

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

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



KIMS-KINGSWAY
HOSPITALS

Kls - Nagpur.

Name : Mrs. Rohini Dedhe Date : 29/3/24
Age : 414 Sex : M/F Weight : 50.9 kg Height : 154.1 inc BMI : 21.4
BP : 118/77 mmHg Pulse : 91/m bpm RBS : _____ mg/dl
SpO2 : 99% LMP - 12/3/24

Dr. Mugdha Jungari (Gill)
MBBS, MS, DNB (OBGY), FMAS
Sr. Consultant Obstetrics & Gynaecology
High Risk Pregnancy Expert & Laparoscopic Surgeon
Reg. No: 2020126915

Name: Robin Date: 29/3/24

Age: 41 yrs Sex: M/F Weight: _____ kg Height: _____ inc BMI: _____

P₁L₁ MTP p₁sev 1 LSC 14 yrs ♂

LMP - 12/3/24.

FBS - 107

P/A soft No hrt
Scar of LSC

PPBS - 173

PS WD ⊕ pap smear

T: Cholesterol 207

Tsh - 4.86.

Adv PV UT

on OCP :: 8 yrs Misena Insetion

Adv

sup ⊕ pap smear

Insetion

Name: Ms. Rehini Dedhe Date: 29/03/24

Age: 41yrs Sex: M/F Weight: _____ kg Height: _____ inc BMI: _____

BP: _____ mmHg Pulse: _____ bpm RBS: _____ mg/dl

Routine dental checkup.

0/E:-

Pit & fissure caries \bar{c} $\frac{c}{c}$

Deep occlusal caries \bar{c} $\frac{6}{}$

grossly decayed \bar{c} $\frac{8}{8}$

Stains +

Calculus +

0/wice:- Restoration \bar{c} $\frac{6}{6}$

RCT \bar{c} $\frac{6}{}$?

Extraction \bar{c} $\frac{8}{8}$

Complete oral prophylaxis .

DPG

|
Dr Megha



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mrs. ROHINI DEDHE **Age / Gender** : 41 Y(s)/Female
Bill No/ UMR No : BIL2324088923/UMR2223131469 **Referred By** : Dr. Vimmi Goel MBBS,MD
Received Dt : 29-Mar-24 08:30 am **Report Date** : 29-Mar-24 10:36 am

HAEMOGRAM

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	11.9	12.0 - 15.0 gm%	Photometric
Haematocrit(PCV)		37.4	36.0 - 46.0 %	Calculated
RBC Count		5.19	3.8 - 4.8 Millions/cumm	Photometric
Mean Cell Volume (MCV)		72	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		22.9	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		31.8	31.5 - 35.0 g/l	Calculated
RDW		17.3	11.5 - 14.0 %	Calculated
Platelet count		241	150 - 450 10^3 /cumm	Impedance
WBC Count		7100	4000 - 11000 cells/cumm	Impedance
<u>DIFFERENTIAL COUNT</u>				
Neutrophils		68.9	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes		22.8	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils		2.7	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes		5.6	2 - 10 %	Flow Cytometry/Light microscopy
Basophils		0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		4891.9	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		1618.8	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		191.7	20 - 500 /cumm	Calculated
Absolute Monocyte Count		397.6	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated
<u>PERIPHERAL SMEAR</u>				
Microcytosis		Microcytosis +(Few)		
Hypochromasia		Hypochromia +(Few)		
WBC		As Above		
Platelets		Adequate		
ESR		15	0 - 20 mm/hr	Automated Westergren's Method

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100131

Test results related only to the item tested.

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Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. ROHINI DEDHE	Age /Gender : 41 Y(s)/Female
Bill No/ UMR No : BIL2324088923/UMR2223131469	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 29-Mar-24 08:29 am	Report Date : 29-Mar-24 10:36 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	107	< 100 mg/dl	GOD/POD,Colorimetric
Post Prandial Plasma Glucose		173	< 140 mg/dl	GOD/POD, Colorimetric

GLYCOSYLATED HAEMOGLOBIN (HBA1C)

HbA1c	5.6	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC
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CONSULTANT PATHOLOGIST

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CIN: U74999MH2018PTC303510



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

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LIPID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	207 < 200 mg/dl	Enzymatic(CHE/CHO/POD)
Triglycerides		117 < 150 mg/dl	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		69 > 50 mg/dl	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		122.77 < 100 mg/dl	Enzymatic
VLDL Cholesterol		23 < 30 mg/dl	Calculated
Tot Chol/HDL Ratio		3 3 - 5	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
No additional major risk or one additional major risk factor	>160	10 yrs risk <10% >160
		>190,optional at 160-189
		<160

*** End Of Report ***

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Bill No/ UMR No : BIL2324088923/UMR2223131469 **Referred By** : Dr. Vimmi Goel MBBS,MD
Received Dt : 29-Mar-24 08:30 am **Report Date** : 29-Mar-24 10:36 am

LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.75	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.31	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.44	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric
Alkaline Phosphatase		113	38 - 126 U/L	pNPP/AMP buffer
SGPT/ALT		15	13 - 45 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		28	13 - 35 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		7.21	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.11	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.10	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.3		

