

 भारत सरकार  
GOVERNMENT OF INDIA


  
अशोक कुमार वर्मा  
Ashok Kumar Verma  
जन्म तिथि / DOB : 25/08/1965  
पुरुष / MALE

7890 5322 4849 

आधार - आम आदमी का अधिकार


For Health Checkup  
Sank



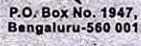
Dr. PIYUSH GOYAL  
MBBS, DMRD (Radiologist)  
RMC No.-037041

 भारतीय विशिष्ट पहचान प्राधिकरण  
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

पता: S/O गणेश लाल वेरमा, सी १५८,  
करधनी योजना, गोविन्दपुरा  
कालवाड रोड, झोटवारा, जयपुर,  
जयपुर, राजस्थान, 302012

Address: S/O Ganesh Lal Verma, c 158,  
KARDHANI YOJANA,  
GOVINDPURA KALWAR  
ROAD, JHOTWARA, Jaipur,  
Jaipur, Rajasthan, 302012



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# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)



- ⦿ B-14, Vidhyadhar Enclave-II, Near Axix Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
- ⦿ +91 141 4824885 ☎ maxcarediagnostics1@gmail.com

## General Physical Examination

Date of Examination: 23/03/24

Name: ASHOK KUMAR VERMA Age: 58 DOB: 25/08/1966 Sex: MALE

Referred By: BANK of BARGA

Photo ID: AAADHAR ID #: 11849

Ht: 157 (cm)

Wt: 78 (Kg)

Chest (Expiration): 103 (cm)

Abdomen Circumference: 102 (cm)

Blood Pressure: 120/80 mm Hg PR: 78 / min RR: 18 / min Temp: Afebrile

BMI 32

Eye Examination: with glass.  
RE - 6/6, N16 NCB  
LE - 6/6, N16

Other: N/A

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

Signature Of Examinee : [Signature] Name of Examinee: ASHOK KUMAR VERMA

Signature Medical Examiner : [Signature] Name Medical Examiner : PIYUSH GOYAL

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RMC No.-037041



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**NAME :- Mr. ASHOK KUIMAR VERMA**

Age :- 58 Yrs 6 Mon 30 Days

Sex :- Male

Patient ID :-12234954

Date :- 23/03/2024

09:19:45

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

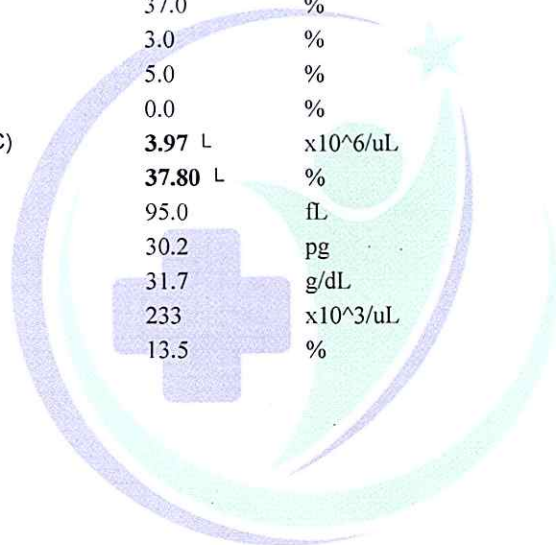
Company :- Mr.MEDIWHEEL

Final Authentication : 24/03/2024 11:20:16

## HAEMOGARAM

### HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP ABOVE 40 MALE			
<b>HAEMOGLOBIN (Hb)</b>	<b>12.0</b> L	g/dL	13.0 - 17.0
<b>TOTAL LEUCOCYTE COUNT</b>	7.20	/cumm	4.00 - 10.00
<b>DIFFERENTIAL LEUCOCYTE COUNT</b>			
NEUTROPHIL	55.0	%	40.0 - 80.0
LYMPHOCYTE	37.0	%	20.0 - 40.0
EOSINOPHIL	3.0	%	1.0 - 6.0
MONOCYTE	5.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	<b>3.97</b> L	$\times 10^6/uL$	4.50 - 5.50
HEMATOCRIT (HCT)	<b>37.80</b> L	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	95.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	30.2	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	31.7	g/dL	31.5 - 34.5
<b>PLATELET COUNT</b>	233	$\times 10^3/uL$	150 - 410
RDW-CV	13.5	%	11.6 - 14.0



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MGR  
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*Tanu*

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## HAEMATOLOGY

**Erythrocyte Sedimentation Rate (ESR)**

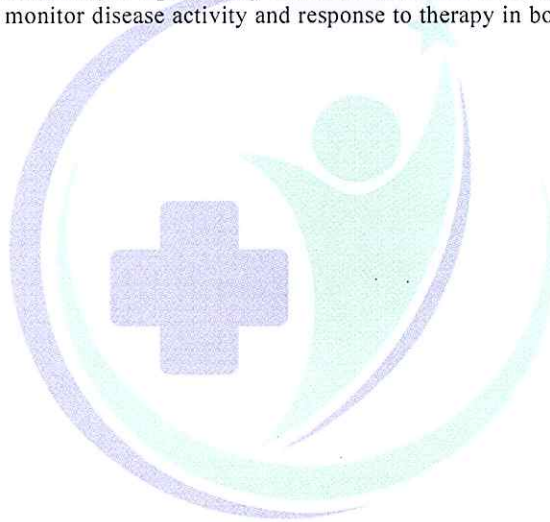
09

mm in 1st hr

00 - 15

Method:- Westergreen

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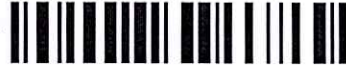
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(CBC): **Methodology:** TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and MCH,MCV,MCHC,MENTZER INDEX are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan





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## BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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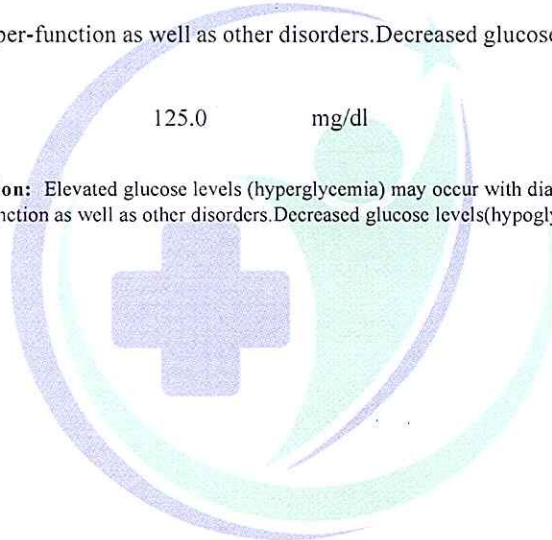
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	105.0	mg/dl	70.0 - 115.0
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Impaired glucose tolerance (IGT)	111 - 125 mg/dL
Diabetes Mellitus (DM)	> 126 mg/dL

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 .

BLOOD SUGAR PP (Plasma) Method:- GOD PAP	125.0	mg/dl	70.0 - 140.0
---	-------	-------	--------------

**Instrument Name: HORIBA 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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Sex :- Male	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

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## HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
<b>GLYCOSYLATED HEMOGLOBIN (HbA1C)</b> Method:- CAPILLARY with EDTA	6.0	mg%	Non-Diabetic < 6.0 Good Control 6.0-7.0 Weak Control 7.0-8.0 Poor control > 8.0
MEAN PLASMA GLUCOSE Method:- Calculated Parameter	125	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

Method:- Haemagglutination reaction

"A" POSITIVE



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## BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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### LIPID PROFILE

TOTAL CHOLESTEROL

Method:- CHOD-PAP methodology

211.00

mg/dl

Desirable <200  
Borderline high 200-239  
High > 240

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

TRIGLYCERIDES

Method:- GPO-PAP

139.00

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.

DIRECT HDL CHOLESTEROL

Method:- Direct clearance Method

47.90

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.

LDL CHOLESTEROL

Method:- Calculated Method

139.93

mg/dl

Optimal <100  
Near Optimal/above optimal 100-129  
Borderline High 130-159  
High 160-189  
Very High > 190

VLDL CHOLESTEROL

Method:- Calculated

27.80

mg/dl

0.00 - 80.00

T.CHOLESTEROL/HDL CHOLESTEROL RATIO

Method:- Calculated

4.41

0.00 - 4.90

LDL / HDL CHOLESTEROL RATIO

Method:- Calculated

2.92

0.00 - 3.50

TOTAL LIPID

Method:- CALCULATED

635.41

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 from peripheral tissues.



