

**Patient Name** : MR. HIWARE PRATIK  
SHANKARRAO  
**Age / Sex** : 31 years / Male  
**LCID No** : 324030949  
**UID No** : 103027

**Reference** : MEDIWHEEL  
**Organization** : Mediwheel  
**Org ID** : NA

**Registered On** : Mar 23, 2024, 09:13 a.m.

**Collected On** : Mar 23, 2024, 09:16 a.m.

**Reported On** : Mar 23, 2024, 12:52 p.m.



## BLOOD GROUP LC

Specimen Type : EDTA

Test Description	Value(s)	Unit(s)	Reference Range
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### SEROLOGY

ABO Group

BySLIDE/TUBE Method

"O"

Rh (Factor)

BySLIDE/TUBE Method

Positive

Remark

Test done by : Agglutination Forward & Reverse Method (Whole Blood & Serum)

\* : *Rechecked*

\*\*END OF REPORT\*\*



Dr. Vijay Varde  
M.D.(Path) D.P.B  
Consultant Pathologist

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**Blood sugar post prandial**

Specimen Type : Plasma

Test Description	Value(s)	Unit(s)	Reference Range
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**BIOCHEMISTRY**

Blood sugar post prandial 77 mg/dl 70 - 140  
*By Hexokinase method*

Remark

Diagnostic criteria of Diabetes Mellitus (ADA guidelines 2021)

Fasting Blood Glucose :  $\geq 126$  mg/dl

OR

2 Hr Post Glucose :  $\geq 200$  mg/dl


OR

HbA1c  $\geq 6.5$  %

OR

Random Blood Glucose :  $\geq 200$  mg/dl**\*\*END OF REPORT\*\***

Dr. Vijay Varde  
M.D.(Path) D.P.B  
Consultant Pathologist

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**T3 T4 TSH**

Specimen Type : Serum

Test Description	Value(s)	Unit(s)	Reference Range
<b>IMMUNOASSAY</b>			
T3	80.42	ng/dl	60 - 181
T4	11.6	ug/dl	3.2 - 12.6
T.S.H (ULTRA SENSITIVE)	2.03	uIU/ml	0.55 - 4.78

Method : By CLIA

Sample Type: Serum

Remark :

1. Decreased value of T3(T4 and TSH normal) have minimal clinical significance and not recommended for diagnosis of hypothyroidism
2. Total T3 and T4 value may also be altered in other condition due to change in serum proteins or binding sites pregnancy,Drugs (Androgens,Estrogens,O C pills,■ Phenytoin),Nephrosis etc. In such cases free T3 and free T4 give corrected values.
3. Total T3 may decrease by <25percent in healthy older individual.

Remark:

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

Test done on ADVIA Centaur XP.

\*\*END OF REPORT\*\*




**Dr. Vijay Varde**  
M.D.(Path) D.P.B  
Consultant Pathologist

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## ERYTHROCYTE SEDIMENTATION RATE (E.S.R) LC

Specimen Type : EDTA

Test Description	Value(s)	Unit(s)	Reference Range
<b><u>HEMATOLOGY</u></b>			
E.S.R.	15	mm	0 - 15

*By Whole Blood Modified Westergren Method*

ESR done on fully automated Easyrate analyzer.

**\*\*END OF REPORT\*\***



**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

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### COMPLETE BLOOD COUNT (CBC) LC

Specimen Type : EDTA

Test Description	Value(s)	Unit(s)	Reference Range
<b>HEMATOLOGY</b>			
Haemoglobin (Mod.Cyanmethemoglobin)	13.1	gms%	13 - 17
R.B.C Count (Impedence)	<b>5.89</b>	x10 <sup>6</sup> /cmm	4.5 - 5.5
PCV (Conductivity)	42.2	%	40 - 50
MCV (Calculated)	<b>71.65</b>	fL	83 - 101
MCH(Calculated)	<b>22.24</b>	Pg	27 - 32
MCHC(Calculated)	<b>31.04</b>	gms%	31.5 - 34.5
W.B.C. Count(Impedence)	6.95	x10 <sup>3</sup> /cmm	4 - 10
RDW(Calculated)	<b>19.4</b>	%	11.6 - 14.0
MPV(Calculated)	8.9	fL	6 - 11
Platelet Count(Impedence)	2.61	x10 <sup>5</sup> /cmm	1.50 - 4.10
<b>DIFFERENTIAL COUNT (Impedence,Light Absorbance)</b>			
Neutrophils	67	%	40 - 80
Lymphocytes	22	%	20 - 40
Eosinophils	04	%	1 - 6
Monocytes	07	%	2 - 10
Basophils	0	%	0 - 2
RBC Morphology <i>Staining &amp; Microscopy</i>	Hypochromasia +, Microcytosis +, Anisocytosis +.		
WBC Morphology <i>Staining &amp; Microscopy</i>	Normal		
PLATELETS <i>Staining &amp; Microscopy</i>	Adequate on smear.		
Other	-		

CBC done on fully Automated Yumizen H550

\*\*END OF REPORT\*\*



  
**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

# Report



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## BUN / Creatinine Ratio

Specimen Type : Blood

Test Description	Value(s)	Unit(s)	Reference Range
<b><u>BIOCHEMISTRY</u></b>			
BUN / Creatinine Ratio <i>Calculation</i>	7.95		10:1 - 20:1

\*\*END OF REPORT\*\*



A handwritten signature in black ink, appearing to read "Rohini Gedam".

**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

# Report



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## Blood Urea/BUN

Specimen Type : Serum

Test Description	Value(s)	Unit(s)	Reference Range
<b><u>BIOCHEMISTRY</u></b>			
Serum Urea <i>By Urease Method</i>	13.27	mg/dl	10 - 38.5
BUN <i>By Serum By Urease with GLDH</i>	6.2	mg/dl	5 - 18
Remark :			

\*\*END OF REPORT\*\*



A handwritten signature in black ink, appearing to read "Rohini Gedam".

**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

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**LIVER FUNCTION TEST (LFT) LC**

Specimen Type : Serum

Test Description	Value(s)	Unit(s)	Reference Range
<b>BIOCHEMISTRY</b>			
Serum Bilirubin (Total) <i>ByDiazo Method</i>	<b>1.14</b>	mg/dl	0.2 - 1.0
Serum Bilirubin (Direct) <i>ByDiazo Method</i>	<b>0.23</b>	mg/dl	0.0 - 0.2
Serum Bilirubin (Indirect) <i>Calculated</i>	<b>0.91</b>	mg/dl	upto 0.90
S.G.O.T (AST) <i>BySerum By Enzymatic Method IFCC</i>	16	U/L	15 - 37
S.G.P.T <i>BySerum by Enzymatic Method</i>	21	U/L	16 - 63
Serum GGTP <i>ByEnzymatic Method</i>	18	U/L	15 - 85
Alkaline Phosphatase	70	U/L	46-116
Serum Proteins <i>ByBiuret Method</i>	7.5	g/dl	6.4 - 8.2
S. Albumin <i>ByBromocresol purple Method</i>	4.4	g/dl	3.4 - 5.0
Serum Globulin	3.10	gm/dl	1.8 - 3.6
A/G Ratio	<b>1.42</b>		1.5 - 3.5
Remark			

**\*\*END OF REPORT\*\***

**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist



# Report



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## Renal Function Test


Specimen Type : Serum

Test Description	Value(s)	Unit(s)	Reference Range
<b>BIOCHEMISTRY</b>			
Urea <i>ByUrease Method</i>	13.27	mg/dl	10 - 38.5
BUN <i>BySerum By Urease with GLDH</i>	6.2	mg/dl	5 - 18
Creatinine <i>ByAlkaline Picrate-Kinetic</i>	0.78	mg/dl	0.7 - 1.3
Uric Acid <i>BySerum by Uricase Method</i>	6.0	mg/dl	2.6 - 6.0
Calcium <i>BySerum Cresolphthaleine complexona Method</i>	9.6	mg/dl	8.5 - 10.1
Phosphorus <i>ByPhosphomolybdate - UV Method</i>	3.5	mg/dl	2.5 - 4.9
Sodium <i>BySerum By ISE Method</i>	140	mEq/L	135 - 145
Potassium <i>BySerum by ISE Method</i>	4.6	mEq/l	3.5 - 5.5
Chloride <i>BySerum by ISE Method</i>	107	mEq/L	96 - 109
Proteins <i>ByBiuret Method</i>	7.5	g/dl	6.4 - 8.2
Albumin <i>ByBromocresol purple Method</i>	4.4	g/dl	3.4 - 5
Globulin	3.10	g/dl	1.8 - 3.6
A/G Ratio	<b>1.42</b>		1.5 - 3.5

\*\*END OF REPORT\*\*



**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

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<b>UID No</b> : 103027		

## LIPID PROFILE LC

Specimen Type : Serum


Test Description	Value(s)	Unit(s)	Reference Range
<b>BIOCHEMISTRY</b>			
Triglycerides <i>By Enzymatic GPO/PAP Method</i>	83	mg/dl	Less than 150
Total Cholesterol <i>By CHOD-PAP Method</i>	135	mg/dl	UPTO 200
HDL Cholesterol <i>By Enzymatic Method</i>	51	mg/dl	40 - 60
VLDL Cholesterol	16.60	mg/dl	6 - 38
LDL Cholesterol	67.40	mg/dl	Upto 100
Cholesterol : HDL Cholesterol Ratio	2.65		Upto - 5
LDL Cholesterol/HDL Cholesterol Ratio	1.32		Upto 4

