

NAME:	Mr. Rahul Ghosh	UHID:	
AGE:	34	DATE OF HEALTHCHECK:	23/2/2024
GENDER:	M		

HEIGHT:	176.5	MARITAL STATUS:	M
WEIGHT:	76.6	NO OF CHILDREN:	1
BMI:	24.6		

C/O:

K/C/O:

PRESENT MEDICATION: *no*

P/M/H: *no*

P/S/H: *no*

ALLERGY: *no*

PHYSICAL ACTIVITY: Active/ Moderate/ Sedentary

H/A: SMOKING:

FAMILY HISTORY FATHER: *HTA*

ALCOHOL:

MOTHER: *HTA*

TOBACCO/PAN: *no*

O/E:

LYMPHADENOPATHY:

BP: *120/70* PULSE: *60/min*

PALLOR/ICTERUS/CYNOSIS/CLUBBING: *no*

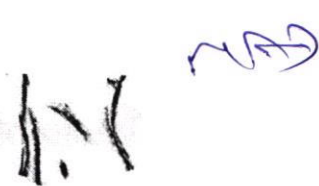
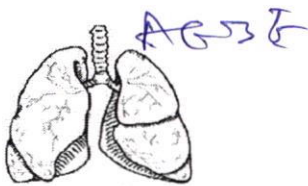
TEMPERATURE: *37* SCARS: *no*

OEDEMA:

S/E:

P/A:

RS:



CVS: *no*

Extremities & Spine: *no*

CNS: *Cerebellum, cerebellum*

ENT: *no*

Skin: *dryness of skin*

Vision:

	Without Glass		With Glass	
	Right Eye	Left Eye	Right Eye	Left Eye
FAR :				
NEAR :				
COLOUR VISION:				

Name: Mr. Rahul Ghosh | Age: 34/M | Date of Health check-up: 23/03/2024.


Findings and Recommendation:

Findings:-

- Renal Calabi
- UAT
- Hb++

Recommendation:-

- Re- Urinology @ pm
- Diet restriction / Iron supplement
- T. Folic. 50 mg x 1 wk.

Signature: 
Consultant -

DR. ANIRBAN DASGUPTA
MBBS, D.N.B. MEDICINE
DIPLOMA CARDIOLOGY
MMC- 2005/02/0920

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OPHTHALMIC EVALUATION

UHID No.: _____

Date: 23/3/24

Name: Mr. Rahul Age: 34 Gender: Male / Female

Without Correction: myopia

Distance: Right Eye _____ Left Eye _____

Near : Right Eye _____ Left Eye _____

With Correction :

Distance: Right Eye 6/6 Left Eye 6/6

Near : Right Eye N6 Left Eye N6

	RIGHT					LEFT				
	SPH	CYL	AXIS	PRISM	VA	SPH	CYL	AXIS	PRISM	VA
Distance	<u>-1.5</u>	<u>-0.25</u>	<u>20°</u>			<u>-1.0</u>	<u>-0.25</u>	<u>120°</u>		
Near					<u>Presbyopia</u>					

Colour Vision : N6

Anterior Segment Examination : N6 B0

Pupils : _____

Fundus : _____

Intraocular Pressure : 12 mmHg B0

Diagnosis : Refractive error

Advice : _____

Re-Check on ann (This Prescription needs verification every year)

Dr. Ruchira
(Consultant Ophthalmologist)
DR. RUCHIRA SHARMA
-M. B. (OPHTH)
CONSULTING OPHTHALMOLOGIST
& MICRO SURGEON
REG. No.: 3262 / 09/02

■ Consultation ■ Diagnostics ■ Health Check-Ups ■ Dent

DENTAL CHECKUP

Name: Rahul Ghosh	MR NO:
Age/Gender: 34/M	Date: 23/8/24

Medical history: Diabetes Hypertension

EXAMINATION	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Calculus & Stains				
Mobility			✓	✓
Caries (Cavities)				
a) Class 1 (Occlusal)				
b) Class 2 (Proximal)				
c) Class 5 (Cervical)				
Faulty Restoration				
Faulty Crown				
Fractured Tooth				
Root Pieces				
Impacted Tooth				
Missing Tooth				
Existing Denture				

TREATMENT ADVISED:

TREATMENT	UPPER RIGHT	UPPER LEFT	LOWER LEFT	LOWER RIGHT
Restoration / Filling				
Root Canal Therapy				
Crown				
Extraction				

Oral Prophylaxis: Scaling & polishing

Orthodontic Advice for Braces: Yes / No

Prosthetic Advice to Replace Missing Teeth: Denture Bridge Implant

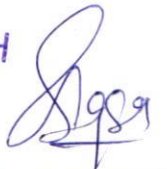
Oral Habits: Tobacco Cigarette Others since ___ years

Advice to quit any form of tobacco as it can cause cancer.