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## BIOCHEMISTRY

### LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method:- DMSO/Diazo	1.02	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.23	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.79	mg/dl	0.30-0.70
SGOT Method:- IFCC	36.6	U/L	0.0 - 40.0
SGPT Method:- IFCC	<b>44.2 H</b>	U/L	0.0 - 40.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	103.00	U/L	80.00 - 306.00

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

SERUM GAMMA GT Method:- Szasz methodology Instrument Name Randox Rx Imola Interpretation: Elevations in GGT levels are seen 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.	32.20	U/L	10.00 - 45.00
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SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	6.54	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	4.23	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	2.31	gm/dl	2.20 - 3.50
A/G RATIO	1.83		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

SERUM UREA Method:- Urease/GLDH	23.30	mg/dl	10.00 - 50.00
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InstrumentName: HORIBA CA 60 Interpretation : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE Method:- Jaffe's Method	1.09	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.

SERUM URIC ACID	5.32	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.

SODIUM Method:- ISE	139.0	mmol/L	135.0 - 150.0
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POTASSIUM Method:- ISE	4.30	mmol/L	3.50 - 5.50
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CHLORIDE Method:- ISE	101.2	mmol/L	94.0 - 110.0
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SERUM CALCIUM Method:- 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.

SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	6.54	g/dl	6.00 - 8.40
---	------	------	-------------

SERUM ALBUMIN Method:- Bromocresol Green	4.23	g/dl	3.50 - 5.50
---	------	------	-------------

SERUM GLOBULIN Method:- CALCULATION	2.31	gm/dl	2.20 - 3.50
--	------	-------	-------------

A/G RATIO	1.83		1.30 - 2.50
-----------	------	--	-------------

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

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## BIOCHEMISTRY

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-hour collections 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 blood increases. 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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**DR.TANU RUNGTA**  
MD (Pathology)  
RMC No. 17226



# P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

📍 B-14, Vidhyadhar Enclave-II, Near Axix Bank  
Central Spine, Vidhyadhar Nagar, Jaipur - 302023  
☎ +91 141 4824885 📧 maxcarediagnostics1@gmail.com



<b>NAME :- Mr. ASHOK KUIMAR VERMA</b>	Patient ID :-12234954	Date :- 23/03/2024	09:19:45
Age :- 58 Yrs 6 Mon 30 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 24/03/2024 11:20:16

## CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
<b>Urine Routine</b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
REACTION(PH)	5.5		5.0 - 7.5
SPECIFIC GRAVITY	1.010		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<b><u>MICROSCOPY EXAMINATION</u></b>			
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		ABSENT

**Technologist**  
MGR  
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*Tanu*  
**DR. TANU RUNGTA**  
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Sex :- Male

Patient ID :-12234954

Date :- 23/03/2024

09:19:45

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 24/03/2024 11:20:16

## CLINICAL PATHOLOGY

URINE SUGAR (FASTING)  
Collected Sample Received

Nil

Nil



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*Tanu*

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## CLINICAL PATHOLOGY

### STOOL ANALYSIS

#### PHYSICAL EXAMINATION

MUCUS

BLOOD

#### MICROSCOPIC EXAMINATION

RBC's

/HPF

WBC/HPF

/HPF

OVA

CYSTS

OTHERS

Collected Sample Received



Technologist  
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Page No: 14 of 16

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09:19:45

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 24/03/2024 11:20:16

## IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

PSA (PROSTATE SPECIFIC ANTIGEN) -TOTAL Method:- Methodology: CLIA	1.275	ng/mL	0.00-4.00
--	-------	-------	-----------

**CLINICAL NOTES:-** Prostate-specific antigen (PSA) is a 34-kD glycoprotein produced almost exclusively by the prostate gland.

PSA is normally present in the blood at very low levels. Increased levels of PSA may suggest the presence of prostate cancer.

1. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels

2. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical findings and other investigations

3. Physiological decrease in PSA level by 18% has been observed in sedentary patients either due to supine position or suspended sexual activity

### Clinical Use

- An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more affected first degree relatives.
- Follow up and management of Prostate cancer patients
- Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer

### NOTE

PSA levels can be also increased by prostatitis, irritation, benign prostatic hyperplasia (BPH), and recent ejaculation, producing a false positive result. Digital rectal examination (DRE) has been shown in several studies to produce an increase in PSA. However, the effect is clinically insignificant, since DRE causes the most substantial increases in patients with PSA levels already elevated over 4.0 ng/mL.

Obesity has been reported to reduce serum PSA levels. Delayed early detection may partially explain worse outcomes in obese men with early prostate cancer. Aftertreatment, higher BMI also correlates to higher risk of recurrence.

**Technologist**  
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**NAME :- Mr. ASHOK KUIMAR VERMA**

Age :- 58 Yrs 6 Mon 30 Days

Sex :- Male

Patient ID :-12234954

Date :- 23/03/2024

09:19:45

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 24/03/2024 11:20:16

## IMMUNOASSAY

### TOTAL THYROID PROFILE

#### THYROID-TRIODOOTHYRONINE T3

Method:- ECLIA

0.89

ng/mL

0.70 - 2.04

#### THYROID - THYROXINE (T4)

Method:- ECLIA

5.28

ug/dl

5.10 - 14.10

#### TSH

Method:- ECLIA

4.380

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 circadian 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  
Page No: 16 of 16

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MR. ASHOK KUMAR VERMA	58 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.

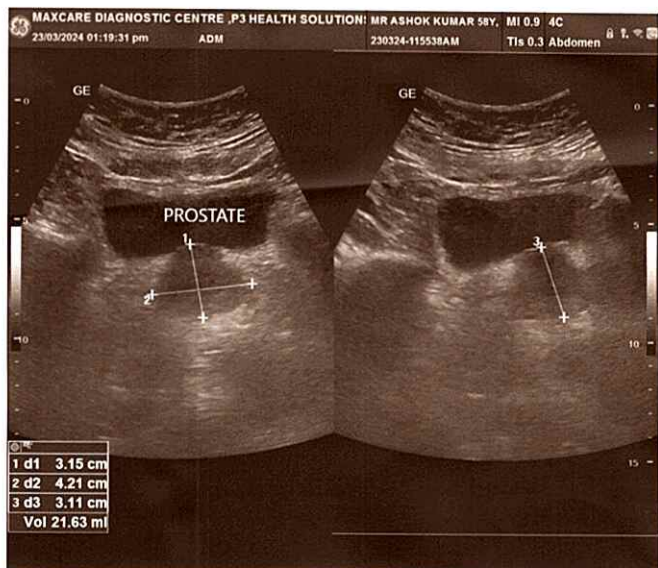
Thoracic soft tissue and skeletal system appear unremarkable.

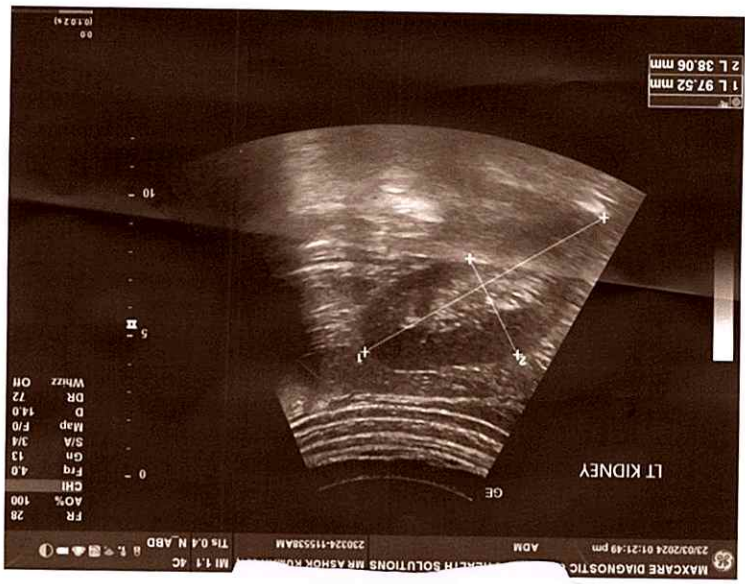
Soft tissue shadows appear normal.

*Degenerative changes are seen in visualized bones and spine.*

**IMPRESSION: No significant abnormality is detected.**

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







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(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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MR. ASHOK KUMAR VERMA	58 Y/M
Registration Date: 23/03/2024	Ref. by: BANK OF BARODA

## ULTRASOUND OF WHOLE ABDOMEN

**Liver** is of normal size (10.7 cm) **with increased echotexture**. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

**Gall bladder** is partially distended. Common bile duct is not dilated.

**Pancreas** is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

**Spleen** is of normal size and shape (8.3 cm). Echotexture is normal. No focal lesion is seen.

**Kidneys** are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. Collecting system does not show any calculus or dilatation.

