भारत सरकार
Government of India

आधार

नेहा राव
Neha Rao
जन्म तिथि / DOB : 21/11/1994
महिला / Female

Issue Date : 08/01/2013

2568 3479 3938

मेरा आधार, मेरी पहचान

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

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

AADHAAR

पता: द्वारा: पंकज कुमार सिंह, ई 215
जगदम्बा नगर रावन गेट, कलवार मार्ग,
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Print Date : 08/03/2023

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General Physical Examination

Date of Examination: 10/09/24

Name: NEHA RAO Age: 29 YRS DOB: 21/11/1994 Sex: Female

Referred By: BANK OF BARODA

Photo ID: AADHAR CARD ID #: 3333

Ht: 164 (cm) Wt: 56 (Kg)

Chest (Expiration): 85 (cm) Abdomen Circumference: 79 (cm)

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

BMI 20.8

Eye Examination: with glass
RE - GIG, NIG, NCB
LE - GIG, NIG, NCB

Other: No

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

Signature Of Examine : ---------- Name of Examinee: NEHA RAO

Dr. PIYUSH GOYAL
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Signature Medical Examiner : ---------- Name Medical Examiner -- DR. PIYUSH GOYAL

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Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

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HAEMOGARAM

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 FEMAL			
HAEMOGLOBIN (Hb)	**11.1** L	g/dL	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	6.70	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	70.0	%	40.0 - 80.0
LYMPHOCYTE	22.0	%	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)	4.65	x10^6/uL	3.80 - 4.80
HEMATOCRIT (HCT)	**35.90** L	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	**77.0** L	fL	83.0 - 101.0
MEAN CORP HB (MCH)	**23.9** L	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	**31.1** L	g/dL	31.5 - 34.5
PLATELET COUNT	295	x10^3/uL	150 - 410
RDW-CV	14.0	%	11.6 - 14.0

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)	12	mm in 1st hr	00 - 20

Methord:- 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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(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) Methord:- GOD POD	79.3	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) Methord:- GOD PAP	81.6	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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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
GLYCOSYLATED HEMOGLOBIN (HbA1C)			
Methord:- CAPILLARY with EDTA	4.9	%	Non-diabetic: < 5.7 Pre-diabetics: 5.7-6.4 Diabetics: = 6.5 or higher ADA Target: 7.0 Action suggested: > 6.5
MEAN PLASMA GLUCOSE	99	mg/dL	68 - 125
Methord:- Calculated Parameter			

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 Methord:- Haemagglutination reaction	"O" POSITIVE

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Methord:- CHOD-PAP methodology	133.00	mg/dl	Desirable <200 Borderline 200-239 High> 240
InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.			
TRIGLYCERIDES Methord:- GPO-PAP	78.20	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 Methord:- Direct clearance Method	43.50	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 Methord:- Calculated Method	76.47	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Methord:- Calculated	15.64	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Methord:- Calculated	3.06		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Methord:- Calculated	1.76		0.00 - 3.50
TOTAL LIPID Methord:- CALCULATED	**397.55** L	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 fromperipheral tissues

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LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Methord:- DMSO/Diazo	0.61	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Methord:- DMSO/Diazo	0.21	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Methord:- Calculated	0.40	mg/dl	0.30-0.70
SGOT Methord:- IFCC	19.9	U/L	0.0 - 40.0
SGPT Methord:- IFCC	22.5	U/L	0.0 - 35.0
SERUM ALKALINE PHOSPHATASE Methord:- DGKC - SCE	122.00	U/L	64.00 - 306.00

InstrumentName:MISPA PLUS **Interpretation**:Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobilary 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 Methord:- Szasz methodology Instrument Name Randox Rx Imola	23.50	U/L	5.00 - 32.00

Interpretation: Elevations in GGT levels areseen 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.

