

 भारत सरकार
GOVERNMENT OF INDIA


मुकेश बागोरिया
Mukesh Bagoriya
जन्म तिथि / DOB : 01/12/1984
पुरुष / MALE



~~2071~~ 0320 6451


मेरा आधार, मेरी पहचान



Mukesh

 भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

Address
S/O Ram Lal Bagoriya 37
Kapoorwala Road vpo
nuhana N B N school ke
pass Muhana Muhana
Jaipur Rajasthan - 302029

पता:
S/O राम लाल बागोरिया, 37, कपूरवाला रोड,
एन बी एन विद्यालय के पास, व्यो मुहना, मुहाना,
जयपुर,
राजस्थान - 302029



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



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General Physical Examination

Date of Examination: 29/09/24

Name: MUKESH BAGORIYA Age: 39YRS DOB: 01/11/84 Sex: Male

Referred By: BANK OF BARODA

Photo ID: AADHAR CARD ID #: 8451

Ht: 173 (cm)

Wt: 71 (Kg)

Chest (Expiration): 99 (cm)

Abdomen Circumference: 90 (cm)

Blood Pressure: 130/80 mm Hg PR: 89/min RR: 18/min Temp: Afebrile

BMI 23.7

Eye Examination: with glass
R/E - SIG, NIG, NCB
L/E - SIG, NIG, NCB

Other: NO

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

Signature Of Examinee : *Mukesh* Name of Examinee: MUKESH BAGORIYA

Signature Medical Examiner: *Dr. PiYush Goyal* Name Medical Examiner: DR. PIYUSH GOYAL
Dr. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No.-037041



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NAME :- Mr. MUKESH BAGORIYA

Age :- 39 Yrs 2 Mon 30 Days

Sex :- Male

Patient ID :-12234743

Date :- 29/02/2024

10:10:19

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 29/02/2024 16:49:05

HAEMOGARAM

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 MALE			
HAEMOGLOBIN (Hb)	15.9	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	6.50	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	60.0	%	40.0 - 80.0
LYMPHOCYTE	35.0	%	20.0 - 40.0
EOSINOPHIL	2.0	%	1.0 - 6.0
MONOCYTE	3.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	5.77 H	$\times 10^6/\mu\text{L}$	4.50 - 5.50
HEMATOCRIT (HCT)	49.50	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	86.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	27.5	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	32.1	g/dL	31.5 - 34.5
PLATELET COUNT	154	$\times 10^3/\mu\text{L}$	150 - 410
RDW-CV	14.1 H	%	11.6 - 14.0

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DR.TANU RUNGTA
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RMC No. 17226



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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)

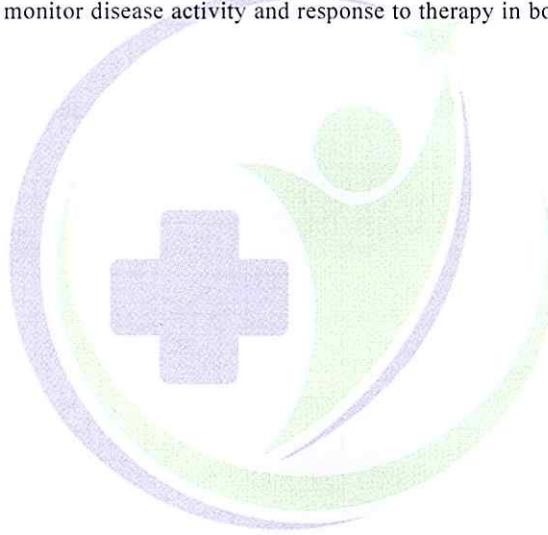
Method:- Westergreen

10

mm in 1st hr

00 - 15

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



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





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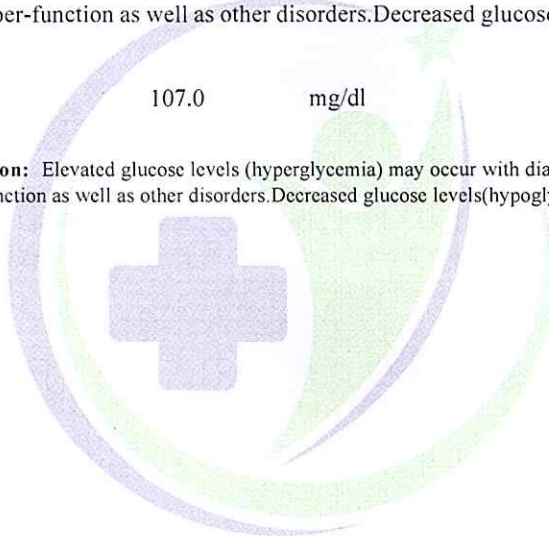
BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	99.4	mg/dl	70.0 - 115.0
Impaired glucose tolerance (IGT)		111 - 125 mg/dL	
Diabetes Mellitus (DM)		> 126 mg/dL	