**Right kidney** is measuring approx. 10.0 x 4.1 cm.

**Left kidney** is measuring approx. 9.7 x 3.8 cm.

**Urinary bladder** is well distended and does not show any calculus or mass lesion.

**Prostate** is normal in size (measuring approx. 3.1 x 4.2 x 3.1 cm, volume 21-22 cc) with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.

No significant free fluid is seen in pelvis.

### IMPRESSION:

- **Grade I fatty liver.**
- **Rest no significant abnormality is detected.**

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

P-3 HEALTH SOLUTIONS LLP  
 B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur  
 10238577/ANR ASHOK KUMAR VERMA 58 Yrs/Male 0 Kg/0 Cms  
 Date: 23-Mar-2024 11:24:18 AM  
 Ref. By : BANK OF BARODA

Protocol : BRUCE  
 History : Nil

Medication : Nil  
 Objective :

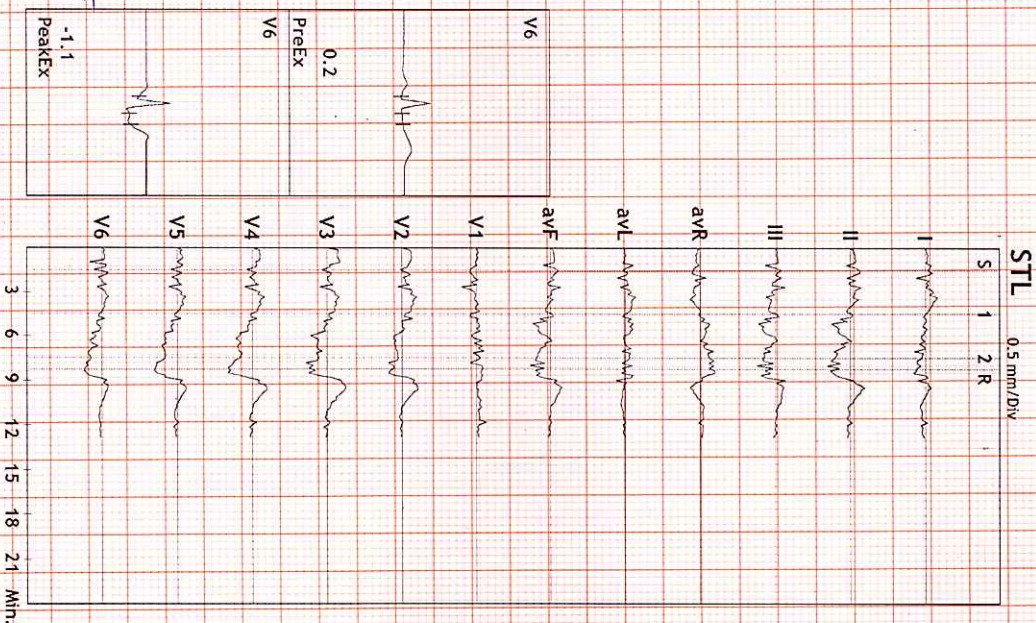
Stage	StageTime (Min:Sec)	PhaseTime (Min:Sec)	Speed (mph)	Grade (%)	METS	H.R. (bpm)	B.P. (mmHg)	R.P.P. x100	PVC	Comments
Supine					1.0	79	120/80	94	-	
Standing					1.0	80	120/80	96	-	
HV					1.0	107	120/80	128	-	
EXStart					1.0	94	120/80	112	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	149	130/80	193	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	168	140/85	235	-	
PeakEx	0:47	6:48	3.4	14.0	7.9	177	140/85	247	-	
Recovery	1:00		0.0	0.0	1.2	146	140/85	204	-	
Recovery	2:00		0.0	0.0	1.0	118	150/85	176	-	
Recovery	3:00		0.0	0.0	1.0	112	140/85	156	-	
Recovery	4:00		0.0	0.0	1.0	107	130/80	139	-	

**Findings :**

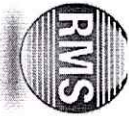
Exercise Time : 06:47  
 Max HR Attained : 177 bpm 109% of Max Predictable HR 162  
 Max BP : 150/85(mmHg)  
 Max Workload attained : 7.9(Fair Effort Tolerance)

Base line ECG showed there is mild ST changes seen during exercise in leads I, aVL, V4, V5, V6 which never reached T wave line within 1 min of recovery. Negative for R/T. Correlate clinically.

Advice/Comments:



Dr. Nitesh K. Jha  
 RMC No. 35705  
 RMC CARDIO (ECCOPIST)  
 DIP CARDIO (K)  
 O.E.M. (RCGP-UK)  
 Dr. Nitesh K. Jha  
 RMC No. 35705  
 RMC CARDIO (ECCOPIST)  
 DIP CARDIO (K)  
 O.E.M. (RCGP-UK)



HR: 80 bpm

MEFS: 1.0

BP: 120/80

MpHR: 49% of 162

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(0.05-100)HZ

Ex Time 00:33

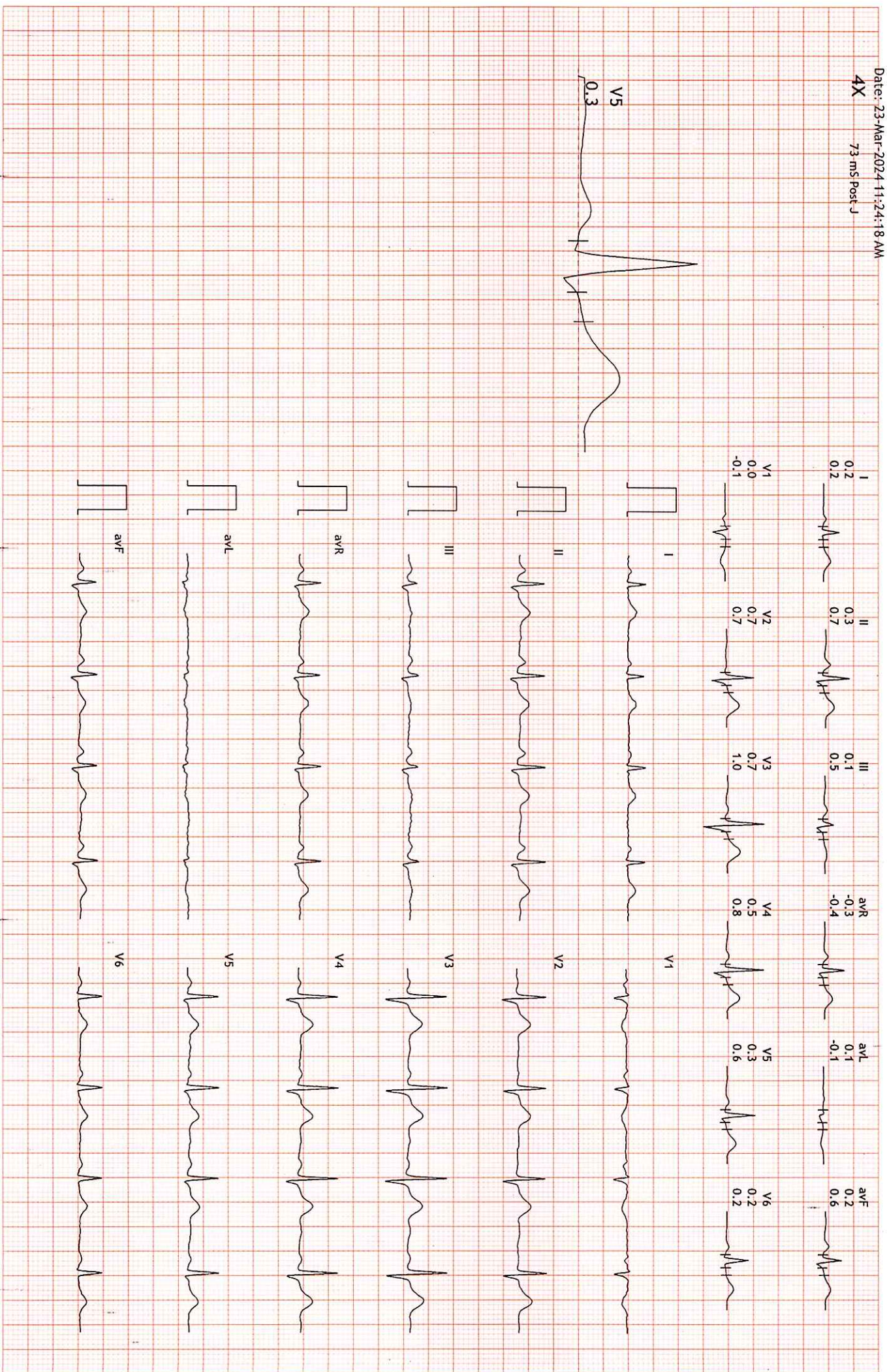
BLC :On

Notch :On

Supine

10.0 mm/mV

25 mm/Sec.