SERUM TOTAL PROTEIN Methord:- Direct Biuret Reagent	6.94	g/dl	6.00 - 8.40
SERUM ALBUMIN Methord:- Bromocresol Green	3.98	g/dl	3.50 - 5.50
SERUM GLOBULIN Methord:- CALCULATION	2.96	gm/dl	2.20 - 3.50
A/G RATIO	1.34		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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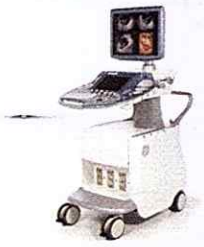

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA Methord:- Urease/GLDH	21.30	mg/dl	10.00 - 50.00

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

SERUM CREATININE Methord:- Jaffe's Method	0.99	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	4.51	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 Methord:- ISE	139.8	mmol/L	135.0 - 150.0
POTASSIUM Methord:- ISE	4.74	mmol/L	3.50 - 5.50
CHLORIDE Methord:- ISE	101.7	mmol/L	94.0 - 110.0
SERUM CALCIUM Methord:- Arsenazo III Method	9.91	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 Methord:- Direct Biuret Reagent	6.94	g/dl	6.00 - 8.40
SERUM ALBUMIN Methord:- Bromocresol Green	3.98	g/dl	3.50 - 5.50
SERUM GLOBULIN Methord:- CALCULATION	2.96	gm/dl	2.20 - 3.50
A/G RATIO	1.34		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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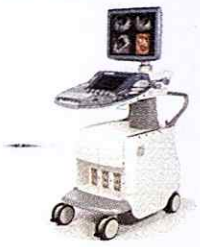

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BIOCHEMISTRY

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-hourcollections 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 bloodincreases. 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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TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
THYROID-TRIIODOTHYRONINE T3 Methord:- ECLIA	1.12	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 ulU/ml
Full Term Infants 4 Days	1.36 - 16 ulU/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 hypothyrodism TSH levels may be low

THYROID - THYROXINE (T4) Methord:- ECLIA	9.50	ug/dl	5.10 - 14.10

NOTE-TSH levels are subject to circardian 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,simoultaneous measurement of TSH with free T4 is useful in evaluating differantial 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 & 'T 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 ulU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 ulU/mL 2nd Trimester : 0.20-3.00 ulU/mL 3rd Trimester : 0.30-3.00 ulU/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 Methord:- ECLIA	1.468	µIU/mL	0.350 - 5.500

Technologist
MGR

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

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 :- Mrs. NEHA RAO		Patient ID :-12234598	Date :- 10/02/2024 10:18:20
Age :-	29 Yrs 2 Mon 22 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Female	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 10/02/2024 18:05:42

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 circardian 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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NAME :- Mrs. NEHA RAO	Patient ID :-12234598	Date :- 10/02/2024	10:18:20
Age :- 29 Yrs 2 Mon 22 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 10/02/2024 18:05:42

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION(PH)	5.0		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
MICROSCOPY EXAMINATION			
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		

Technologist
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MRS. NEHA RAO	Age : 29 Y/F
Registration Date: 10/02/2024	Ref. by: BANK OF BARODA

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

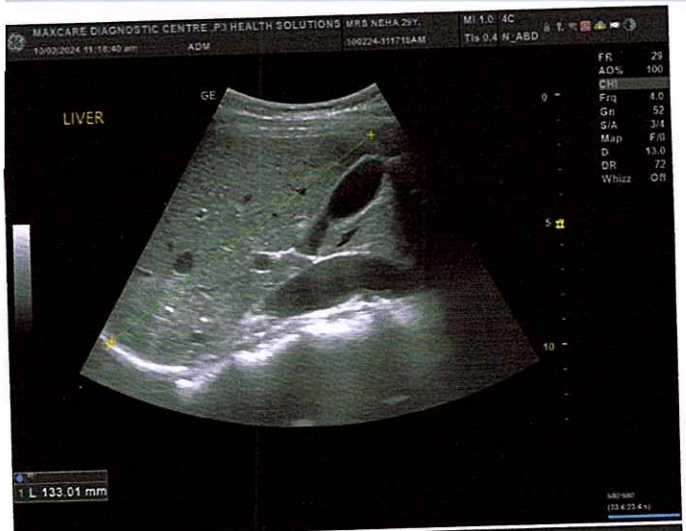
Cardiothoracic ratio is normal.