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

BLOOD SUGAR PP (Plasma) Method:- GOD PAP	107.0	mg/dl	70.0 - 140.0
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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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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
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GLYCOSYLATED HEMOGLOBIN (HbA1C)

Method:- CAPILLARY with EDTA

5.6 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

110 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

"AB" POSITIVE



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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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LIPID PROFILE

TOTAL CHOLESTEROL 181.00 mg/dl
 Desirable <200
 Borderline 200-239
 High > 240
 Method:- CHOD-PAP methodology

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

TRIGLYCERIDES 168.00 H mg/dl
 Normal <150
 Borderline high 150-199
 High 200-499
 Very high >500
 Method:- GPO-PAP

InstrumentName:Radox 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 46.50 mg/dl
 MALE- 30-70
 FEMALE - 30-85
 Method:- Direct clearance Method

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 106.50 mg/dl
 Optimal <100
 Near Optimal/above optimal 100-129
 Borderline High 130-159
 High 160-189
 Very High > 190
 Method:- Calculated Method

VLDL CHOLESTEROL 33.60 mg/dl
 0.00 - 80.00
 Method:- Calculated

T.CHOLESTEROL/HDL CHOLESTEROL RATIO 3.89
 0.00 - 4.90
 Method:- Calculated

LDL / HDL CHOLESTEROL RATIO 2.29
 0.00 - 3.50
 Method:- Calculated

TOTAL LIPID 596.31 mg/dl
 400.00 - 1000.00
 Method:- CALCULATED

- Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
- 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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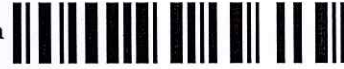
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BIOCHEMISTRY

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	0.69	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.21	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.48	mg/dl	0.30-0.70
SGOT Method:- IFCC	33.9	U/L	0.0 - 40.0
SGPT Method:- IFCC	36.0	U/L	0.0 - 40.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	87.20	U/L	53.00 - 141.00
SERUM GAMMA GT Method:- Szasz methodology Instrument Name Randox Rx Imola	33.50	U/L	10.00 - 45.00
<small>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.</small>			
SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	6.85	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	4.21	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	2.64	gm/dl	2.20 - 3.50
A/G RATIO	1.59		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 anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA 35.90 mg/dl 10.00 - 50.00
 Method:- Urease/GLDH

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

SERUM CREATININE 0.90 mg/dl Males : 0.6-1.50 mg/dl
 Method:- Jaffe's Method 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 5.69 mg/dl 2.40 - 7.00

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

SODIUM 140.4 mmol/L 135.0 - 150.0
 Method:- ISE

POTASSIUM 4.13 mmol/L 3.50 - 5.50
 Method:- ISE

CHLORIDE 98.3 mmol/L 94.0 - 110.0
 Method:- ISE

SERUM CALCIUM 9.87 mg/dL 8.80 - 10.20
 Method:- Arsenazo III Method

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 6.85 g/dl 6.00 - 8.40
 Method:- Direct Biuret Reagent

SERUM ALBUMIN 4.21 g/dl 3.50 - 5.50
 Method:- Bromocresol Green

SERUM GLOBULIN 2.64 gm/dl 2.20 - 3.50
 Method:- CALCULATION

A/G RATIO 1.59 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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CLINICAL PATHOLOGY

URINE SUGAR (FASTING)
Collected Sample Received

Nil

Nil



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TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
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THYROID-TRIiodothyronine T3

Method:- ECLIA

1.10 ng/mL

0.70 - 2.04

NOTE: In pregnancy total T3,T4 increase to 1.5 times the normal range.