<b>Total Cholesterol :</b>	<b>HDL-Cholesterol:</b>
<i>Desirable : Less than 200 mg%</i>	<i>Desirable : More than 40 mg%</i>
<i>Borderline High : 200 - 239 mg% High : More than 239 mg%</i>	<i>Low : Less than 40 mg%</i>
<b>LDL-Cholesterol (Non-protective cholesterol) :</b>	<b>Triglycerides :</b>
<i>Optimal : Less than 100 mg% NearOptimal : 100 - 129 mg%</i>	<i>Normal : Less than 150 mg%</i>
<i>Borderline High : 130 - 159 mg%</i>	<i>Borderline : 150 - 199 mg%</i>
<i>High : 160 - 189 mg%</i>	<i>High : 200 - 499 mg%</i>
<i>Very High : More than 189 mg%</i>	<i>Very High : More than 499 mg%</i>

\*\*END OF REPORT\*\*



**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

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### Glycosylated HB A1c

Specimen Type : EDTA

Test Description	Value(s)	Unit(s)	Reference Range
<b><u>BIOCHEMISTRY</u></b>			
Glycosylated HBA1C	5.3	%	
AVERAGE BLOOD GLUCOSE LEVEL	105.41	mg/dl	

Reference Values : Glyco HB A1c

Non Diabetic : 4.0 - 6.0

Good Diabetic Control : 6.0 - 7.0

Fair Diabetic Control : 7.0 - 8.0

Poor Diabetic Control : > 8.0

Maintaining HbA1c levels to less than 7% will reduce risk of long term complications of Diabetes.

Method : Ion Exchange HIGH Pressure Liquid Chromatography (HPLC), on Fully Automated Biorad D10 analyser.

**INFORMATION** : Glycosylated Haemoglobin accumulates within the red blood cells & exists in this form throughout the lifespan of red cells. Thus a single HbA1c value taken every 2 - 3 months

serves over those months. The measurement of HbA1c has been used as an index of metabolic control of diabetes during the preceding 2 - 3 months providing physician with an objective look at patient-s diabetes control. HbA1c is not affected by factors like intake of carbohydrates, timing of antidiabetes drugs, daily activities.

Test done on BIORAD D10.

This test has been performed at Lifecare Diagnostics & Research Centre Pvt. Ltd.

Diagnostic criteria of Diabetes Mellitus (ADA guidelines 2021)

Fasting Blood Glucose :  $\geq$  126 mg/dl

OR

2 Hr Post Glucose :  $\geq$  200 mg/dl

OR

HbA1c  $\geq$  6.5 %

OR

Random Blood Glucose :  $\geq$  200 mg/dl

**\*\*END OF REPORT\*\***

# Report



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**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

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## Blood sugar fasting LC

Specimen Type : Plasma

Test Description	Value(s)	Unit(s)	Reference Range
<b><u>BIOCHEMISTRY</u></b>			
Blood Sugar Fasting			
<b><u>Glucose value</u></b> <i>By Hexokinase method</i>	98	mg/dl	70 - 110

Diagnostic criteria of Diabetes Mellitus (ADA guidelines 2021)

Fasting Blood Glucose :  $\geq 126$  mg/dl

OR

2 Hr Post Glucose :  $\geq 200$  mg/dl

OR

HbA1c  $\geq 6.5$  %

OR

Random Blood Glucose :  $\geq 200$  mg/dl

\*\*END OF REPORT\*\*



**Dr. Rohini Gedam D.P.B.**  
Consultant Pathologist

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**Reported On** : Mar 26, 2024, 11:53 a.m.



## X-RAY CHEST PA

### Report:

The visualised lung fields appear clear.

Both cardio & costo-phrenic angles appear clear.

Both hila appear normal.

Cardiac shadow appears normal.

Both domes of diaphragm are normal.

Visualised bones appear normal.

### Impression :

No significant abnormality detected.

\*\*END OF REPORT\*\*

Dr. Smita Dudhal  
DNB DMRD MBBS  
Consultant Radiologist

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## SONOGRAPHY OF FULL ABDOMEN & PELVIS

**LIVER:** Liver appears normal in size (13.8 cm), shape and shows mildly increased parenchymal echotexture. No abnormal focal lesion is seen. Intra-hepatic biliary radicals and portal venous system appears normal.

**COMMON BILE DUCT & PORTAL VEIN:** CBD and Portal vein appear normal in caliber.

**GALL BLADDER:** Gall bladder is physiologically distended with no evidence of abnormal intra-luminal contents. The wall thickness is normal. No pericholecystic fluid collection is noted.

**SPLEEN:** Spleen ( 12.6 cm) appears mildly enlarged in size, normal in position and echotexture.

**PANCREAS:** Pancreas appears normal in size, position and echotexture.

**KIDNEYS:** Right and Left kidneys measure 10.6 x 4.2 cm and 11 x 4.4 cm respectively.

Both kidneys appear normal in size, shape, position and echotexture. Pelvicalyceal system appears normal. Normal cortico-medullary differentiation is seen. No intra-renal calculus or abnormal focal lesion is seen.

**URINARY BLADDER:** Urinary Bladder is well distended and shows no abnormal intraluminal contents. Bladder wall thickness appears normal.

**PROSTATE:** Prostate is normal in size, shape and echotexture. It measures 3.8 x 3.2 x 2.5 cm, volume - 17 cc. No focal lesion is seen.

No evidence of lymphadenopathy or ascites is noted.

Visualized bowel loops are normal in caliber and show normal peristalsis.

A small anterior abdominal wall defect is seen in the region of umbilicus with herniation of omentum through it. The defect measures 3.4 mm & sac measures 10 x 9.6 mm.

# Report



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## IMPRESSION :

- Grade I fatty liver.
- Mild splenomegaly.
- Small umbilical hernia as described.

\*\*END OF REPORT\*\*

A handwritten signature in blue ink, appearing to read "Smita Dudhal".

**Dr. Smita Dudhal**  
**DNB DMRD MBBS**  
**Consultant Radiologist**



# Report



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## Post Prandial Urine Sugar

Specimen Type : Blood

Test Description	Value(s)	Unit(s)	Reference Range
<b><u>CLINICAL PATHOLOGY</u></b>			
Post Prandial Urine Sugar <i>Urine dipstik method</i>	Absent		Absent

\*\*END OF REPORT\*\*



A handwritten signature in black ink, appearing to read "Dr. Varde".

**Dr. Vijay Varde**  
**M.D.(Path) D.P.B**  
Consultant Pathologist

# Report



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## Fasting urine sugar


Specimen Type : Blood

Test Description	Value(s)	Unit(s)	Reference Range
<b><u>CLINICAL PATHOLOGY</u></b>			
Fasting urine sugar <i>Urine dipstik method</i>	Absent		Absent

\*\*END OF REPORT\*\*



**Dr. Vijay Varde**  
M.D.(Path) D.P.B  
Consultant Pathologist

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<b>UID No</b> : 103027		

## Urine Routine LC

Specimen Type : Urine

Test Description	Value(s)	Unit(s)	Reference Range
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### CLINICAL PATHOLOGY

#### Physical Examination

Quantity	20	ml	-
Colour <i>By Visual Examination</i>	Pale yellow		
Appearance	Slightly Hazy		
Specific Gravity <i>By Ion Concentration / Color Indicator</i>	1.015		1.000 - 1.035
Reaction (pH) <i>By Color Indicator</i>	6.0		5.0 - 8.0

#### Chemical Examination

Proteins <i>By Turbidometric Method</i>	Absent		Absent
Bile salts	Absent		Absent
Bile Pigments <i>By Diazo / Fouchets</i>	Absent		
Occult Blood <i>By Oxidation / Microscopy</i>	Absent		Absent
Glucose <i>By Enzymatic, GOD, POD &amp; Benedicts Test</i>	Absent		Absent
Ketones	Absent		Absent
Urobilinogen <i>By Diazo/p-amino Benzaldehyde react</i>	Normal		Normal

#### Microscopic Examination (per H.P.F.)

Epithelial Cells	Occasional	/hpf	3 - 5
Leucocytes	0 - 1	/hpf	0 - 5
Red Blood Cells	Absent	/hpf	0 - 2
Casts	Absent		
Crystals	Absent		
Trichomonas vaginalis	Absent		
Yeast	Absent		

CHEMICAL EXAMINATION DONE BY MULTISTIX.SG (SIEMENS)

\*\*END OF REPORT\*\*

# Report



**Patient Name** : MR. HIWARE PRATIK  
SHANKARRAO  
**Age / Sex** : 31 years / Male  
**LCID No** : 324030949  
**UID No** : 103027

**Reference** : MEDIWHEEL  
**Organization** : Mediwheel  
**Org ID** : NA

**Registered On** : Mar 23, 2024, 09:13 a.m.

**Collected On** : Mar 23, 2024, 09:16 a.m.

**Reported On** : Mar 23, 2024, 01:26 p.m.



**Dr. Vijay Varde**  
**M.D.(Path) D.P.B**  
Consultant Pathologist

**Health Check up Booking Request(bobE18179)**

Mediwheel <wellness@mediwheel.in>  
 To: crm.lokhandwala@lifecarediagnostics.com  
 Cc: customercare@mediwheel.in

Fri, Mar 22, 2024 at 6:14 PM



**011-41195959**

Dear Life Care Diagnostics

We have received a booking request with the following details. Provide your confirmation by clicking on the Yes button.