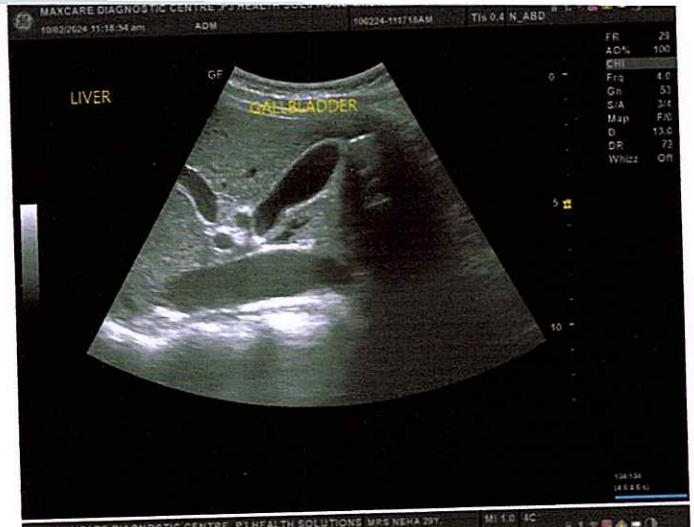
Thoracic soft tissue and skeletal system appear unremarkable.

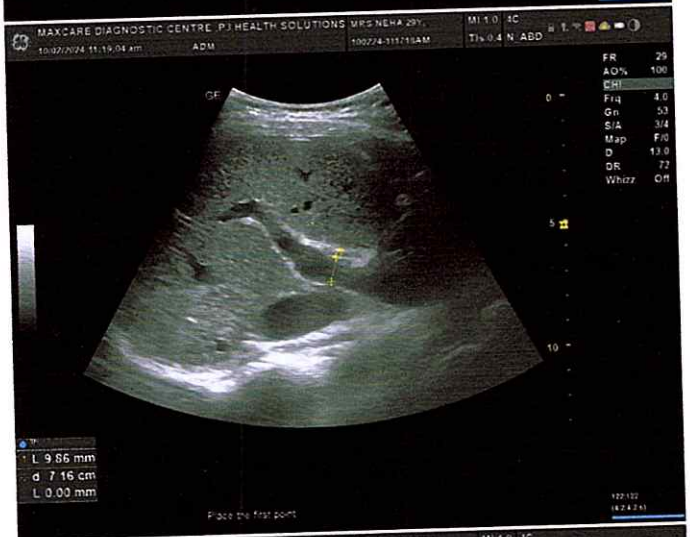
Soft tissue shadows appear normal.

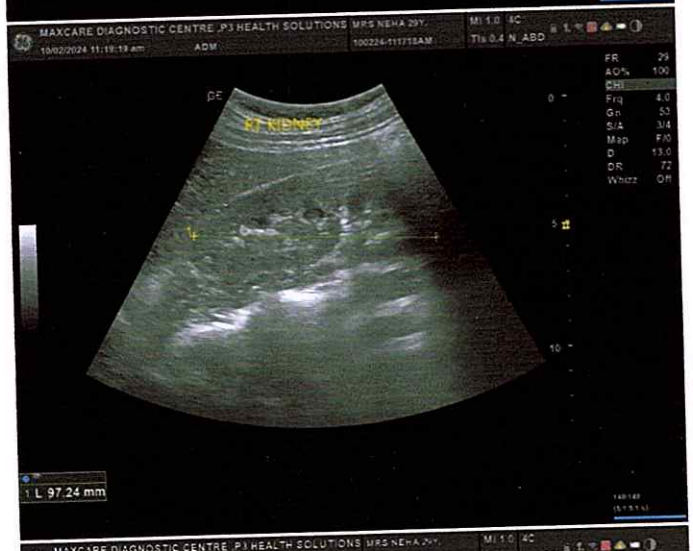
IMPRESSION: No significant abnormality is detected