Reference Range (T3): Premature Infants 26-30 Weeks ,3-4 days	0.24 - 1.32 ng/ml
Full-Term Infants 1-3 days	0.89 - 4.05 ng/ml
1 Week	0.91 - 3.00 ng/ml
1- 11 Months	0.85 - 2.50 ng/ml
Prepubertal Children	1.19 - 2.18 ng/ml

Reference Ranges (T4): Premature Infants 26-30 weeks ,3-4 days	2.60 - 14.0 ug/dl
Full -Term Infants 1-3 days	8.20 - 19.9 ug/dl
1 weeks 6.00 - 15.9 ug/dl 1-11 Months	6.10 - 14.9 ug/dl
Prepubertal children 12 months-2yrs	6.80 - 13.5 ug/dl
Prepubertal children 3-9 yrs	5.50 - 12.8 ug/dl

Reference Ranges (TSH): Premature Infants 26-32 weeks ,3-4 Days	0.80 - 6.9 uIU/ml
Full Term Infants 4 Days	1.36 - 16 uIU/ml

1 - 11 Months:0.90 - 7.70 | Prepubertal children:0.60 - 5.50.Primary malfunction of the thyroid gland may result in hyper or low release of T3 or T4 In additional as TSH directly affect thyroid function malfunction of the pituitary or the hypothalamus influences the thyroid gland activity. Disease in any portion of the thyroid pituitary hypothalamus system may influence the level of T3 and T4 in the blood in Primary hypo thyroidism TSH levels are significantly elevated while in secondary and tertiary hypothyroidism TSH levels may be low

THYROID THYROXINE (T4)

Method:- ECLIA

12.5 ug/dl

5.10 - 14.10

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. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with * TSH level.2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test-Delayed response seen in patients with Tertiary hypothyroidism 7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & *serum TSH levels8.Normal T4 levels accompanied by * T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis9.Normal or * T3 & * T4 10.Normal T3 & T4 along with * TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & * T4 along with * TSH is seen in Hypothyroidism .12.Normal T3 & T4 levels with * TSH indicate Mild / Subclinical Hypoth

DURING 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.

REMARK-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. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.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.

TSH	1.659	μIU/mL	0.350 - 5.500
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Method:- ECLIA

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

Technologist
MGR
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P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
- +91 141 4824885 ● maxcarediagnostics1@gmail.com



NAME :- Mr. MUKESH BAGORIYA

Patient ID :-12234743

Date :- 29/02/2024

10:10:19

Age :- 39 Yrs 2 Mon 30 Days

Ref. By Doctor:-BANK OF BARODA

Sex :- Male

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 29/02/2024 16:49:05

IMMUNOASSAY

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
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DR.TANU RUNGTA
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NAME :- Mr. MUKESH BAGORIYA	Patient ID :-12234743	Date :- 29/02/2024	10:10:19
Age :- 39 Yrs 2 Mon 30 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

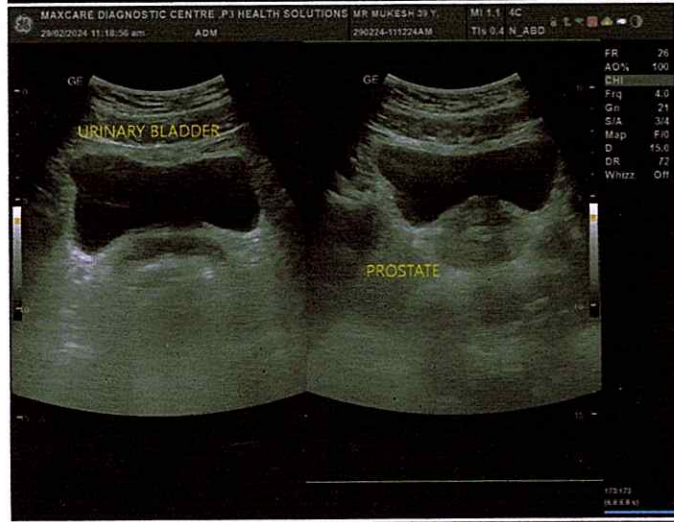
Final Authentication : 29/02/2024 16:49:05

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
<u>PHYSICAL EXAMINATION</u>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION(PH)	5.0		5.0 - 7.5
SPECIFIC GRAVITY	1.025		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<u>MICROSCOPY EXAMINATION</u>			
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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DR. TANU RUNGTA
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MR. MUKESH BAGORIYA	39 Y/M
Registration Date: 29/02/2024	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (12.4 cm) **with increased echotexture**. No focal space occupying lesion is seen within liver parenchyma. Intrahepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is well distended. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. 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 mildly enlarged in size (13.3 cm), however, normal in shape. 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. 11.1 x 4.8 cm.