**You confirm this booking?**       Yes       No

**Name** : MR. HIWARE PRATIK SHANKARRAO  
**Contact Details** : 9975253344  
**Hospital Package Name** : Mediwheel Full Body Annual Plus  
**Location** : 1st Floor, Sunshine, Opp, Shastri Nagar Rd, Lokhandwala Complex, Andheri West- 400053.  
**Appointment Date** : 23-03-2024

Member Information		
Booked Member Name	Age	Gender
MR. HIWARE PRATIK SHANKARRAO	31 year	Male

**Tests included in this Package -**

- Bmi Check
- Ent Consultation
- Dietician Consultation
- Thyroid Profile
- ESR
- Blood Glucose (Fasting)
- General Physician Consultation
- TMT OR 2D ECHO
- Blood Group
- Blood Glucose (Post Prandial)
- Chest X-ray
- ECG
- USG Whole Abdomen
- Eye Check-up consultation
- Urine Sugar Fasting
- Urine Sugar PP
- Dental Consultation
- Urine analysis
- CBC
- HbA1c

आयकर विभाग  
INCOME TAX DEPARTMENT



भारत सरकार  
GOVT. OF INDIA

PRATIK S HIWARE

SHANKARRAO NAMDEORAO HIWARE

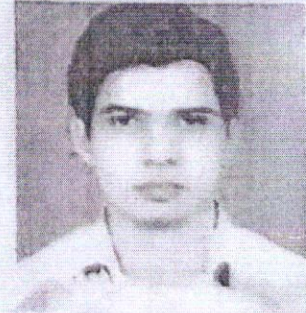
26/03/1992

Permanent Account Number

ANHPH7053E

*Hiware*

Signature



30062015

*Hiware*



EQAS  
BIORAD

26  
Years of Service

24/7  
Path



# Lifecare

diagnostics

## MEDICAL EXAMINATION REPORT

Name : Hivare Shankarao Date : 23-3-24  
 Date of Birth 26-3-1992 Age : 30 Sex : male  
 Referred by : Melwcheel Proof of Identification : pancard

PLEASE TICK THE RELEVANT BOXES	Yes	No	PLEASE TICK THE RELEVANT BOXES	Yes	No
1) GENERAL APPEARANCE : Is there any abnormalities in general appearance & built up of the Examinee?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	7) RESPIRATORY SYSTEM: a. Are there any abnormality in air entry and breath sounds? b. Are there any abnormalities in the chest wall? b. is there any evidence/ history of abnormality or disease of the respiratory system like breathlessness, wheezing, persistent cough, chronic bronchitis, emphysema, asthma, TB, Pneumonia?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
1) DETAILS OF PHYSICAL EXAMINATION : a. Height <u>171.0</u> cm b. Weight <u>73.5</u> kg. c. Blood Pressure : <u>110/60</u> mm Hg. d. Pulse Rate <u>70</u> /min			8) CARDIO VASCULAR SYSTEM: a. History of chest pain, palpitation, breathlessness esp. on mild-moderate exertion, night sleep. b. History of any peripheral vascular disorder? c. Is there any abnormality in heart sound? If a murmur is present, give the extent, grade point of maximum intensity and conduction and the probable diagnosis. d. Any history of CABG, Open Heart [Surgery, Angiography PTCA, other intervention.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3) WHETHER IN THE PAST THE EXAMINEE a. Has been hospitalized? (If YES, please give details) b. Was involved in any accident? c. Underwent Surgery? d. Is the examinee currently under any medication? e. Has there been any recent weight gain or weight loss?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	9) SKIN: a. Any evidence of psoriasis, eczema, burn marks, rashes and varicose veins or xanthelasma? b. Any history of allergy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4) FAMILY HISTORY: Has any of the examinee's immediate family members (natural only) ever suffered or is suffering from heart disease kidney disease, stroke, hypertension, diabetes, cancer, mental illness or any hereditary disease? (please specify)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	10) GI SYSTEM: a. Is there any evidence/history disease of liver, gall bladder pancreas, stomach, intestines? b. is there any evidence of enlargement of liver or spleen or any other organ in abdomen & pelvis? c. Any history of plies or fistula? d. Any history of Jaundice	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5) ENT. EYE & ORAL CAVITY: a. Are there any abnormalities in oral cavity? b. Are there any tobacco stains? c. Is there any history or evidence of abnormality in eyes error of refraction etc.? d. Is there any abnormality found on history/examination on ears? (Ear discharge, perforation, impaired hearing) e. Is there any abnormality found on examination of nose and throat? Active nose bleed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	11) GU SYSTEM: Has the examinee suffered from or is suffering from Kidney/ Ureter / Bladder disease / Stones or any other urinary disease?	<input type="checkbox"/>	<input type="checkbox"/>
6) NERVOUS SYSTEM: a. Is there any evidence/histroy of disease of Central or Peripheral Nervous Systems (including cranial nerves)? b. Is there any evidence or history of paralysis, seizures (focal or generalized), peripheral neuritis, fainting, frequent headaches, wasting, tremors, involuntary movement etc? c. Are there any abnormality in gait and speech? d. Is there any history of sleep apnea syndrome?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	12) MUSCULOSKELETAL SYSTEM: a. Is there any back, spine, joint muscle or bone disorder? b. Any history of bone fracture or joint replacement or gout? if yes, give details?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE TICK THE RELEVANT BOXES		Yes	No	PLEASE TICK THE RELEVANT BOXES		Yes	No
13) OTHERS				15) Has the examinee or his/her spouse received medical advice counseling or treatment in connection with HIV-AIDS or STD eg. syphilis, gonorrhoea)			
a. Is the examinee on treatment for Hypertension/diabetes? If yes, mention medication and duration of P?	<input type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
b. Is there any enlargement of Thyroid?	<input type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
c. Is there any suspicion of any other Endocrine disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
d. Is hernia present? If yes, give details.	<input type="checkbox"/>	<input checked="" type="checkbox"/>		16) FEMALE APPLICANTS ONLY:			
e. Are there any abnormalities in testes? If yes, give details.	<input type="checkbox"/>	<input checked="" type="checkbox"/>		a. Have you suffered from or any you aware of any breast lumps or any other disorder of your breasts?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
f. Is there any history or evidence suggestive of cancer, tumor growth or cyst?	<input type="checkbox"/>	<input checked="" type="checkbox"/>		b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorder of the female organs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
g. Was the examinee treated for any psychiatric ailment? If so, give details about medication given.	<input type="checkbox"/>	<input checked="" type="checkbox"/>		c. For females who have conceived, were there any complications during pregnancy such as gestational diabetes, hypertension etc?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
h. History of anxiety / stress / depression / sleep disorder.	<input type="checkbox"/>	<input checked="" type="checkbox"/>		d. Are you now pregnant? If yes, how many months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
14) HABITS & ADDICTIONS							
Does the examinee consume tobacco/alcohol.drugs/narcotics in any form? If yes, please ascertain the type, quantity, duration and frequency of consumption.				<input type="checkbox"/>	<input checked="" type="checkbox"/>		

**Please mention details:**

Q. NO.	Please provide details of all answers marked as 'yes'
-	Jauundice at age of 10yr
=	History of Fracture over H&D wrist at age of 16

Remarks on present health status : Normal

Recommendations (if any): \_\_\_\_\_

<p><b>Lifecare Diagnostics &amp; Research Center Pvt. Ltd.</b>          1st Floor, Sunshine, Opp. Shashtri Nagar,          Lokhandwala Complex, Andheri (W),          Mumbai- 400053.</p> <p><b>Name &amp; Signature of Doctor</b></p>	<p>The above statements and answers made to the medical examiner(s) are complete and true.</p> <p><i>[Signature]</i></p> <p><b>Signature of Examinee</b></p>
--	--

Date 23-3-24 Place Mumbai

**NOTES:**



**Main Centre :** 1st Floor, Sunshine, Opp. Shastri Nagar, Lokhandwala, Andheri (W), Mumbai. Tel.: 2633 2527-32  
**Central Laboratory :** 206, Cosmos Plaza, Opp. Indian Oil Nagar, J P Road, Andheri (W), Mumbai. Tel.: 26372527  
**Versova Branch :** 10, 11, First Floor, Silver Streak, Near Bus Depot, Yari Road, Versova, Andheri (W), Mumbai. Tel.: 26399210  
**Worli Branch :** B-101, Trade World, Kamala Mills, Senapati Bapat Marg, Lower Parel West, Lower Parel, Mumbai- 400013. Tel: 9167223844  
**Mumbai : Versova | Lokhandwala | Goregaon | Kandivali | Dahisar | Worli | Pune : Aundh | Chinchwad | Gujrat : Vadodra**  
 E-mail : admin@lifecarediagnostics.com | feedback@lifecarediagnostics.com | Website : www.lifecarediagnostics.com

NOTE : General physical examination & investigation included in the health checkup have certain limitations and may not be able to detect any latent or asymptomatic disease. Hence any new symptoms arising after the medical checkup should be notified to attending physician.





## OPHTHALMIC REPORT

NAME: Mr. Hiware Pratik Shankar Rao.  
 AGE: 3/yr / Male.

DATE: 23/03/2024.