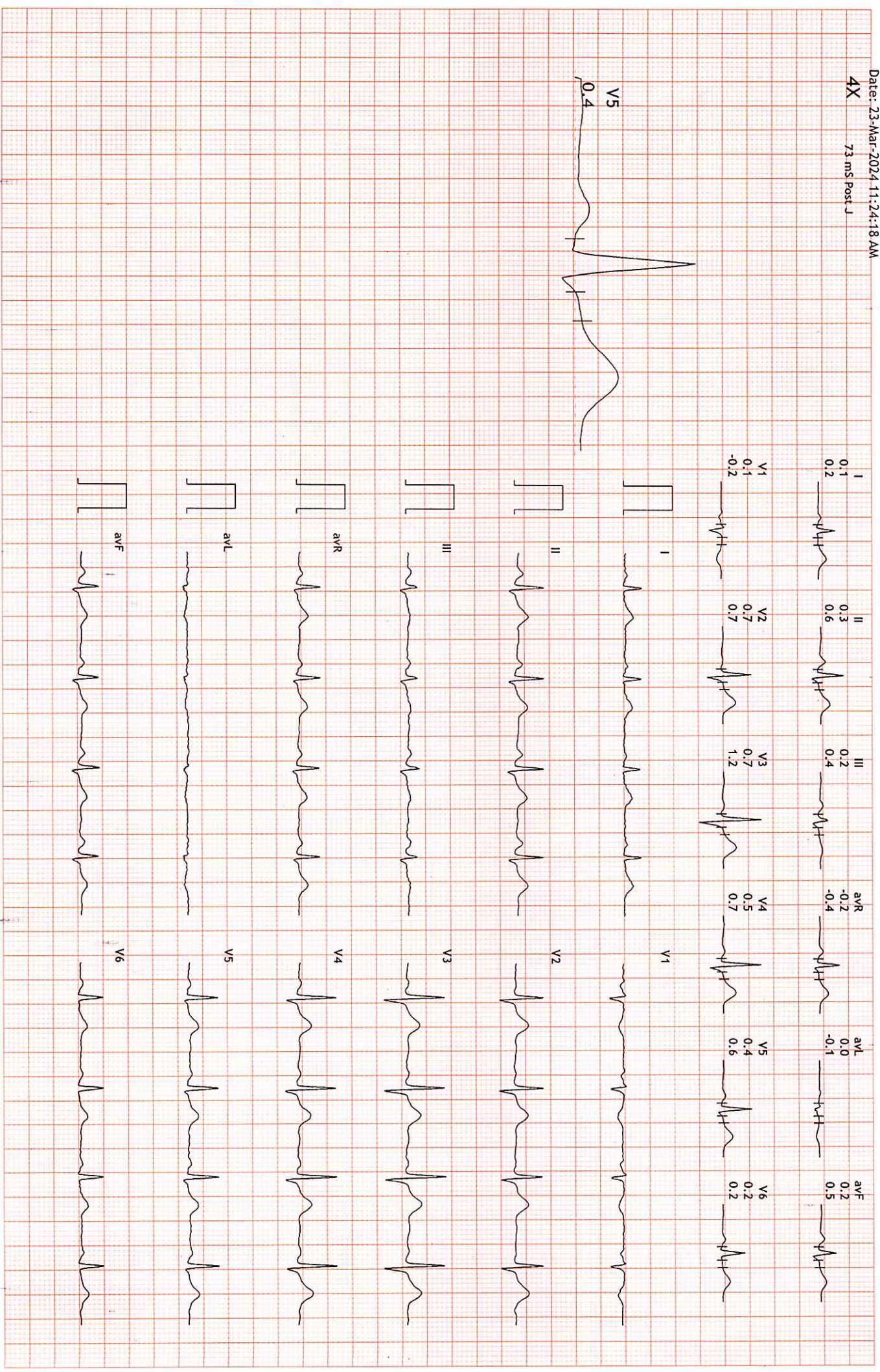
HR: 80 bpm  
METS: 1.0  
BP: 120/80

MPHR: 49% of 162  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 00:39  
BLC: On  
Notch: On

Standing  
10.0 mm/mV  
25 mm/Sec.



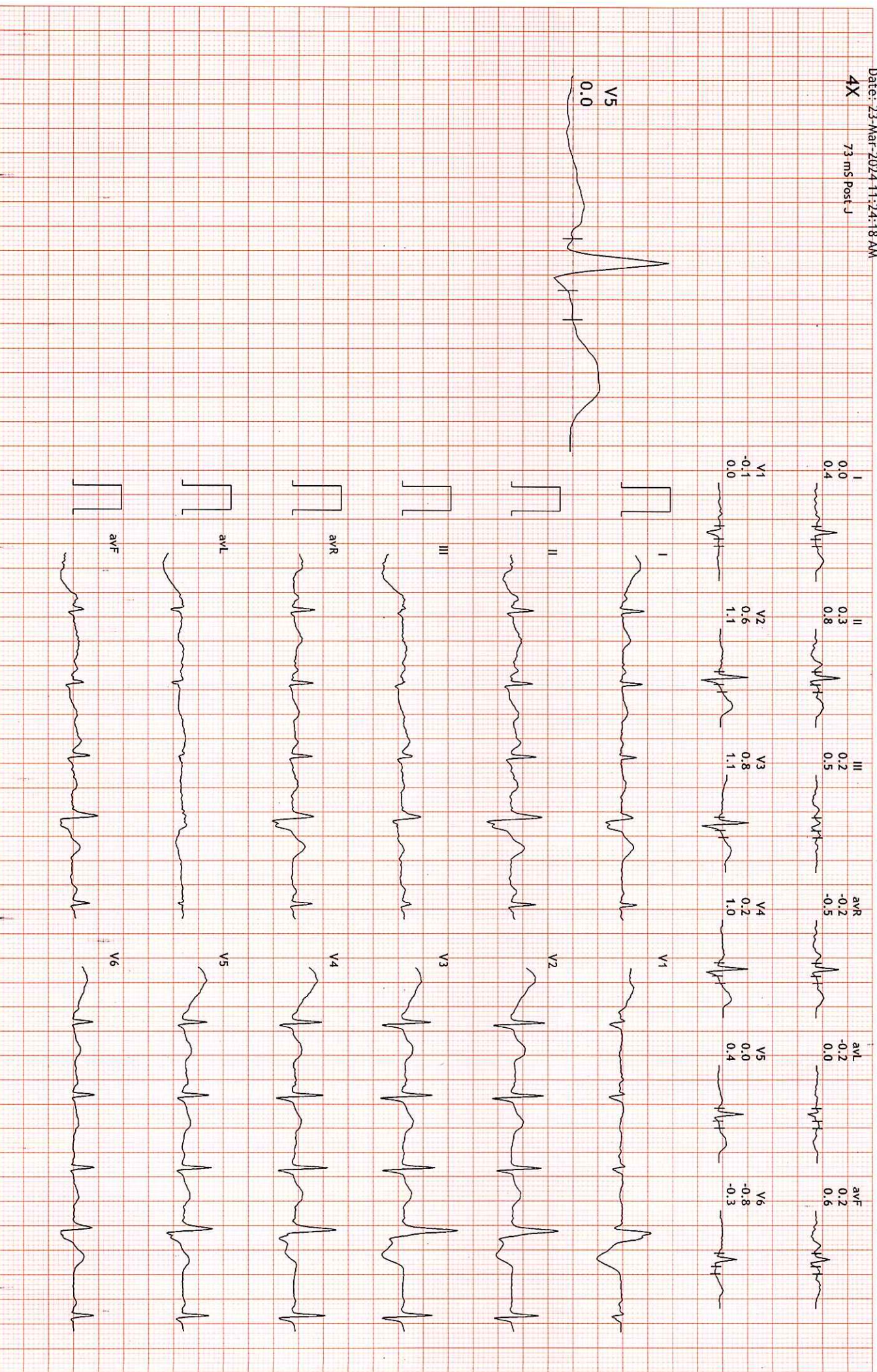
HR: 119 bpm  
METs: 1.0  
BP: 120/80

MPPHR: 73% of 162  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 01:00  
BLC: On  
Notch: On

HV  
10.0 mm/mV  
25 mm/Sec.