Left kidney is measuring approx. 11.8 x 5.1 cm.

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

Prostate is normal in size with normal echotexture and outline.

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

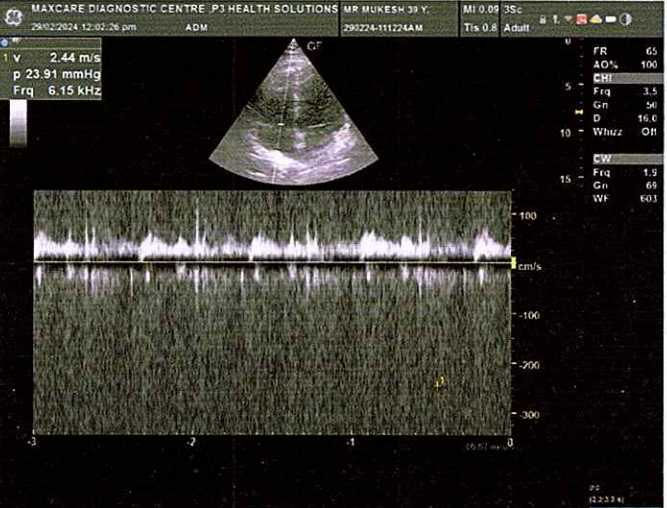
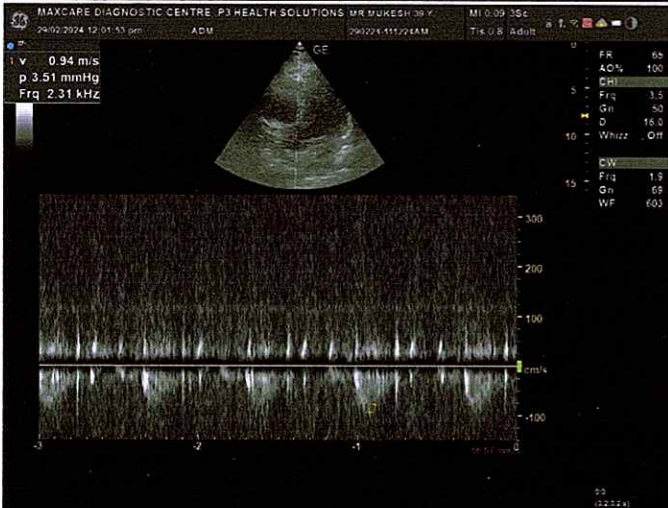
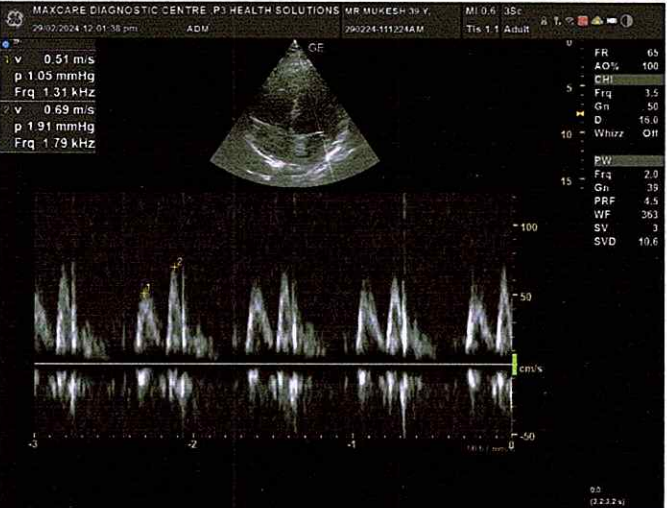
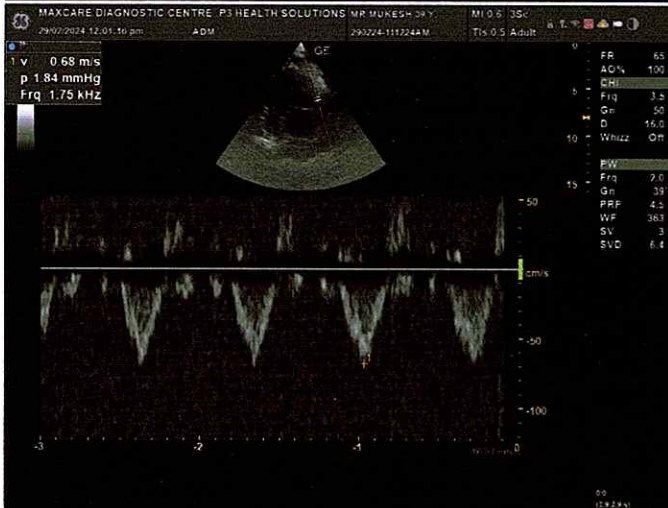
No significant free fluid is seen in pelvis.