Distance Vision	Right Eye	Left Eye	Both Eyes
Without Glasses	6/6	6/6	6/6.
With Glasses	—	—	—

Near Vision	Right Eye	Left Eye	Both Eyes
Without Glasses	NG	NG	NG
With Glasses	—	—	—

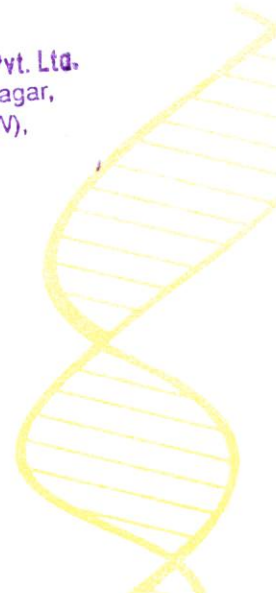
	Right Eye	Left Eye
Colour Vision	Normal	Normal
Anterio Segment	Normal	Normal
External Eye Exam	Normal	Normal
Intra ocular tension	—	—
Fundus	—	—

Advise:

← Both Eyes fit

Lifecare Diagnostics & Research Center Pvt. Ltd.  
 1st Floor, Sunshine Opp. Shashtri Nagar,  
 Lokhandwala Complex, Andheri (W),  
 Mumbai- 400053.

OPTOMETRIST



# Report

To,  
Life care Diagnostics..  
Mumbai

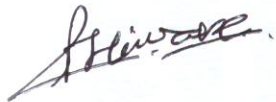
Sub: skip of stool Routine test.

Dear Sir/madam,

I Pratik Hiwase, request you to skip my  
stool routine test.

Thanking you.

Yours faithfully.



(Pratik Hiwase)

Bank of Baroda.

Lifecare  
diagnostics



# LIFECARE DIAGNOSTIC

**Patient Details**                      **Date:** 23-Mar-24                      **Time:** 10:33:07 AM  
**Name:** MR HIWARE PRATIK SHANKARRAO ID: 102930  
**Age:** 31 y                      **Sex:** M                      **Height:** 171 cms                      **Weight:** 73 Kgs  
**Clinical History:** NIL

**Medications:** NIL

## Test Details

**Protocol:** Bruce                      **Pr.MHR:** 189 bpm                      **THR:** 160 (85 % of Pr.MHR) bpm  
**Total Exec. Time:** 7 m 23 s                      **Max. HR:** 165 (87% of Pr.MHR) bpm                      **Max. Mets:** 10.20  
**Max. BP:** 135 / 80 mmHg                      **Max. BP x HR:** 22275 mmHg/min                      **Min. BP x HR:** 6240 mmHg/min  
**Test Termination Criteria:** Target HR attained

## Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	0 : 13	1.0	0	0	79	110 / 80	-1.06 aVR	2.12 V3
Standing	0 : 3	1.0	0	0	79	110 / 80	-1.06 aVR	2.12 V3
Hyperventilation	0 : 2	1.0	0	0	78	110 / 80	-1.06 aVR	2.48 V3
1	3 : 0	4.6	1.7	10	116	120 / 80	-1.27 aVR	3.54 V3
2	3 : 0	7.0	2.5	12	147	125 / 80	-1.06 III	4.25 V3
Peak Ex	1 : 23	10.2	3.4	14	165	125 / 80	-1.27 III	4.60 V4
Recovery(1)	1 : 0	1.8	1	0	135	135 / 80	-1.70 aVR	5.31 V4
Recovery(2)	1 : 0	1.0	0	0	110	135 / 80	-1.91 aVR	5.31 V3
Recovery(3)	0 : 23	1.0	0	0	107	125 / 80	-1.06 aVR	4.25 V3

## Interpretation

The patient exercised according to the Bruce protocol for 7 m 23 s achieving a work level of Max. METS : 10.20. Resting heart rate initially 79 bpm, rose to a max. heart rate of 165 (87% of Pr.MHR) bpm. Resting blood Pressure 110 / 80 mmHg, rose to a maximum blood pressure of 135 / 80 mmHg.  
 NORMAL RESTING HR, BP AND ECG  
 NORMAL CHRONOTROPIC AND IONOTROPIC RESPONSE  
 NO ANGINA OR ARRHYTHMIAS DURING THE TEST  
 NO FRESH ST-T CHANGES DURING THE TEST AS COMPARED TO RESTING ECG  
 THEREFORE TEST IS NEGATIVE FOR INDUCIBLE ISCHAEMIA  
 GOOD EFFORT TOLERANCE



Ref. Doctor: MEDIWHEEL  
 (Summary Report edited by user)

Doctor: DR HANISH D  
 (c) Schiller Healthcare India Pvt. Ltd. V 4.7

MR HIWARE PRATIK SHANKARRAO (31 ~~MM~~) 102930

Date: 23-Mar-24 Exec Time : 0 m 0 s Stage Time : 0 m 7 s HR: 80 bpm

Protocol: Bruce

Stage: Supine

Speed: 0 mph

Grade: 0%

(THR: 160 bpm)

B.P: 110 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

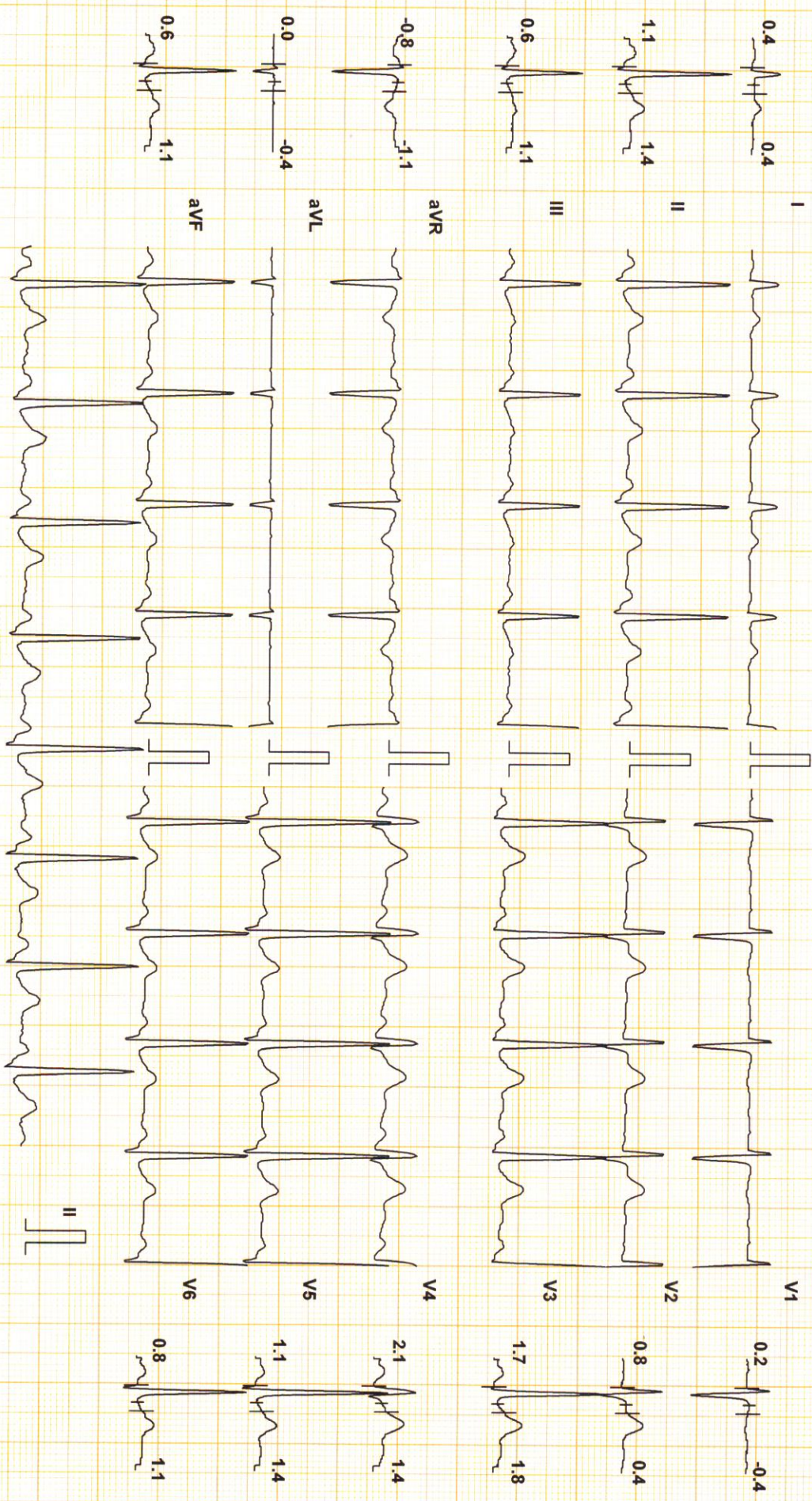


Chart Speed: 25 mm/sec  
Schiller Spandan V4.7

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

Protocol: Bruce

Stage: Standing

Speed: 0 mph

Grade: 0 %

(THR: 160 bpm)

B.P: 110 / 80

Date: 23-Mar-24

Exec Time : 0 m 0 s

Stage Time : 0 m 10 s

HR: 80 bpm

ST Level (mm)

ST Slope (mV/s)

I

ST Level (mm)

ST Slope (mV/s)