HR: 94 bpm

METS: 1.0

BP: 120/80

MpHR: 58% of 162

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(0.05-100)Hz

Ex Time 01:27

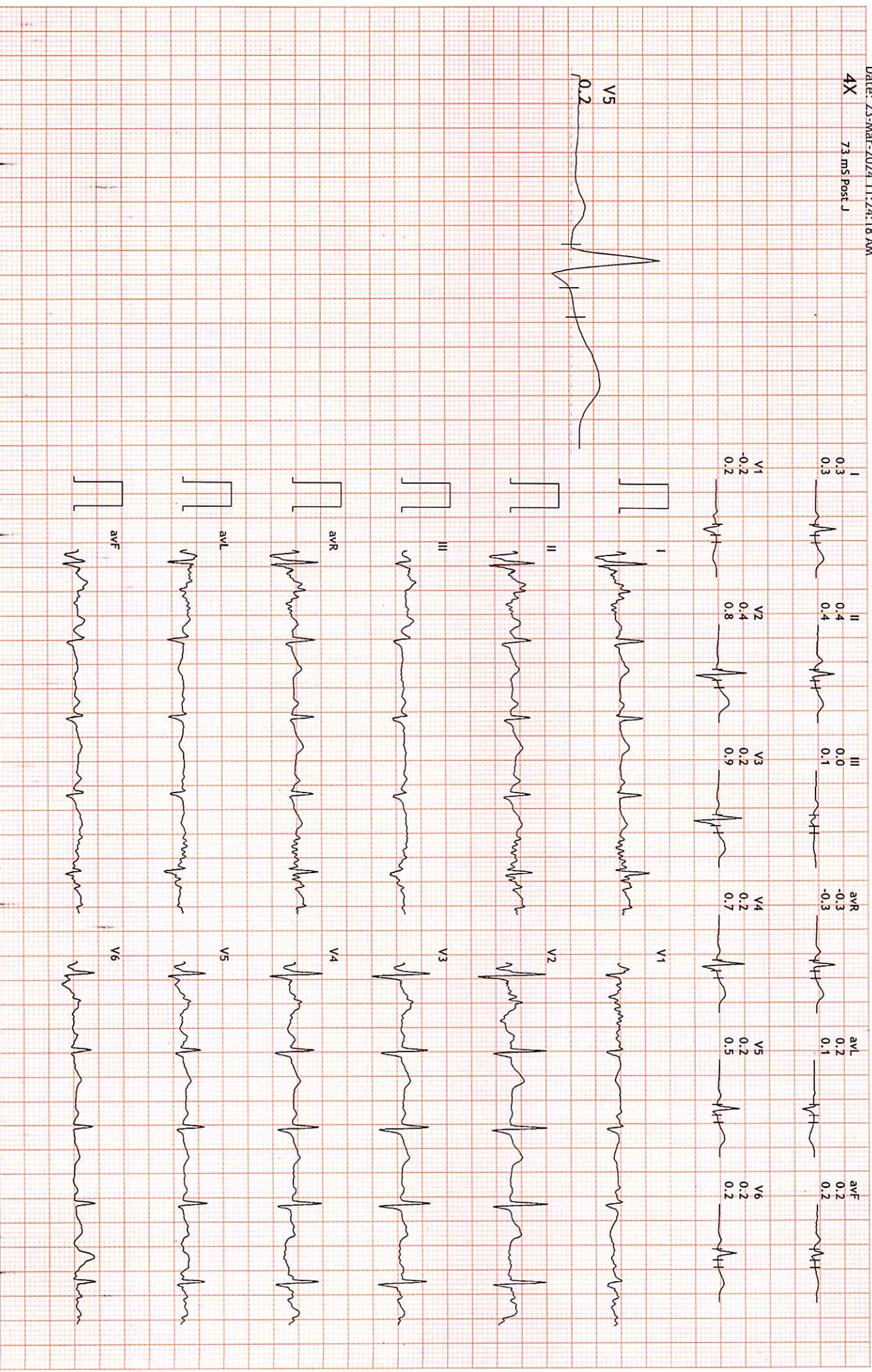
BLC: On

Notch: On

ExStart

10.0 mm/mV

25 mm/Sec.



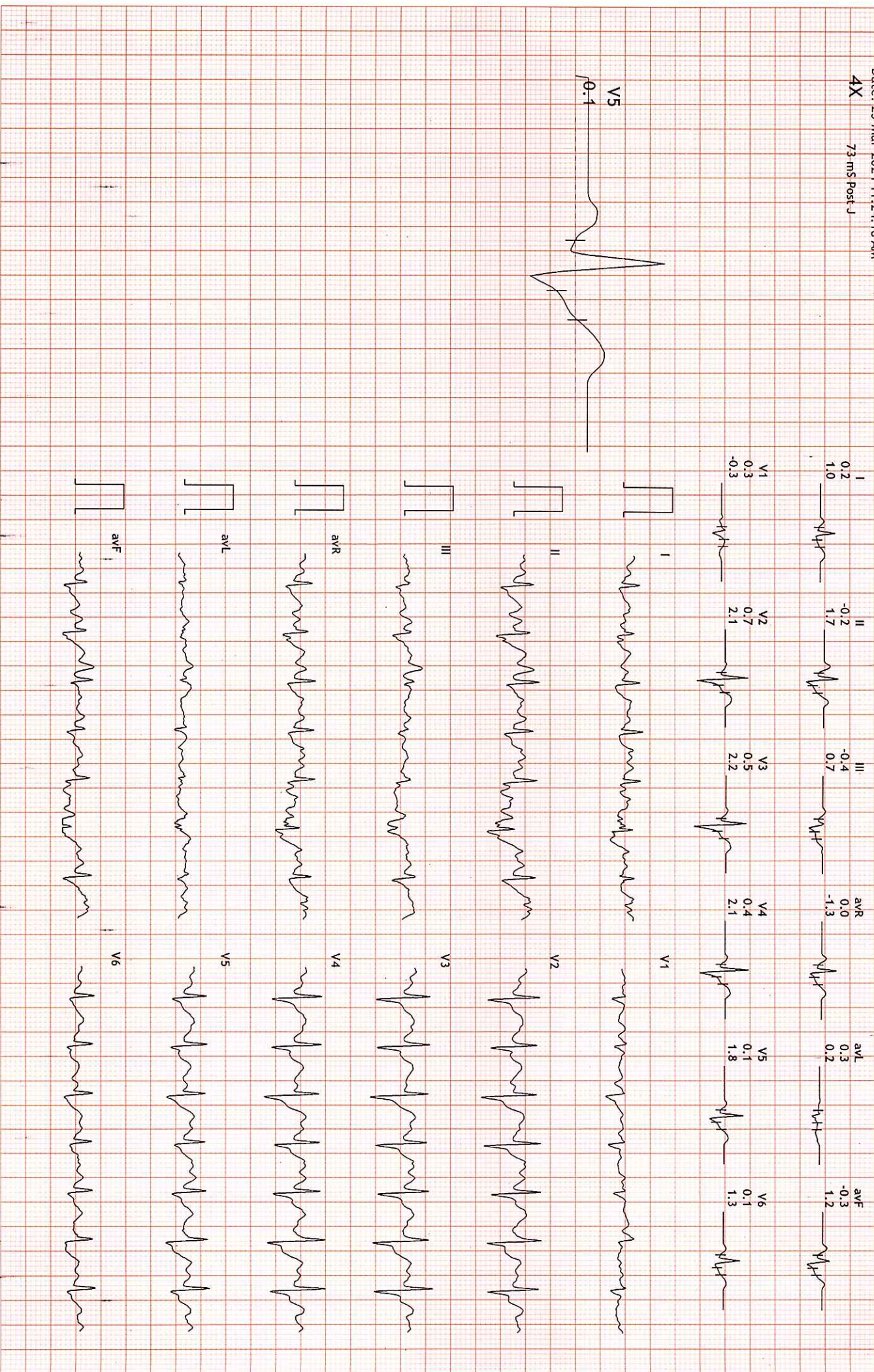
HR: 149 bpm  
METs: 4.7  
BP: 130/80

MPPR: 91% of 162  
Speed: 1.7 mph  
Grade: 10.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 02:59  
BLC : On  
Notch : On

BRUCE: Stage 1 (3:00)  
10.0 mm/mV  
25 mm/Sec.



