0.05Hz - 35Hz 10mm/mV 25mm/Sec

PR Interval: 136 ms
QRS Duration: 86 ms
QT/QTc: 331/373ms
P-QRS-T Axis: 65 - 44 - 35 (Deg)



I avL V3
II avF V4
III V1 V5
avR V2 V6
II

TWNL

FINDINGS: Normal Variant with Non Specific IVCD
Vent Rate : 76 bpm; **PR Interval :** 136 ms; **QRS Duration:** 86 ms; **QT/QTc Int :** 331/373 ms
P-QRS-T axis: 65• 44• 35• (Deg)
Comments :

RMC No.: 35703
MBBS, DIP. CARDIO (ESCORTS)
D.E.M. (RCGP-UK)