Other Findings: _____

- Scaling & polishing :- 1300 .

DR. AQSA SHAIKH
B. D. S
Reg. No: A 42611



• ANDHERI • COLABA • NASHIK • VASHI

Name : Mr. Rahul Ghosh Gender : Male Age : 34 Years
 UHID : FVAH 11116. Bill No : Lab No : V-2753-23
 Ref. by : SELF Sample Col.Dt : 23/03/2024 08:25
 Barcode No : 3231 Reported On : 23/03/2024 15:30

TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HAEMOGRAM(CBC,ESR,P/S)-WB (EDTA)

Haemoglobin(Colorimetric method)	12.6	g/dl	13 - 18
RBC Count (Impedance)	5.14	Millions/cumm.	4 - 6.2
PCV(Haematocrit(Calculated))	39.8	%	35 - 55
MCV:(Calculated)	77.5	fl	78 - 98
MCH:(Calculated)	24.5	pg	26 - 34
MCHC:(Calculated)	31.6	gm/dl	30 - 36
RDW-CV:	14.9	%	11.5 - 16.5
Total Leucocyte count(Impedance)	5330	/cumm.	4000 - 10500
Neutrophils:	60	%	40 - 75
Lymphocytes:	28	%	20 - 40
Eosinophils:	08	%	0 - 6
Monocytes:	04	%	2 - 10
Basophils:	00	%	0 - 2
Platelets Count(Impedance method)	1.63	Lakhs/c.mm	1.5 - 4.5
MPV	11.8	fl	6.0 - 11.0
ESR(Westergren Method)	14	mm/1st hr	0 - 20
Peripheral Smear (Microscopic examination)			
RBCs:	Hypochromasia(+), Microcytosis(+)		
WBCs:	Eosinophilia		
Platelets	Adequate		
Note:	Test Run on 5 part cell counter. Manual diff performed.		

Vasanti Gondal
Entered By

Ms Kaveri Gaonkar
Verified By

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 Dr. Milind Patwardhan
 M.D(Path)
 Chief Pathologist

End of Report
 Results are to be correlated clinically

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TEST

RESULTS

Blood Grouping (ABO & Rh)-WB(EDTA) Serum

ABO Group: **:B:**
Rh Type: **Positive**
Method : Matrix gel card method (forward and reverse)

Dilpreetkaur S Singh
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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

HbA1c(Glycosylated Haemoglobin)WB-EDTA

(HbA1C) Glycosylated Haemoglobin : 5.5 %
 Normal <5.7 %
 Pre Diabetic 5.7 - 6.5 %
 Diabetic >6.5 %
 Target for Diabetes on therapy < 7.0 %
 Re-evaluation of therapy > 8.0 %

Mean Blood Glucose : 111.15 mg/dL

Corelation of A1C with average glucose

A1C (%)	Mean Blood Glucose (mg/dl)
6	126
7	154
8	183
9	212
10	240
11	269
12	298

Method High Performance Liquid Chromatography (HPLC).

INTERPRETATION

- * The HbA1c levels corelate with the mean glucose concentration prevailing in the course of Pts recent history (apprx 6-8 weeks) & therefore provides much more reliable information for glycemia control than the blood glucose or urinary glucose.
- * This Methodology is better then the routine chromatographic methods & also for the daibetic pts. having HEMOGLBINOPATHIES OR UREMIA as Hb varaints and uremia does not INTERFERE with the results in this methodology.
- * It is recommended that HbA1c levels be performed at 4 - 8 weeks during therapy in uncontrolled DM pts.& every 3 - 4 months in well controlled daibetics .
- * Mean blood glucose (MBG) in first 30 days (0-30)before sampling for HbA1c contributes 50% whereas MBG in 90 - 120 days contribute to 10% in final HbA1c levels

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
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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
PLASMA GLUCOSE			
Fasting Plasma Glucose :	99	mg/dL	Normal < 100 mg/dL Impaired Fasting glucose : 101 to 125 mg/dL Diabetes Mellitus : \geq 126 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)
Post Prandial Plasma Glucose :	105	mg/dL	Normal < 140 mg/dL Impaired Post Prandial glucose : 140 to 199 mg/dL Diabetes Mellitus : \geq 200 mg/dL (on more than one occasion) (American diabetes association guidelines 2016)