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


MAXCARE DIAGNOSTIC CENTRE ,P3 HEALTH SOLUTIONS
LIVER
1 L 133.01 mm


MAXCARE DIAGNOSTIC CENTRE ,P3 HEALTH SOLUTIONS
LIVER
GALL BLADDER


MAXCARE DIAGNOSTIC CENTRE ,P3 HEALTH SOLUTIONS
L 9.86 mm
d 7.16 cm
L 0.00 mm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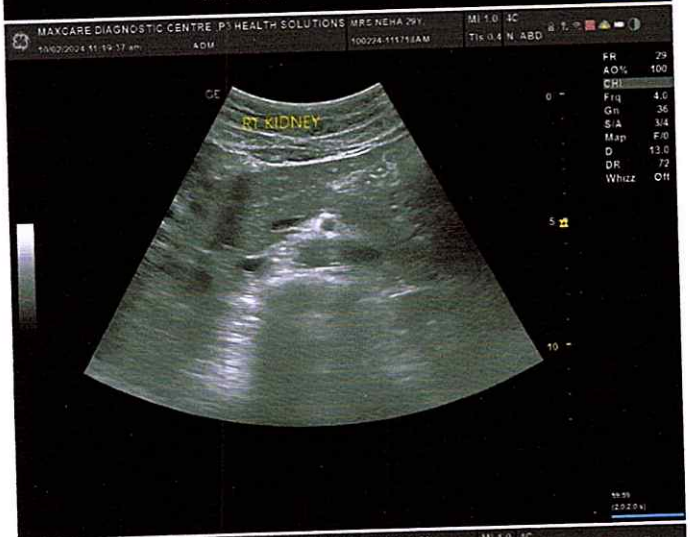
RT KIDNEY