HR: 169 bpm  
METS: 7.1  
BP: 140/85

MPPHR: 104% of 162  
Speed: 2.5 mph  
Grade: 12.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 05:59  
BLC : On  
Notch : On

BRUCE: Stage 2(3:00)  
10.0 mm/mV  
25 mm/Sec.



4X 73 ms Post J

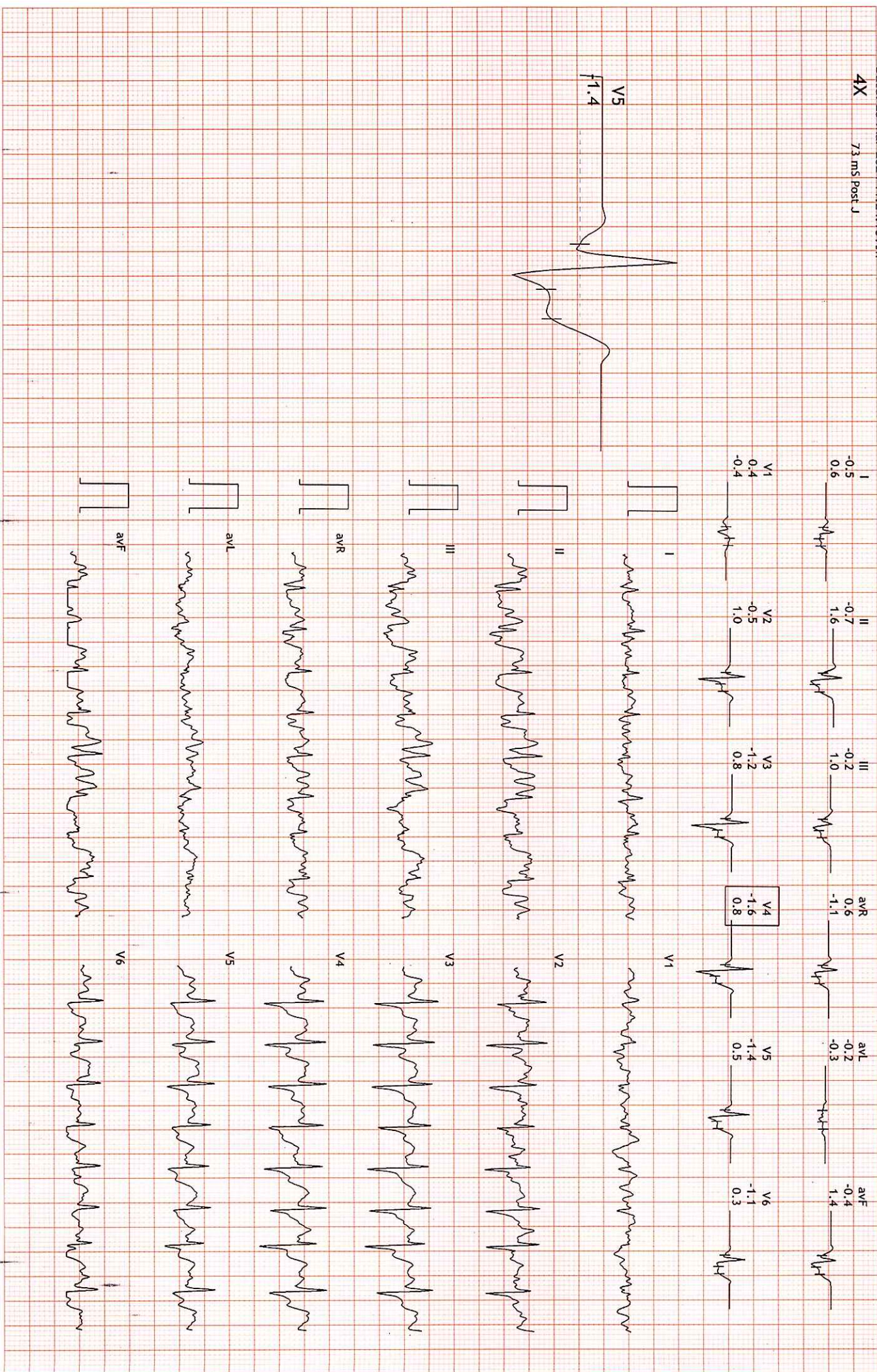
HR: 177 bpm  
METS: 7.9  
BP: 140/85

MpHR: 109% of 162  
Speed: 3.4 mph  
Grade: 14.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 06:45  
BLC: On  
Notch: On

BRUCE: PeakEx(0:45)  
10.0 mm/mV  
25 mm/Sec.



4X

73 ms Post J

HR: 148 bpm

METS: 1.3

BP: 140/85

MPPHR: 91% of 162

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(0.05-100)Hz

Ex Time 06:47

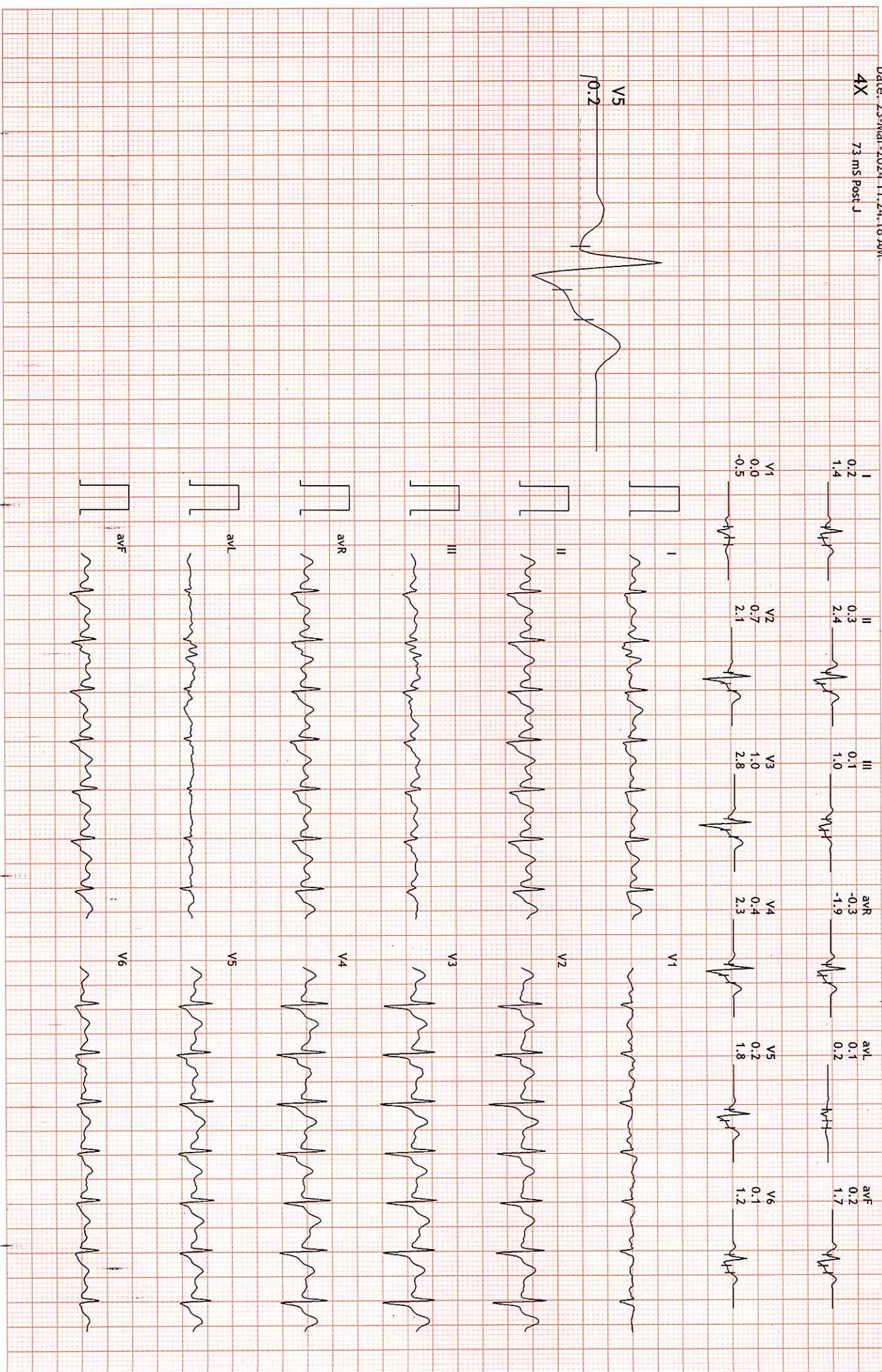
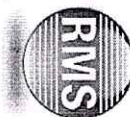
BLC :On

Notch :On

Recovery(1:00)

10.0 mm/mV

25 mm/Sec.