*** End Of Report ***

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CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

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Bill No/ UMR No : BIL2324088923/UMR2223131469
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Received Dt : 29-Mar-24 08:30 am
Report Date : 29-Mar-24 10:36 am

THYROID PROFILE

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
T3	Serum	1.72	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.41	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		4.86	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence

*** End Of Report ***

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CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. ROHINI DEDHE	Age / Gender : 41 Y(s)/Female
Bill No/ UMR No : BIL2324088923/UMR2223131469	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 29-Mar-24 11:26 am	Report Date : 29-Mar-24 01:04 pm

URINE SUGAR

Parameter

Urine Glucose

NOTE:

Result Values

3+ (Approx 300 mg/dl)

urine sugar post meal

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100400

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CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. ROHINI DEDHE
Age / Gender : 41 Y(s)/Female
Bill No/ UMR No : BIL2324088923/UMR2223131469
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 29-Mar-24 08:30 am
Report Date : 29-Mar-24 10:36 am

RFT

Parameter

Blood Urea
Creatinine
GFR
Sodium
Potassium

Specimen

Serum

Result Values

13

0.7

111.4

140

4.47

Biological Reference

15.0 - 36.0 mg/dl

0.52 - 1.04 mg/dl

>90 mL/min/1.73m square.

136 - 145 mmol/L

3.5 - 5.1 mmol/L

Method

Urease with indicator dye
Enzymatic (creatinine amidohydrolase)
Calculation by CKD-EPI 2021
Direct ion selective electrode
Direct ion selective electrode

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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DR. GAURI HARDAS, MBBS, MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mrs. ROHINI DEDHE	Age /Gender : 41 Y(s)/Female
Bill No/ UMR No : BIL2324088923/UMR2223131469	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 29-Mar-24 09:47 am	Report Date : 29-Mar-24 11:34 am

URINE MICROSCOPY

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<u>PHYSICAL EXAMINATION</u>			
Volume	Urine	40 ml	
Colour.		Pale yellow	
Appearance		Clear	Clear
<u>CHEMICAL EXAMINATION</u>			
Reaction (pH)		5.0	4.6 - 8.0
Specific gravity		1.010	1.005 - 1.025
Urine Protein		Negative	Negative
Sugar		Negative	Negative
Bilirubin		Negative	Negative
Ketone Bodies		Negative	Negative
Nitrate		Negative	Negative
Urobilinogen		Normal	Normal
<u>MICROSCOPIC EXAMINATION</u>			
Epithelial Cells		0-1	0 - 4 /hpf
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		5-7	0 - 4 /hpf
Casts		Absent	Absent



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

Patient Name : Mrs. ROHINI DEDHE
Age / Gender : 41 Y(s)/Female
Bill No/ UMR No : BIL2324088923/UMR2223131469
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 29-Mar-24 09:47 am
Report Date : 29-Mar-24 11:34 am

Parameter
Crystals

Specimen

Results

Absent

*** End Of Report ***

Method

Suggested Clinical Correlation * If necessary, Please discuss

Verified By : : 11100400

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Dr. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY

Patient Name : Mrs. ROHINI DEDHE
Bill No/ UMR No : BIL2324088923/UMR2223131469
Received Dt : 29-Mar-24 08:30 am

Age /Gender : 41 Y(s)/Female
Referred By : Dr. Vimmi Goel MBBS,MD
Report Date : 29-Mar-24 11:25 am

BLOOD GROUPING AND RH

Parameter
BLOOD GROUP.

Specimen Results
EDTA Whole " O "
Blood &
Plasma/
Serum

Gel Card Method

Rh (D) Typing.

" Positive "(+Ve)
*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

Verified By :: 11100131

Test results related only to the item tested.

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DR. GAURI HARDAS, MBBS,MD
CONSULTANT PATHOLOGIST

PATIENT NAME:	ROHINI DEDHE	AGE /SEX:	41 YRS / FEMALE
UMR NO:	2223131469	BILL NO:	2324088923
REF BY	DR. VIMMI GEOEL	DATE:	29/03/2024

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]

PATIENT NAME:	MRS. ROHINI DEDHE	AGE /SEX:	41 YRS / FEMALE
UMR NO:	2223131469	BILL NO:	2324088923
REF BY	DR. VIMMI GEOEL	DATE:	29/03/2024

USG ABDOMEN AND PELVIS

LIVER is normal in size and echotexture.

No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated.
PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No stones or sludge seen within it.
Wall thickness is within normal limits.

Visualized head and body of PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in size, shape 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.

URINARY BLADDER is partially distended. No calculus or mass lesion seen.