1 L 97.24 mm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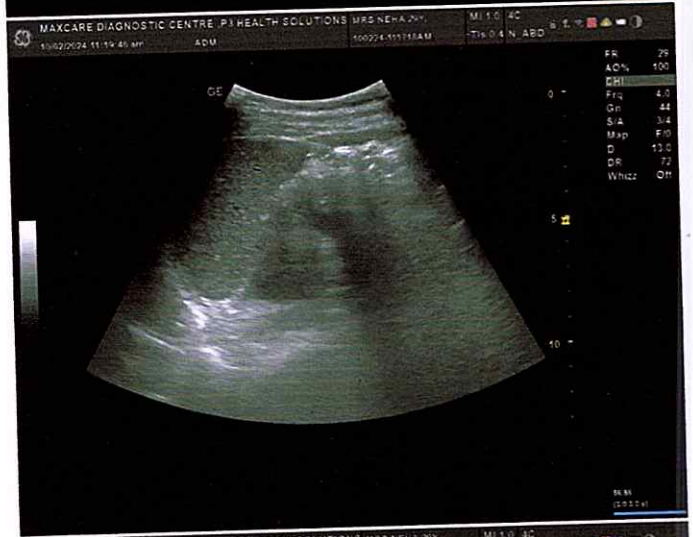
RT KIDNEY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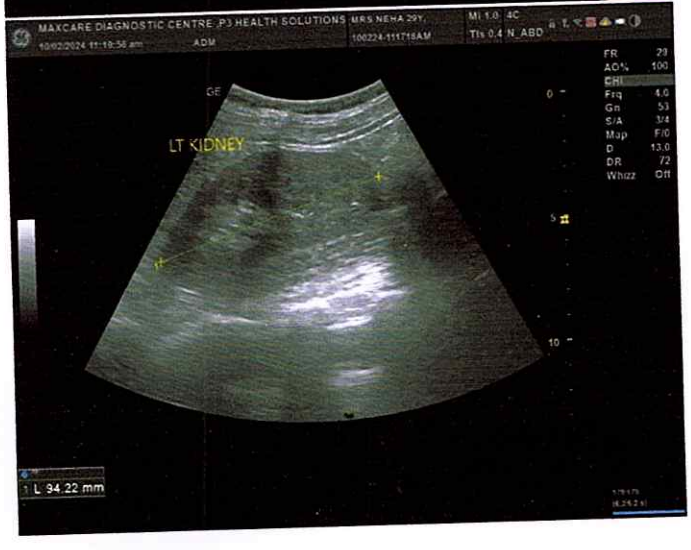
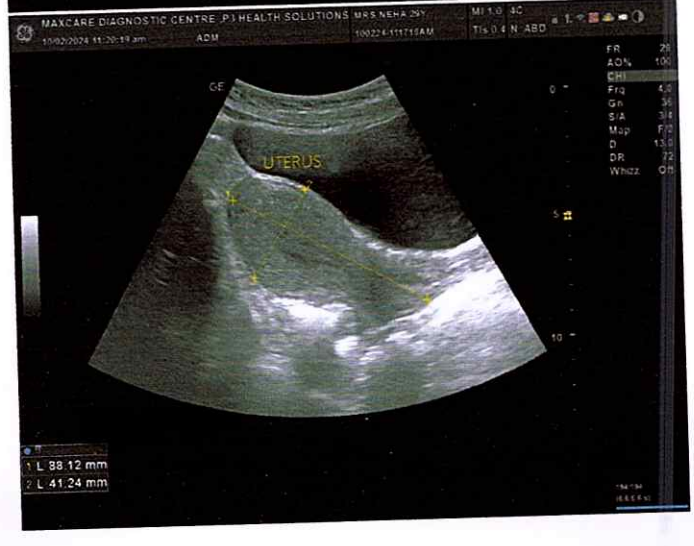
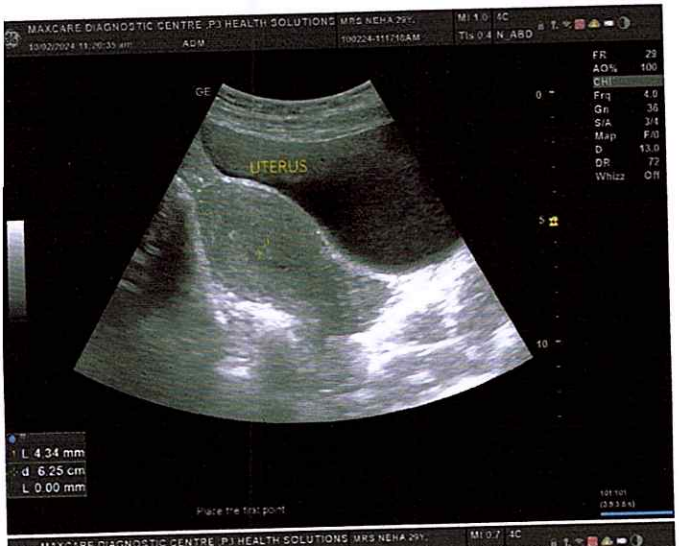
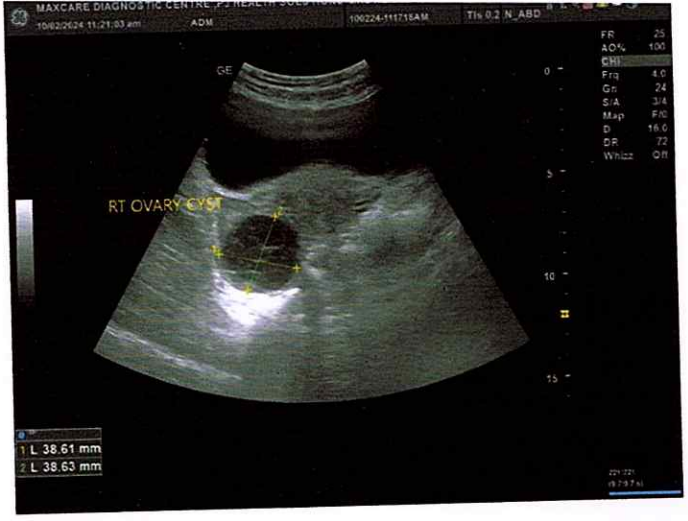
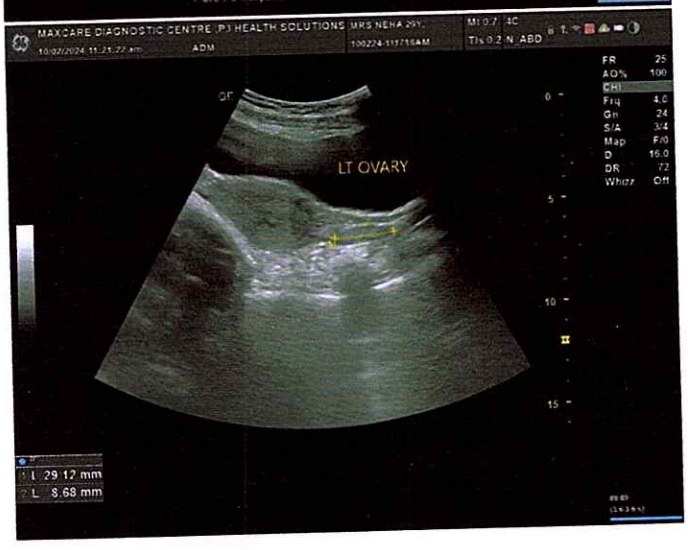