IMPRESSION:

- Mild splenomegaly.
- Grade I fatty liver.

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

Dr. SHALINI GOEL
MBBS, DNB (Radiologist)
RMC No. 21954
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P3 HEALTH SOLUTIONS LLP

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MR. MUKESH BAGORIYA	39 Y/M
Registration Date: 29/02/2024	Ref. by: BANK OF BARODA

2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:

FAIR TRANSTHORACIC ECHOCARDIOGRAPHIC WINDOW MORPHOLOGY:

MITRAL VALVE	NORMAL	TRICUSPID VALVE	NORMAL
AORTIC VALVE	NORMAL	PULMONARY VALVE	NORMAL

M.MODE EXAMINATION:

AO	3.5	Cm	LA	3.0	cm	IVS-D	1.1	cm
IVS-S	1.3	cm	LVID	4.9	cm	LVSD	3.6	cm
LVPW-D	1.0	cm	LVPW-S	1.3	cm	RV		cm
RVWT		cm	EDV		ml	LVVS		ml
LVEF	55-60%		RWMA			ABSENT		

CHAMBERS:

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM		NORMAL	

COLOUR DOPPLER:

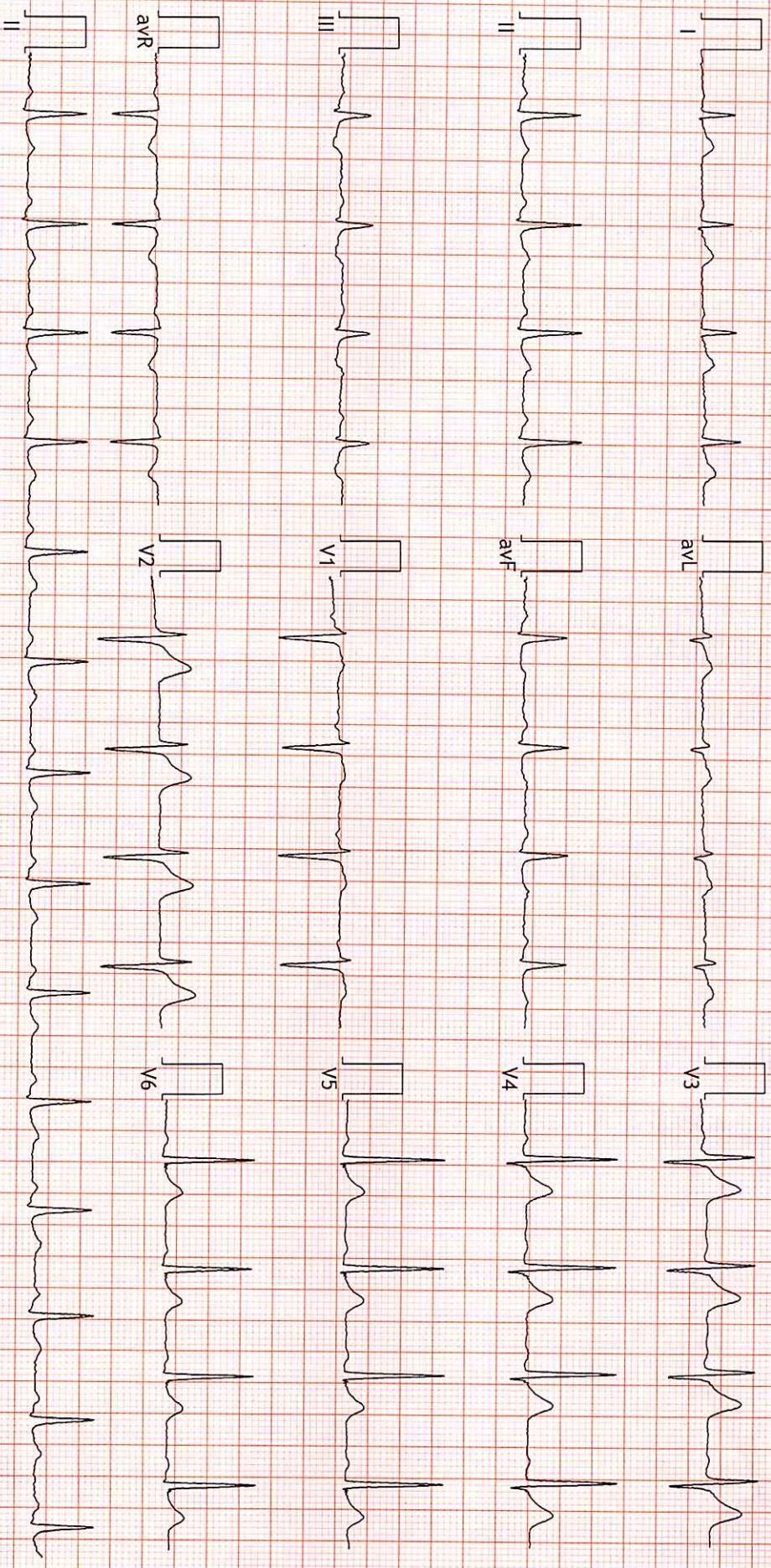
MITRAL VALVE					
E VELOCITY	0.51	m/sec	PEAK GRADIENT		Mm/hg
A VELOCITY	0.69	m/sec	MEAN GRADIENT		Mm/hg
MVA BY PHT		Cm2	MVA BY PLANIMETRY		Cm2
MITRAL REGURGITATION	ABSENT				
AORTIC VALVE					
PEAK VELOCITY	0.94	m/sec	PEAK GRADIENT		mm/hg
AR VMAX		m/sec	MEAN GRADIENT		mm/hg
AORTIC REGURGITATION	ABSENT				