Method : Hexokinase

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LIPID PROFILE - Serum

S. Cholesterol(Oxidase)	165	mg/dL	Desirable < 200 Borderline:>200-<240 Undesirable:>240
S. Triglyceride(GPO-POD)	72	mg/dL	Desirable < 150 Borderline:>150-<499 Undesirable:>500
S. VLDL:(Calculated)	14.4	mg/dL	Desirable <30
S. HDL-Cholesterol(Direct)	36.5	mg/dL	Desirable > 60 Borderline:>40-<59 Undesirable:<40
S. LDL:(calculated)	114.1	mg/dL	Desirable < 130 Borderline:>130-<159 Undesirable:>160
Ratio Cholesterol/HDL	4.5		3.5 - 5
Ratio of LDL/HDL	3.1		2.5 - 3.5

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TEST RESULTS UNITS BIOLOGICAL REFERENCE INTERVAL

LFT(Liver Function Tests)-Serum

S.Total Protein (Biuret method)	7.36	g/dL	6.6 - 8.7
S.Albumin (BCG method)	4.28	g/dL	3.5 - 5.2
S.Globulin (Calculated)	3.08	g/dL	2 - 3.5
S.A/G Ratio:(Calculated)	1.39		0.9 - 2
S.Total Bilirubin (DPD):	0.45	mg/dL	0.1 - 1.2
S.Direct Bilirubin (DPD):	0.18	mg/dL	0.1 - 0.3
S.Indirect Bilirubin (Calculated)	0.27	mg/dL	0.1 - 1.0
S.AST (SGOT)(IFCC Kinetic with P5P):	15	U/L	5 - 40
S.ALT (SGPT) (IFCC Kinetic with P5P):	14	U/L	5 - 41
S.Alk Phosphatase(pNPP-AMP Kinetic):	125	U/L	40 - 129
S.GGT(IFCC Kinetic):	13	U/L	11 - 50

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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
	BIOCHEMISTRY	
S.Urea(Urease Method)	23.5 mg/dl	10.0 - 45.0
BUN (Calculated)	10.96 mg/dL	5 - 20
S.Creatinine(Jaffe's Method)	0.81 mg/dl	0.50 - 1.3
BUN / Creatinine Ratio	13.53	9:1 - 23:1
S.Uric Acid(Uricase Method)	<u>7.5</u> mg/dl	3.4 - 7.0

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TEST	RESULTS	UNITS	BIOLOGICAL REFERENCE INTERVAL
Thyroid (T3,T4,TSH)- Serum			
Total T3 (Tri-iodo Thyronine) (ECLIA)	1.7	nmol/L	1.3 - 3.1 nmol/L
Total T4 (Thyroxine) (ECLIA)	74.83	nmol/L	66 - 181 nmol/L
TSH-Ultrasensitive (Thyroid-stimulating hormone) Method : ECLIA	2.56	□IU/ml	Euthyroid : 0.35 - 5.50 □IU/ml Hyperthyroid : < 0.35 □IU/ml Hypothyroid : > 5.50 □IU/ml

Grey zone values observed in physiological/therapeutic effect.

Note:

T3 :

- Decreased values of T3 (T4 and TSH normal) have minimal Clinical significance and not recommended for diagnosis of hypothyroidism.
- Total T3 and T4 values may also be altered in other conditions due to changes in serum proteins or binding sites ,Pregnancy, Drugs (Androgens,Estrogens,O C pills, Phenytoin) etc. In such cases Free T3 and free T4 give corrected Values.
- Total T3 may decrease by < 25 percent in healthy older individuals

T4 :

- Total T3 and T4 Values may also be altered in other condition due to changes in serum proteins or binding sites, Pregnancy Drugs (Androgens,Estrogens,O C pills, Phenytoin), Nerphrosis etc. In such cases Free T3 and Free T4 give Corrected values.

TSH :

- TSH Values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart failure. Severe burns, trauma and surgery etc.
- Drugs that decrease TSH values e,g L dopa, Glucocorticoids.
- Drugs that increase TSH values e.g. Iodine,Lithium, Amiodarone

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M.D(Path)

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TEST RESULTS BIOLOGICAL REFERENCE INTERVAL

URINE REPORT

PHYSICAL EXAMINATION

QUANTITY 20 mL
COLOUR Pale Yellow
APPEARANCE Slightly Hazy Clear
SEDIMENT Absent Absent

CHEMICAL EXAMINATION(Strip Method)