0.4

0.4

0.2

-0.4

1.1

1.4

0.8

0.4

0.6

1.1

1.7

1.8

-0.8

-1.1

2.1

1.4

0.0

-0.4

1.1

1.4

0.6

1.1

0.8

1.1

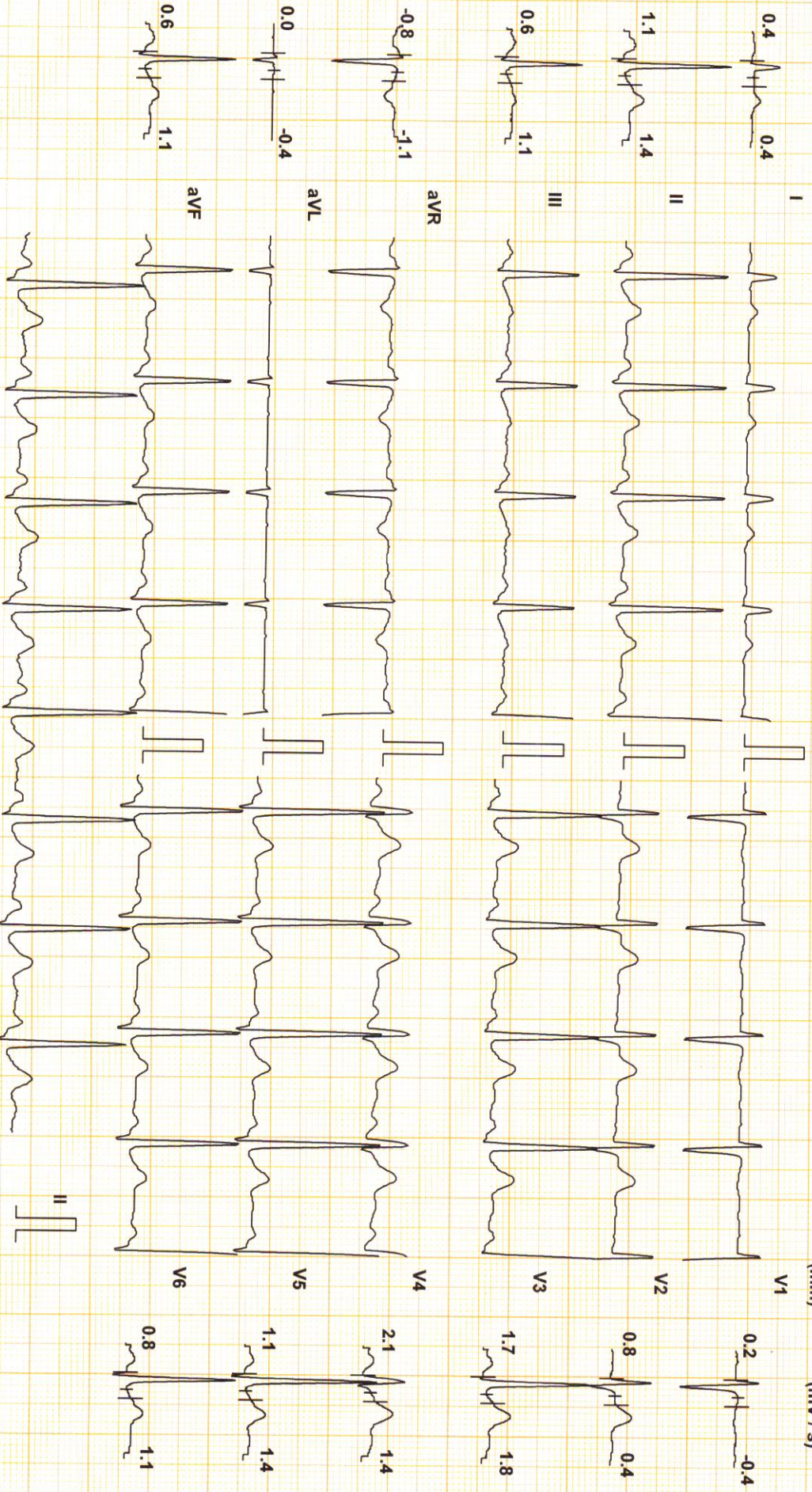


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Schiller Spandan V4.7

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

# LIFECARE DIAGNOSTIC

## Test Report

Protocol: Bruce

Stage: Hyperventilation

Speed: 0 mph

Grade: 0 %

(THR: 160 bpm)

B.P: 110 / 80

ST Level (mm)      ST Slope (mV/s)

ST Level (mm)      ST Slope (mV/s)