TRICUSPID VALVE					
PEAK VELOCITY		m/sec	PEAK GRADIENT		mm/hg
MEAN VELOCITY		m/sec	MEAN GRADIENT		mm/hg
VMax VELOCITY					
TRICUSPID REGURGITATION	MILD				
PULMONARY VALVE					
PEAK VELOCITY	0.68	M/sec.	PEAK GRADIENT		Mm/hg
MEAN VELOCITY			MEAN GRADIENT		Mm/hg
PULMONARY REGURGITATION	ABSENT				

Impression—

- NORMAL LV SIZE & CONTRACTILITY.
- NO RWMA, LVEF 55-60%.
- MILD TR/ PAH (RVSP 23 MMHG+ RAP).
- GRADE I DIASTOLIC DYSFUNCTION.
- NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.

Dr. JYOTI AGARWAL
(Cardiologist)
M.D.B.S. / MDCC (Cardiologist)
RMC No.- 27255

Tams (P) Ltd
 #P3 HEALTH SOLUTIONS LLP B-14, Vidhyadhar nahar , Jaipur
 128541925460970/Mr Mukesh Bagoriya 39Yrs-11Months/Male Kgs/ Cms BP: ___ / ___ mmHg HR: 83 bpm
 Ref.: BANK OF BARODA Test Date: 29-Feb-2024(10:44:43) Notch: 50Hz 0.05Hz - 35Hz 10mm/mV 25mm/Sec
 PR Interval: 150 ms
 QRS Duration: 74 ms
 QT/QTc: 320/377ms
 P-QRS-T Axis: 61 - 56 - 9 (Deg)



FINDINGS: Normal Sinus Rhythm
 Vent Rate : 83 bpm; PR Interval : 150 ms; QRS Duration: 74 ms; QT/QTc-Int : 320/377 ms
 P-QRS-T axis: 61 • 56 • 9 • (Deg)
 Comments :



Dr. Naresh Kumar Mohanka
 RMC No. 35703
 MBBS, DIP. CARDIO (ESCORTS)
 DEM (RCGP/UK)