MAXCARE DIAGNOSTIC CENTRE ,P3 HEALTH SOLUTIONS
LT KIDNEY
1 L 94.22 mm


MAXCARE DIAGNOSTIC CENTRE ,P3 HEALTH SOLUTIONS
UTERUS
1 L 88.12 mm
2 L 41.24 mm


MAXCARE DIAGNOSTIC CENTRE (P) HEALTH SOLUTIONS
MRS NEHA 29Y,
ADM
GE
UTERUS
L 4.34 mm
d 6.25 cm
L 0.00 mm


MAXCARE DIAGNOSTIC CENTRE (P) HEALTH SOLUTIONS
ADM
GE
RT OVARY CYST
1 L 38.61 mm
2 L 38.63 mm


MAXCARE DIAGNOSTIC CENTRE (P) HEALTH SOLUTIONS
MRS NEHA 29Y,
ADM
GE
LT OVARY
1 L 29.12 mm
2 L 8.68 mm

P3 HEALTH SOLUTIONS LLP
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MRS. NEHA RAO	**Age : 29 Y/F**
Registration Date: 10/02/2024	**Ref. by: BANK OF BARODA**

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (133 mm). Echo-texture is normal. 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 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 of normal size and 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. No focal lesion is seen. Collecting system does not show any dilatation or calculus.
Right kidney is measuring approx. 97 mm.
Left kidney is measuring approx. 94 mm.

Urinary bladder does not show any calculus or mass lesion.

Uterus is anteverted and normal in size (measuring approx. 88 x 41 mm).
Myometrium shows normal echo -pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 4.3 mm.

Both ovaries are visualized. **A small, well-defined, thick-walled, avascular, cystic lesion of size 38 x 38 mm is noted in right ovary with thin internal septations giving fishnet appearance.** Left ovary appears normal.

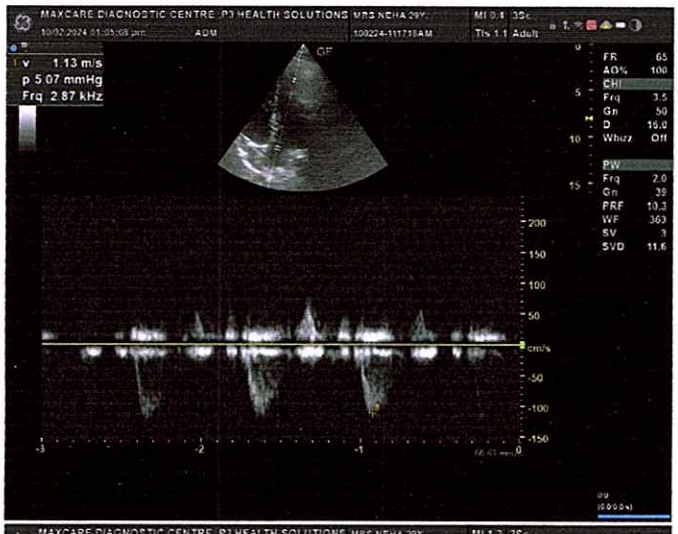
No enlarged nodes are visualized. No retro-peritoneal lesion is identified.
No significant free fluid is seen in pouch of Douglas.

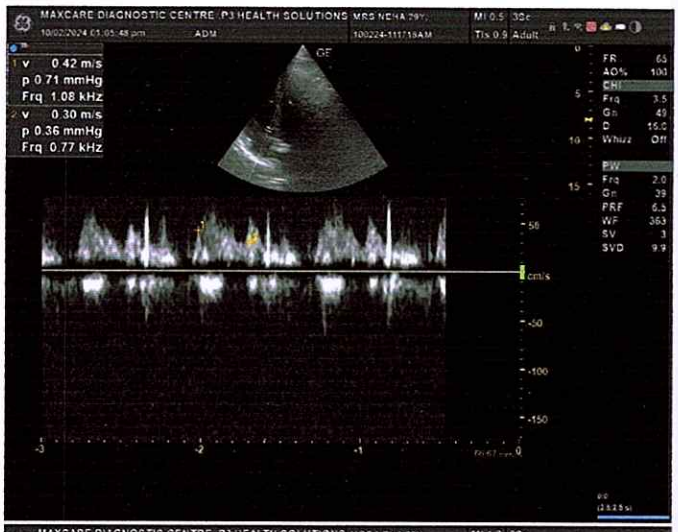
IMPRESSION:

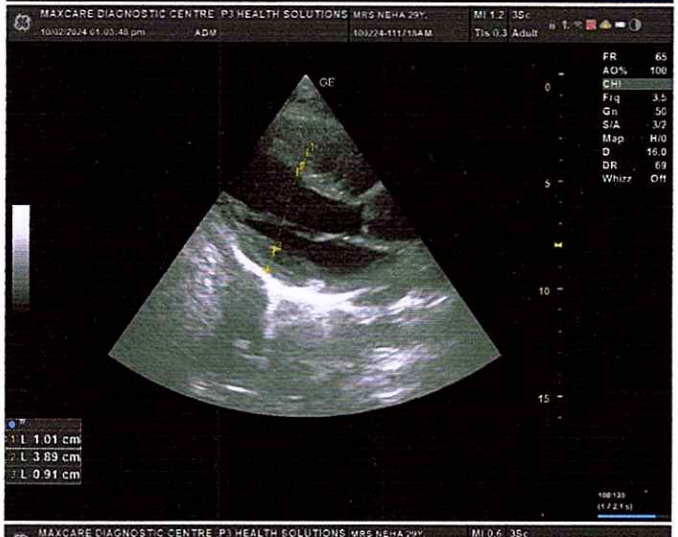
- **Right ovarian hemorrhagic cyst.**
- **No free fluid or lymphadenopathy.**

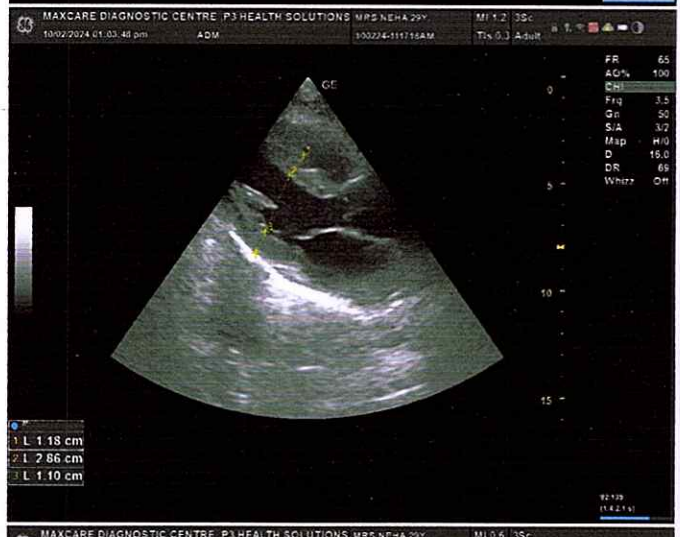
Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437

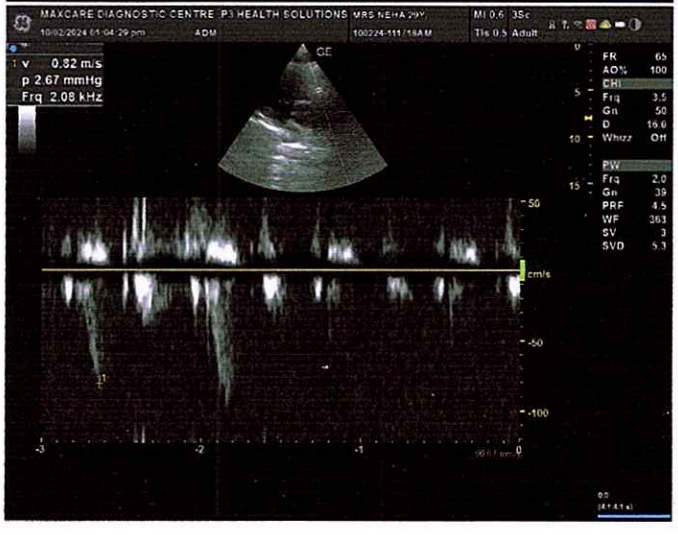
Dr. MUKESH SHARMA
M.B.B.S., M.D.(Radiodiagnosis)
RMC No. : 43418/17437
P3 Health Solutions LLP