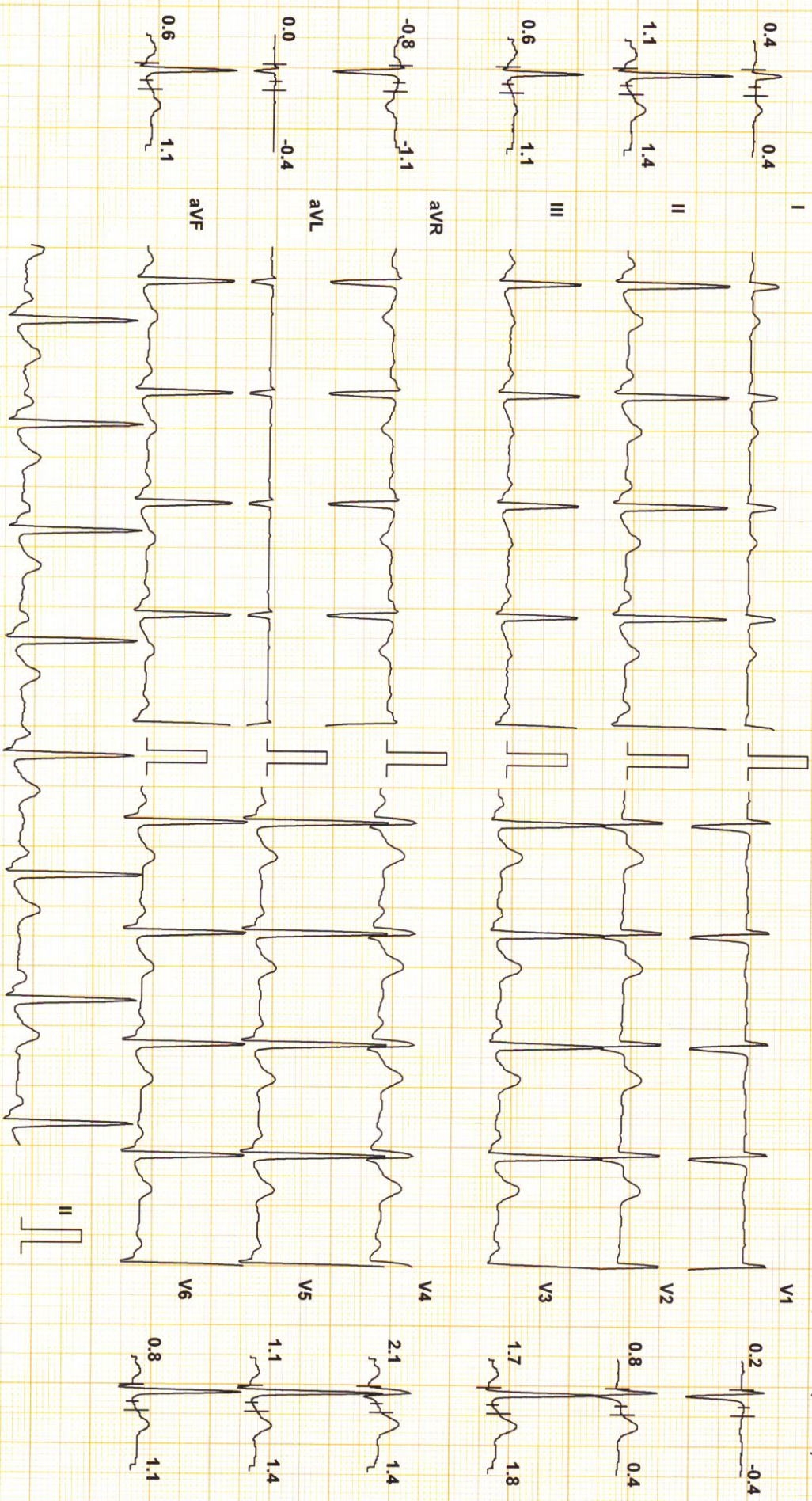


Chart Speed: 25 mm/sec  
Schiller Spandan V 4.7

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

Protocol: Bruce Stage: 1

Speed: 1.7 mph Grade: 10 % (THR: 160 bpm) B.P: 120 / 80

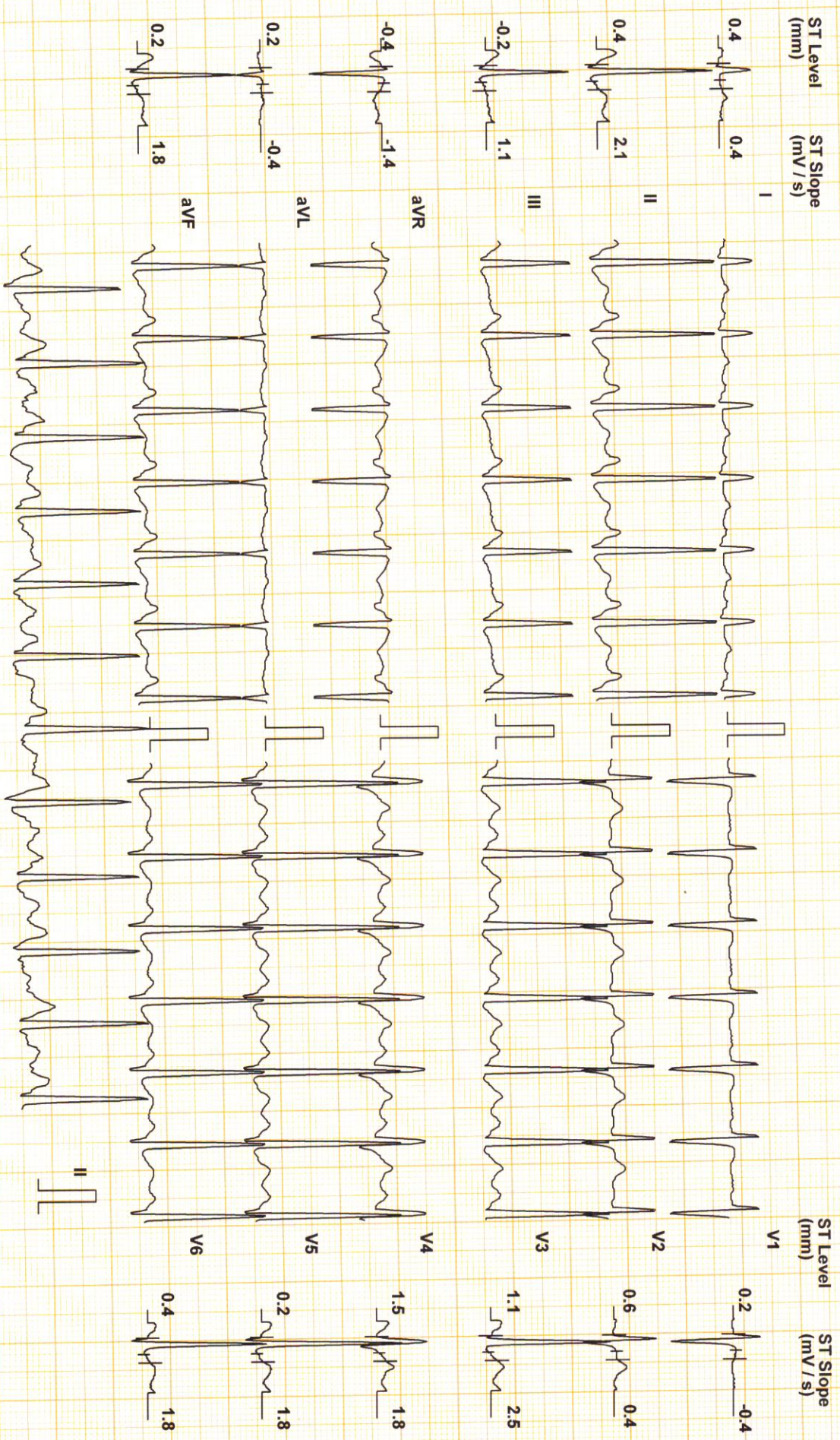


Chart Speed: 25 mm/sec  
Schiller Spandan V 4.7

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

MR HIWARE PRATIK SHANKARRAO (31 **IM**) 1029330

Date: 23-Mar-24 Exec Time : 5 m 54 s Stage Time : 2 m 54 s **HR: 145 bpm**

Protocol: Bruce

Stage: 2

Speed: 2.5 mph Grade: 12 %

(THR: 160 bpm)

B.P: 125 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

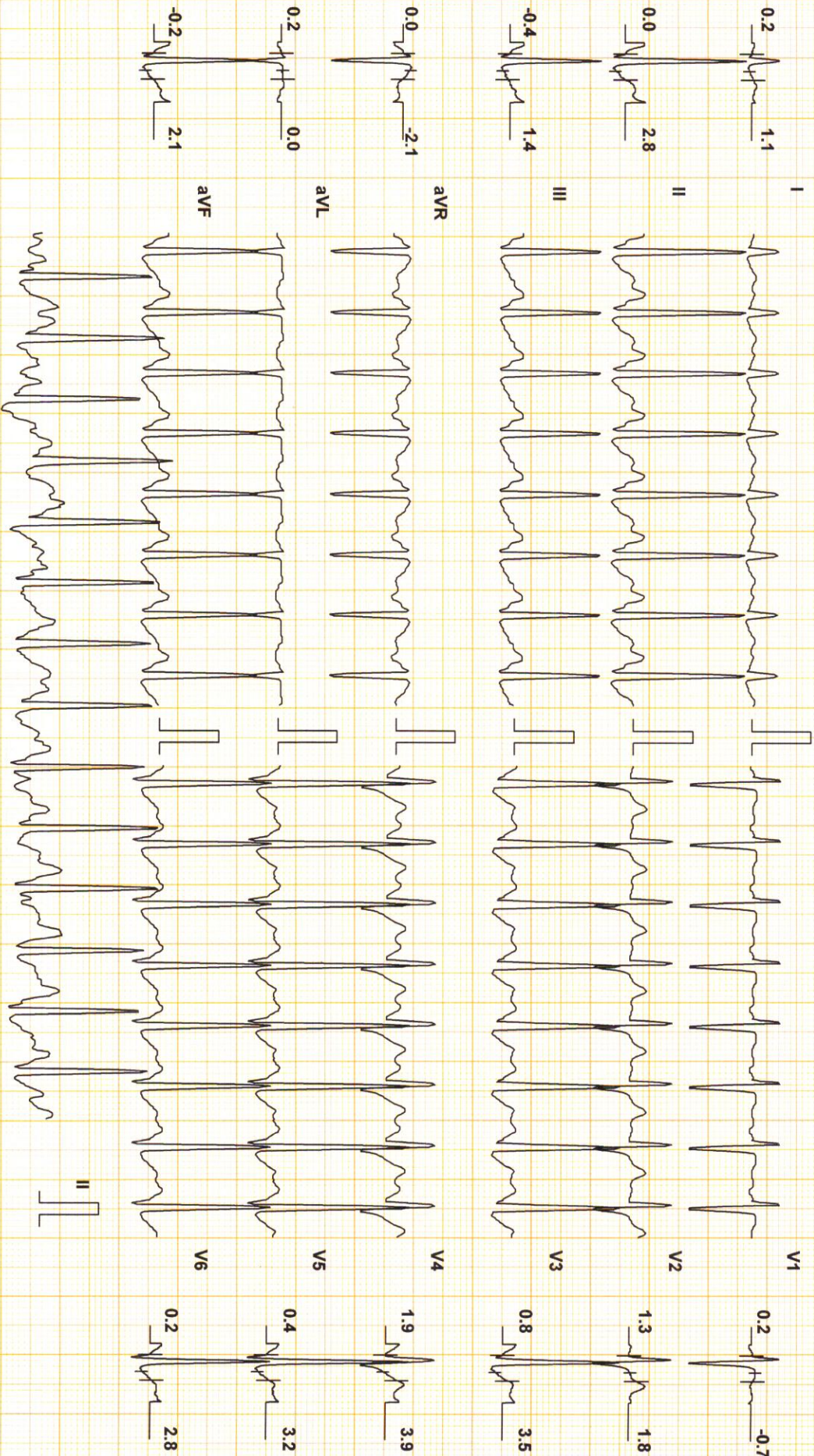


Chart Speed: 25 mm/sec  
Schiller Spandan V 4.7

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms  
Linked Median



Protocol: Bruce

Stage: Peak Ex

Speed: 3.4 mph

Grade: 14 %

(THR: 160 bpm)

B.P: 125 / 80

ST Level (mm) ST Slope (mV / s)

ST Level (mm) ST Slope (mV / s)