REACTION(PH) 8.0 4.6 - 8.0
SPECIFIC GRAVITY 1.010 1.005 - 1.030
URINE ALBUMIN Absent Absent
URINE SUGAR(Qualitative) Absent Absent
KETONES Absent Absent
BILE SALTS Absent Absent
BILE PIGMENTS Absent Absent
UROBILINOGEN Normal(< 1 mg/dl) Normal
OCCULT BLOOD Absent Absent
Nitrites Absent Absent

MICROSCOPIC EXAMINATION

PUS CELLS Occasional 0 - 3/hpf
RED BLOOD CELLS Nil /HPF Absent
EPITHELIAL CELLS 2 - 3 /hpf 3 - 4/hpf
CASTS Absent Absent
CRYSTALS Absent Absent
BACTERIA Absent Absent

Anushka Chavan
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Dr. Milind Patwardhan
M.D(Path)
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UHID	: FVAH 11116.	Bill No	:	Lab No	: V-2753-23
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TEST	RESULTS	BIOLOGICAL REFERENCE INTERVAL
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STOOL EXAMINATION

PHYSICAL EXAMINATION

COLOUR	Brown	
CONSISTENCY	Semi Solid	
MUCUS	Absent	Absent

CHEMICAL EXAMINATION

OCCULT BLOOD (Guaiac method)	Absent	Absent
PH(Litmus paper)	Acidic	Acidic/Alkaline

MICROSCOPIC EXAMINATION

PUS CELLS	Absent	0 - 1
EPITHELIAL CELLS	Absent	Absent
RED BLOOD CELLS	Nil /HPF	Absent
FAT GLOBULES	Absent	Absent
VEGETABLE FIBRES	Present	Present
YEASTS	Absent	Absent
CYST	Absent	Absent
VEGETATIVE FORMS	Absent	Absent
OVA	Absent	Absent
LARVAE	Absent	Absent

Anushka Chavan
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Chief Pathologist

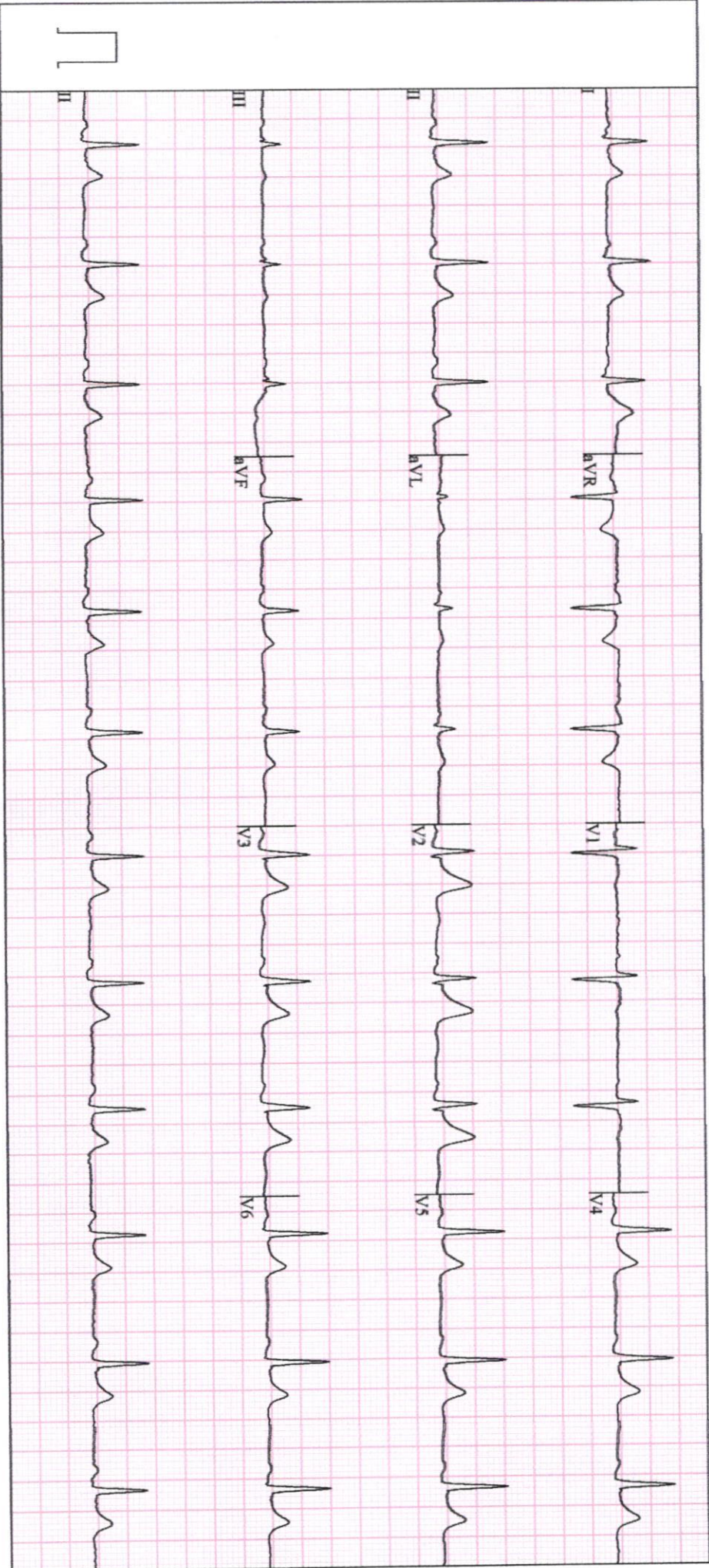
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NORMAL ECG