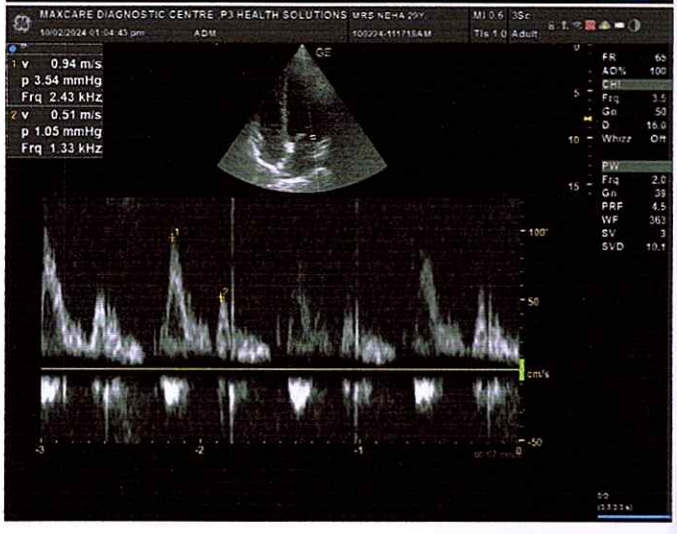

MAXCARE DIAGNOSTIC CENTRE P3 HEALTH SOLUTIONS
1 v 1.13 m/s
p 5.07 mmHg
Frq 2.87 kHz
cm/s


MAXCARE DIAGNOSTIC CENTRE P3 HEALTH SOLUTIONS
1 v 0.42 m/s
p 0.71 mmHg
Frq 1.08 kHz
2 v 0.30 m/s
p 0.36 mmHg
Frq 0.77 kHz
cm/s


MAXCARE DIAGNOSTIC CENTRE P3 HEALTH SOLUTIONS
1 L 1.01 cm
2 L 3.89 cm
3 L 0.91 cm


MAXCARE DIAGNOSTIC CENTRE P3 HEALTH SOLUTIONS
1 L 1.18 cm
2 L 2.86 cm
3 L 1.10 cm


MAXCARE DIAGNOSTIC CENTRE P3 HEALTH SOLUTIONS
1 v 0.82 m/s
p 2.67 mmHg
Frq 2.08 kHz
cm/s


MAXCARE DIAGNOSTIC CENTRE P3 HEALTH SOLUTIONS
1 v 0.94 m/s
p 3.54 mmHg
Frq 2.43 kHz
2 v 0.51 m/s
p 1.05 mmHg
Frq 1.33 kHz
cm/s

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MRS. NEHA RAO	Age : 29 Y/F
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2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:

FAIR TRANSTHORACIC ECHOCARIDIOGRAPHIC WINDOW MORPHOLOGY:

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

M.MODE EXAMITATION:

AO	3.2	Cm	LA	2.8	cm	IVS-D	1.0	cm
IVS-S	1.2	cm	LVID	3.9	cm	2.8	3.4	cm
LVPW-D	0.9	cm	LVPW-S	1.1	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	0.94	m/sec	PEAK GRADIENT		Mm/hg
A VELOCITY	0.51	m/sec	MEAN GRADIENT		Mm/hg
MVA BY PHT		Cm2	MVA BY PLANIMETRY		Cm2
MITRAL REGURGITATION			ABSENT		

AORTIC VALVE					
PEAK VELOCITY	1.13	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			ABSENT		

PULMONARY VALVE					
PEAK VELOCITY	0.82	M/sec.	PEAK GRADIENT		Mm/hg
MEAN VALOCITY			MEAN GRADIENT		Mm/hg
PULMONARY REGURGITATION			ABSENT		

Impression—

- **NORMAL LV SIZE & CONTRACTILITY.**
- **NO RWMA, LVEF 55-60%.**
- **ALL CARDIAC VALVES ARE NORMAL.**
- **NORMAL DIASTOLIC FUNCTION.**
- **NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.**

Dr. JYOTI AGARWAL
M.B.B.S., PGDCC (Cardiologist)
(Cardiologist) RMC No. 27255