HR: 118 bpm  
METs: 1.0  
BP: 150/85

MPHR: 72% of 162  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 06:47  
BLC : On  
Notch : On

Recovery(2:00)  
10.0 mm/mV  
25 mm/Sec.

4X

73 ms Post J

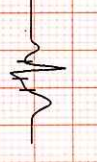
V5  
0.2



I  
0.0  
0.5



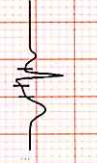
II  
0.4  
1.7



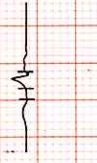
III  
0.4  
1.1



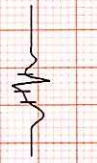
avR  
-0.2  
-1.1



avL  
-0.2  
-0.2



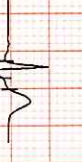
avF  
0.4  
1.4



V1  
-0.1  
-0.1



V2  
0.5  
1.4



V3  
0.6  
1.8



V4  
0.4  
1.6



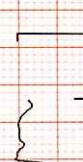
V5  
0.2  
1.3



V6  
0.2  
0.8



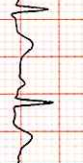
I



II



III



avR



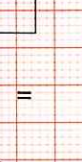
avL



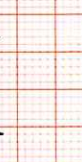
avF



I



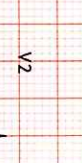
II



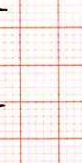
III



avR



avL



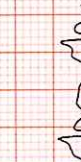
avF



I



II



III



avR



avL



avF



I



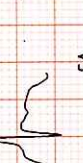
II



III



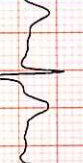
avR



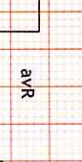
avL



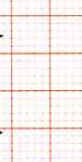
avF



I



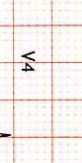
II



III



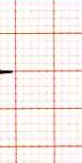
avR



avL



avF



I



II



III



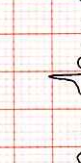
avR



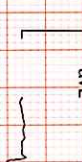
avL



avF



I



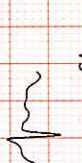
II



III



avR



avL



avF



I



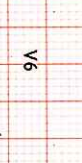
II



III



avR



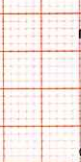
avL



avF



I



II



III



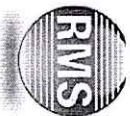
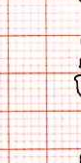
avR



avL



avF





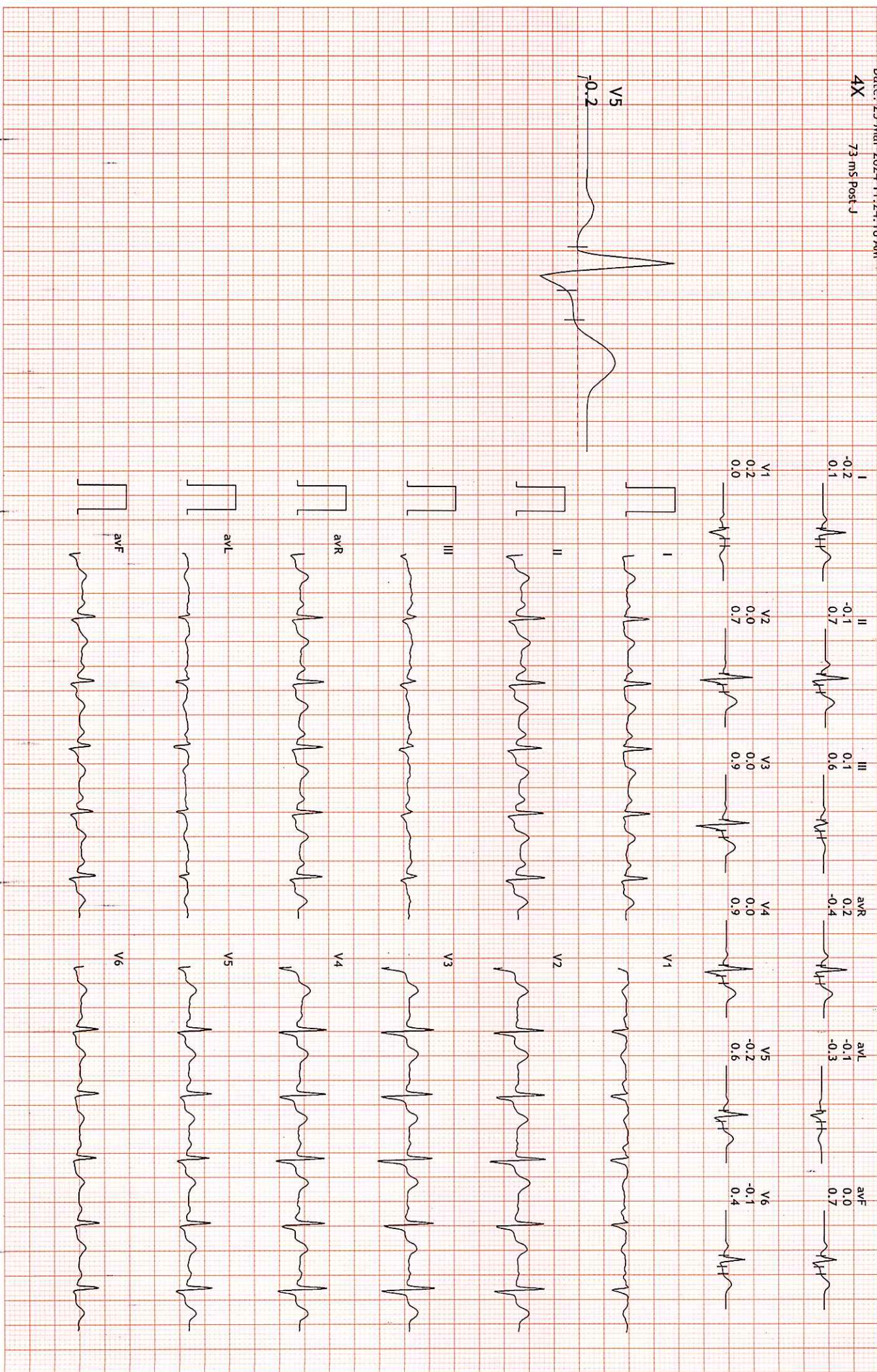
HR: 112 bpm  
MET5: 1.0  
BP: 140/85

MPPR: 69% of 162  
Speed: 0.0 mph  
Grade: 0.0%

Raw ECG  
BRUCE  
(0.05-100)Hz

Ex Time 06:47  
BLC : On  
Notch : On

Recovery(3:00)  
10.0 mm/mV  
25 mm/Sec.