Normal sinus rhythm
Normal ECG

QRS : 86 ms
QT/QTcBaz : 346/381 ms
PR : 136 ms
P : 100 ms
RR/PP : 826/821 ms
P/QRS/T : 45/48/30 degrees

Dr. Anirban Dasgupta
Dr. ANIRBAN DASGUPTA
M.B., B.S., D.N.B. Medicine
Diploma Cardiology
MMC-2005/02/0920



Apollo Clinic
The Emerald, Plot No-195/B, Sector-12,
Neel Siddhi Towers, Vashi-400703

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: RAHUL, GHOSH
Patient ID: 11116
Height:
Weight:

DOB: 06.05.1990
Age: 33yrs
Gender: Male
Race: Asian

Study Date: 23.03.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR.ANIRBAN DASGUPTA
Technician: Anita Gaikwad

Medications:
NIL

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	00:09	0.00	0.00	84	120/80	
	STANDING	00:11	0.00	0.00	85		
	HYPERV.	00:20	0.00	0.00	83		
EXERCISE	WARM-UP	00:05	0.00	0.00	83		
	STAGE 1	03:00	1.70	10.00	130	130/80	
	STAGE 2	03:00	2.50	12.00	151	140/90	
	STAGE 3	01:01	3.40	14.00	169	150/90	
RECOVERY		01:04	0.00	0.00	130	160/90	

The patient exercised according to the BRUCE for 7:00 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 85 bpm rose to a maximal heart rate of 169 bpm. This value represents 90 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 160/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
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 MYOCARDIAL ISCHAEMIA AT THE WORKLOAD ACHIEVED.

Physician-DR.ANIRBAN DASGUPTA

Dr. ANIRBAN DASGUPTA
M.B.B.S., D.N.B. Medicine
Diploma Cardiology
MMC -2003/C2/0920

PATIENT'S NAME	RAHUL GHOSH	AGE :- 34 Y/M
UHID	11116	DATE :- .23 Mar. 24

X-RAY CHEST PA VEIW

OBSERVATION:

Patient is in positional obliquity.
Bilateral lung fields are clear.
Both hila are normal.
Bilateral cardiophrenic and costophrenic angles are normal.
The trachea is central.
Aorta appears normal.
The mediastinal and cardiac silhouette are normal.
Soft tissues of the chest wall are normal.
Bony thorax is normal.

IMPRESSION:

- No significant abnormality seen.



DR. CHHAYA S. SANGANI
CONSULTANT SONOLOGIST
Reg No. 073826

PATIENT'S NAME	RAHUL GHOSH	AGE :- 34y/M
UHID NO	11116	23 Mar 2024

USG WHOLE ABDOMEN

LIVER is normal in size, shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears well distended with normal wall thickness. There is no calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

SPLEEN is normal in size and echotexture. No focal lesion seen. SV is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or mass seen.

RIGHT KIDNEY measures 11.8 x 4.4 cm. There is 2.7 mm calculus in lower calyx of right kidney.

LEFT KIDNEY measures 11.4 x 5.3 cm. There is 2.6 mm calculus in lower calyx of left kidney.

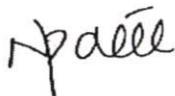
Urinary Bladder is adequately distended; no e/o any obvious wall thickening or mass or calculi seen.

PROSTATE is normal in size, shape & echotexture.
It measures approximately 20.1 gms.

Visualised bowel loops appear normal. There is no free fluid seen.

IMPRESSION –

- **Bilateral renal lower calyx calculi.**
- **No other significant abnormality detected.**



DR. NITESH PATEL
DMRE (RADIOLOGIST)