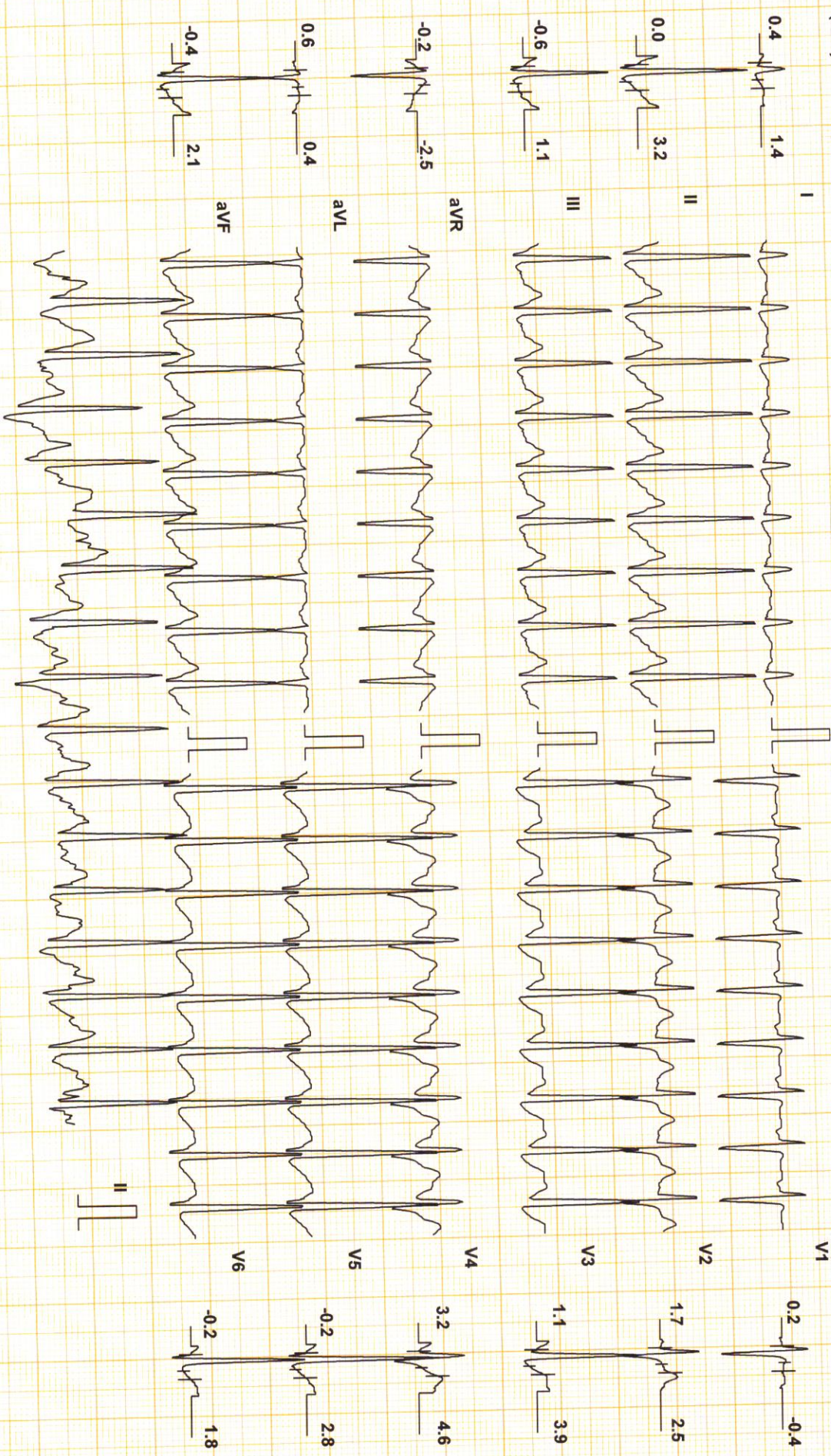


Chart Speed: 25 mm/sec  
Schiller Spandan V 4.7

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

MR HIWARE PRATIK SHANKARRAO (31 M) 102930

Date: 23-Mar-24 Exec Time : 7 m 23 s Stage Time : 0 m 54 s HR: 137 bpm

Protocol: Bruce Stage: Recovery(1) Speed: 1 mph Grade: 0% (THR: 160 bpm) B.P: 135 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

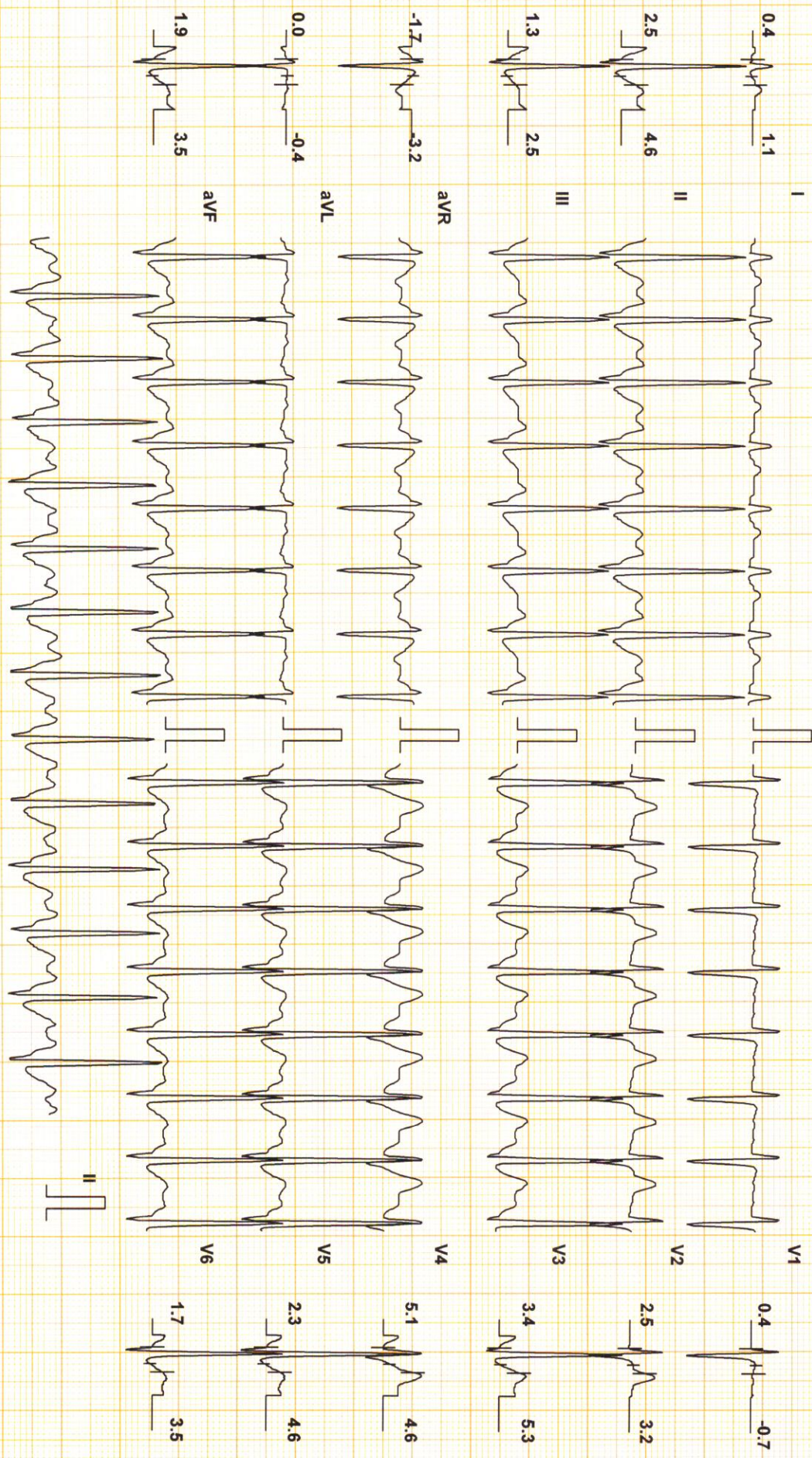


Chart Speed: 25 mm/sec  
Schiller Spandan V 4.7

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

Date: 23-Mar-24

Exec Time : 7 m 23 s Stage Time : 0 m 54 s HR: 110 bpm

Protocol: Bruce

Stage: Recovery(2)

Speed: 0 mph

Grade: 0 %

(THR: 160 bpm)