HR: 107 bpm

METS: 1.0

BP: 130/80

MPHR: 66% of 162

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(0.05-100)Hz

Ex Time 06:47

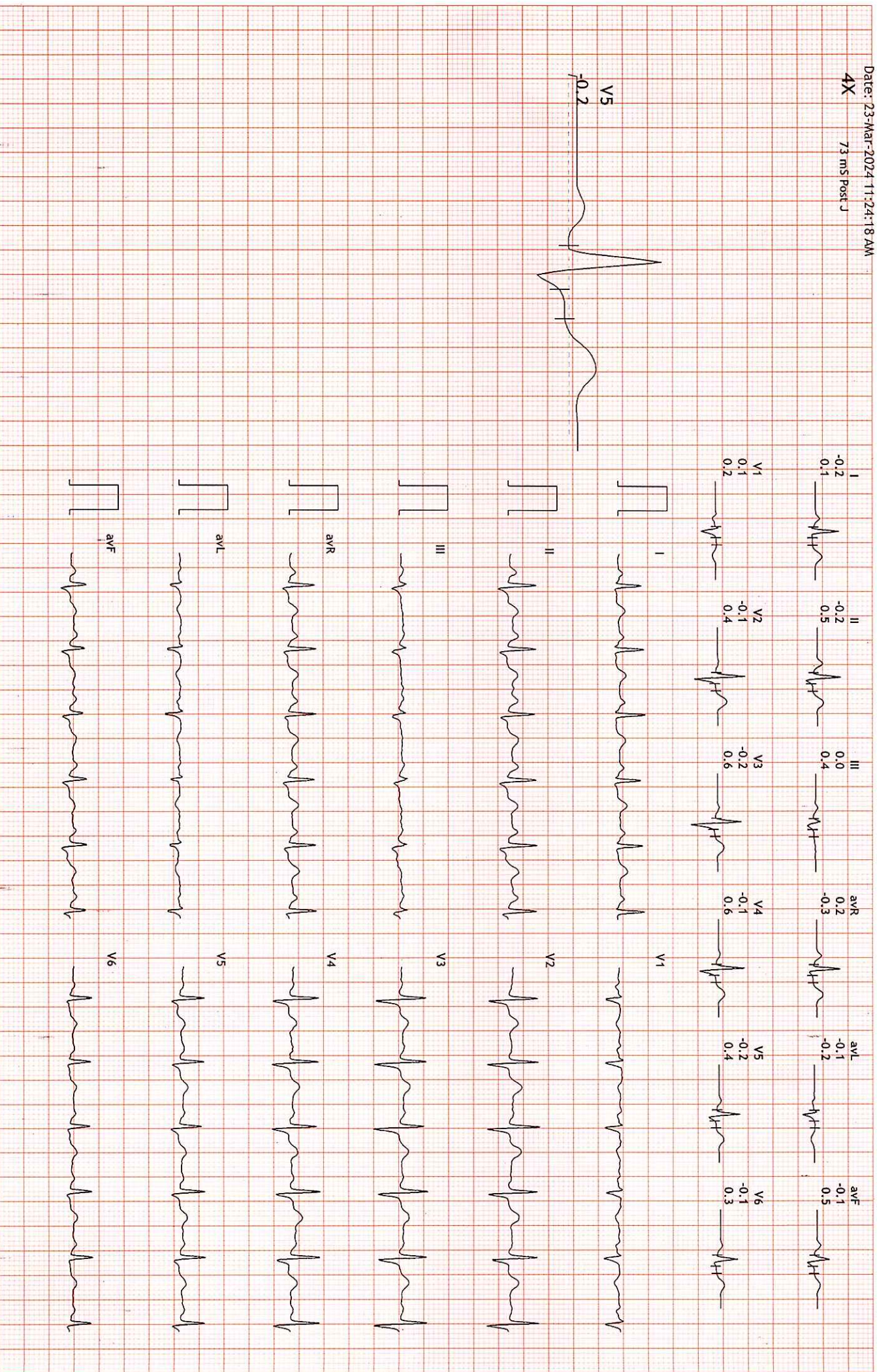
BLC :On

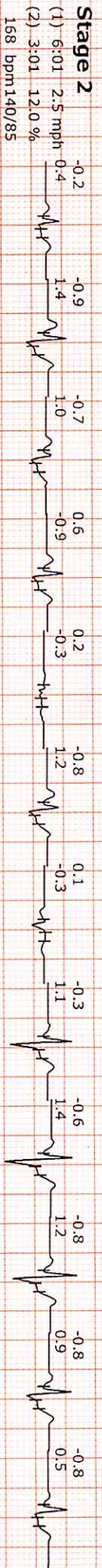
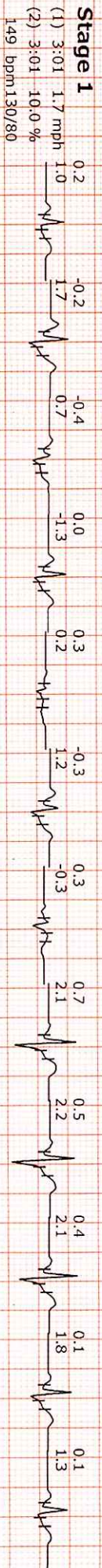
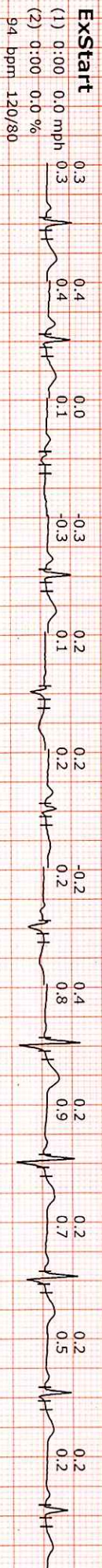
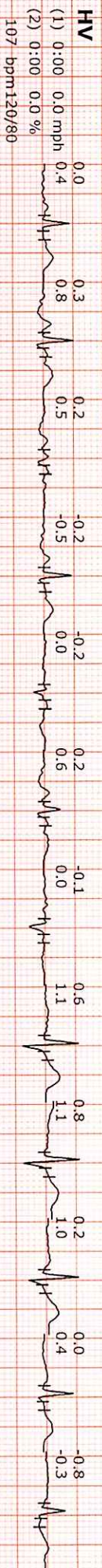
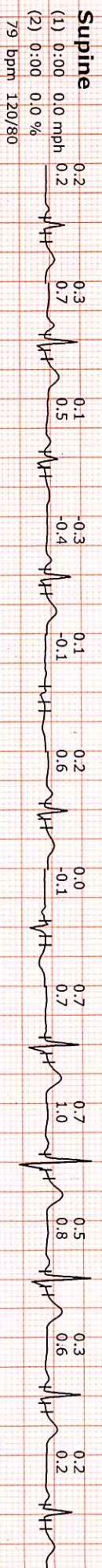
Notch :On

Recovery(4:00)

10.0 mm/mV

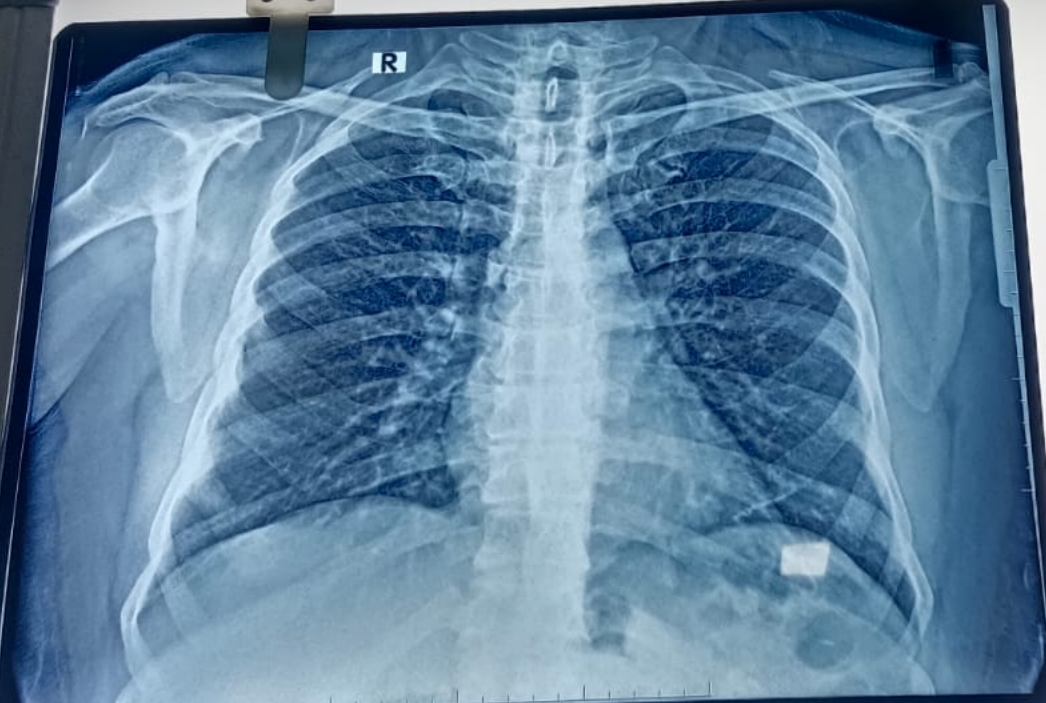
25 mm/Sec.





Average





A frontal chest X-ray showing the thoracic cavity. The lungs are visible with some vascular markings. The heart silhouette is in the center. The ribs and spine are clearly visible. A white 'R' marker is at the top center. A white 'X' marker is at the bottom left. A white rectangular marker is on the right side of the image. The image is mounted on a dark blue frame with metal clips at the top.

12234954 ASHOK KUMAR VERMA 58 YRS BOB M  
23.MAR.2024  
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)

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