Uterus is anteverted and normal. It measures 7.4 x 3.3 x 4.4 cm.
No focal myometrial lesion seen.
Endometrial echo-complex appear normal. ET- 5 mm.
No adnexal mass lesion seen.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION:

No significant visceral 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: Mrs. Rohini , Dedhe
Patient ID: 1314690
Height:
Weight:
Study Date: 29.03.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

DOB: 15.05.1982
Age: 41yrs
Gender: Female
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	00:28	0.00	0.00	123	120/70	
	WARM-UP	00:05	0.00	0.00	133		
EXERCISE	STAGE 1	03:00	1.70	10.00	148	120/70	
	STAGE 2	03:00	2.50	12.00	157	130/70	
	STAGE 3	01:17	3.40	14.00	166		
RECOVERY		01:00	0.00	0.00	137		
		02:00	0.00	0.00	134	120/70	
		00:16	0.00	0.00			

The patient exercised according to the BRUCE for 7:17 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 117 bpm rose to a maximal heart rate of 166 bpm. This value represents 92 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/70 mmHg , rose to a maximum blood pressure of 130/70 mmHg. The exercise test was stopped due to Fatigue.

Interpretation:

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: appropriate.

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

Chest Pain: none.

Arrhythmias: none.

ST Changes: Insignificant ST-T changes seen..

Overall impression: Normal stress test.

Conclusions:

TMT is negative for inducible ischemia.

Insignificant ST-T changes seen.

Physical deconditioning noted.

To be correlated clinically.


Dr. VIMMI GOEL

MBBS, MD

Sr. Consultant Non Invasive Cardiology

Reg.No.: 2014/01/0113

MRS ROHINI DEBHA
Female

PHC DEPT.

41 Years

Rate 98 Sinus rhythm.....normal P axis, V-rate 50- 99
 PR 143 Abnormal R-wave progression, early transition.....QRS area>0 in V2
 QRS 85 Baseline wander in lead(s) V5
 QT 350
 QTC 447

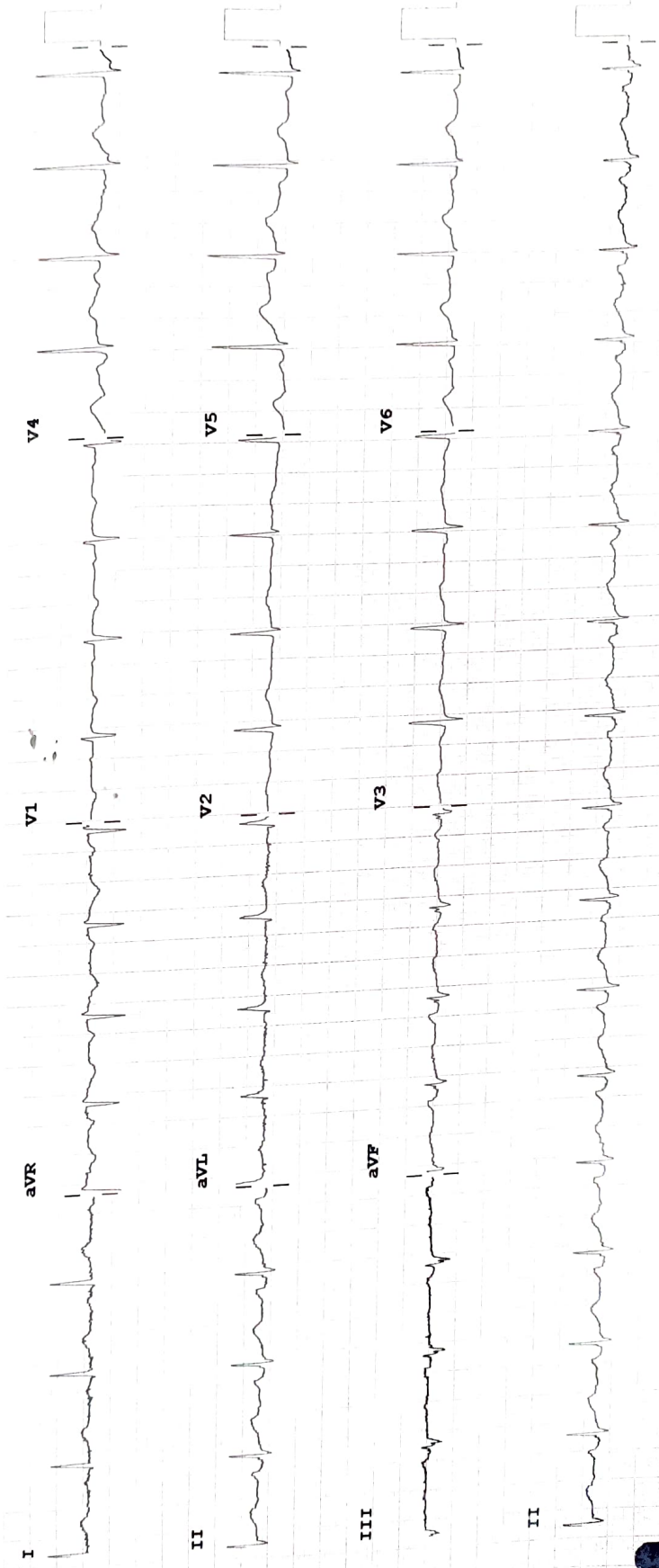
--AXIS--

P 74
 QRS 8
 T 38

12 Lead; Standard Placement

- OTHERWISE NORMAL ECG -

Unconfirmed Diagnosis



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

F 50~ 0.50-150 Hz W

100B CL

P?