B.P: 135 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

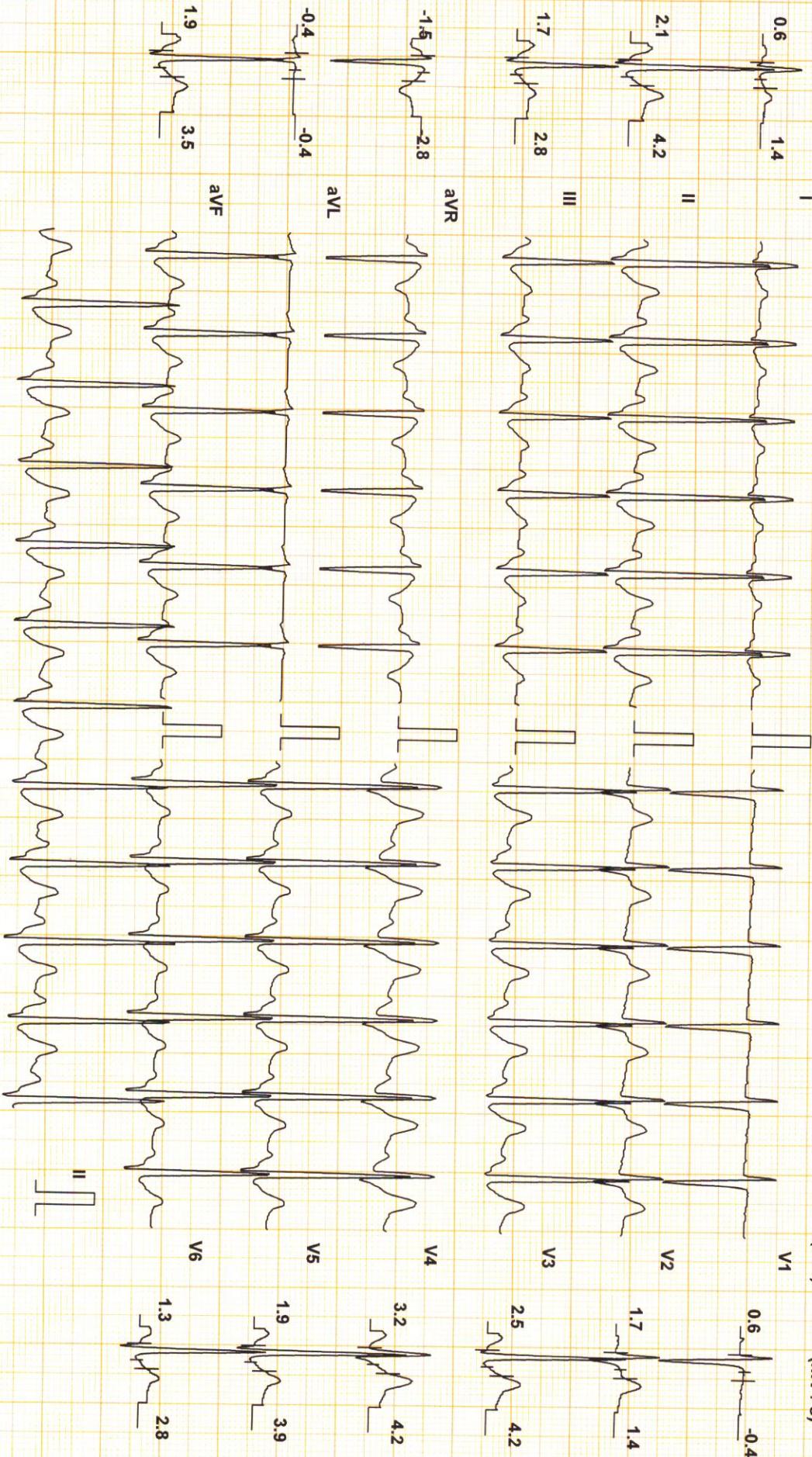


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

Schiller Spandan V 4.7

MR HIMWARE PRATIK SHANKARRAO (31 M) 102930

Date: 23-Mar-24 Exec Time : 7 m 23 s Stage Time : 0 m 17 s HR: 108 bpm

Protocol: Bruce

Stage: Recovery(3)

Speed: 0 mph

Grade: 0 %

(THR: 160 bpm)

B.P: 125 / 80

ST Level (mm) ST Slope (mV/s)

ST Level (mm) ST Slope (mV/s)

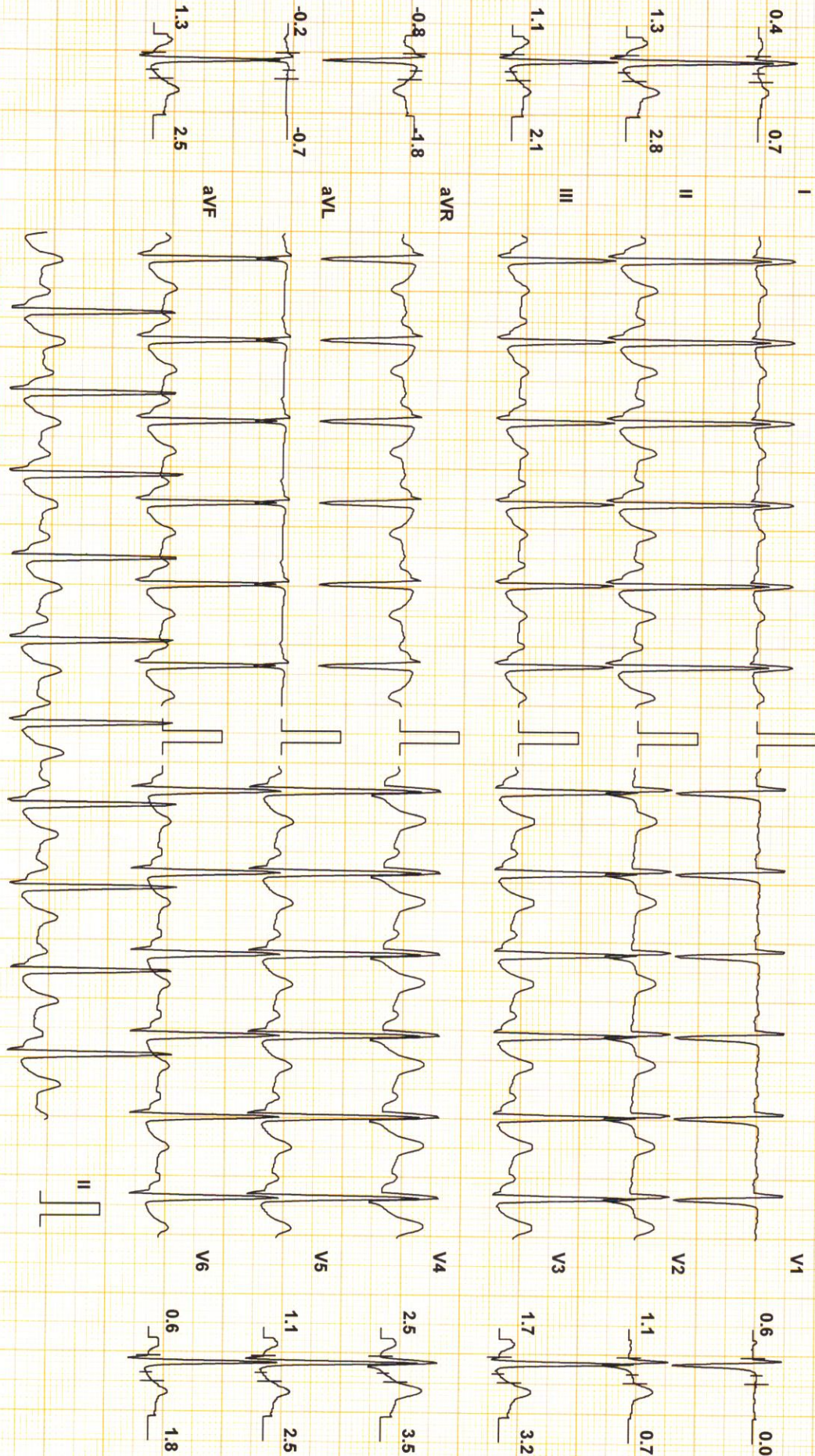


Chart Speed: 25 mm/sec  
Schiller Spandan V4.7

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

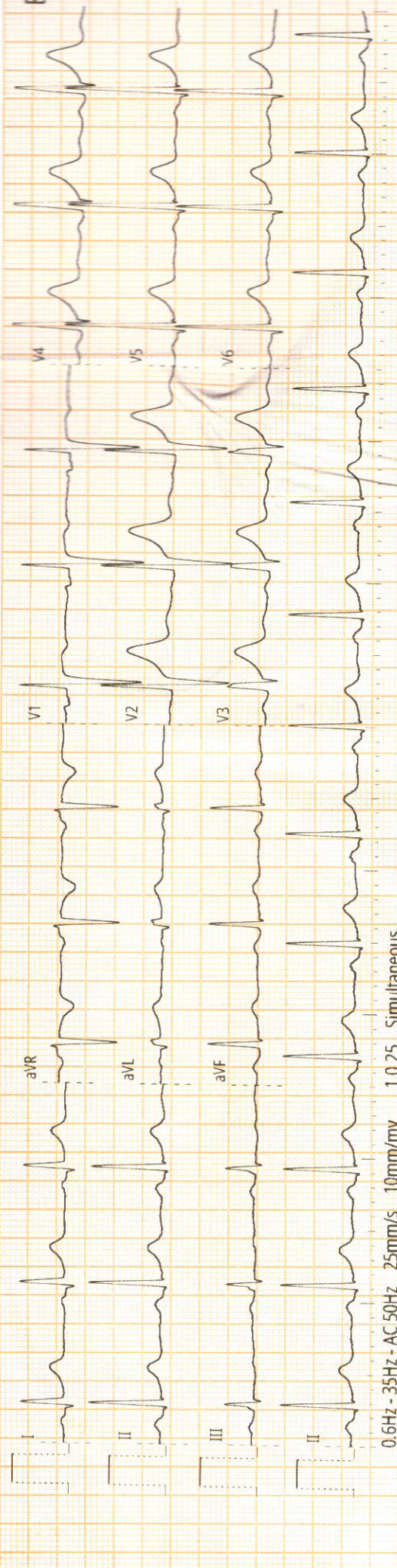
Isr = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Linked Median

ECG report  
ID : 21  
Name :  
Gender :  
Age :  
Dept :  
Bed No :



0.6Hz - 35Hz - AC 50Hz 25mm/s 10mm/mv 1.025 Simultaneous

MSD (M.D. PH.D.)

MSD - III - 20.C2

ECG report

ID : 2024032222126  
Name : Hiwari  
Gender : Shantkaraj  
Age : 31/M  
Dept :  
Bed No :  
HR : 75 bpm  
PR : 158 ms  
QRS : 88 ms  
QTc : 388/414 ms  
P/QRS/T : 59/54/28°  
RV5/SVI : 1.963/1.234 mV  
RV5+SVI : 3.197 mV

*Hiwari*



## REPORT

— Sinus rhythm  
— normal ECG

**Central Laboratory**  
206, Cosmos Plaza,  
Opp. Indian Oil Nagar,  
J. P. Road, Andheri (W),  
Mumbai  
Tel.: 26372527

**Versova Branch**  
10, 11, First Floor, Silver Streak,  
Near Bus Depot, Yari Road,  
Versova, Andheri (W),  
Mumbai  
Tel.: 26399210

**Worli Branch**  
B-101, Trade World,  
Kamala Mills,  
Senapati Bapat Marg,  
Lower Parel (W),  
Mumbai - 400013  
Tel.: 9167223844

**Lifecare Diagnostics & Research Center Pvt. Ltd.**  
1st Floor, Sunshine Opp. Shashtri Nagar,  
Lokhandwala Complex, Andheri (W),  
Mumbai - 400053.

  
M.D.  
CARDIOLOGIST

For Home visits call : 9167117755 / 9167223838

