

Dr. Goyal's

Path Lab & Imaging Centre

B-51, Ganesh Nagar, Near Metro Piller No. 109-110, New Sanganer Road,
Sodala, Jaipur-302019

Tele : 0141-2293346, 4049787, 9887049787

General Physical Examination

Website: www.drgoyalspathlab.com | E-mail: drgoyalpiyush@gmail.com

Date of Examination: 16.03.2024

Name: NIRJOSH Age: 32 Sex: Male

DOB: 12-09-1991

Referred By: BOB (Medisheel)

Photo ID: DIL ID #: _____ P _____

Ht: 172 (cm) Wt: 101 (Kg)

Chest (Expiration): 115 (cm) Abdomen Circumference: 105 (cm)

Blood Pressure: 125/74 mm Hg PR: 89 / min

BMI 34.1

Eye Examination: vision Normal G/G, N/G B/L eyes.

Normal Color vision

Other: Not significant

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

Signature Of Examinee : _____ Name of Examinee: _____

Signature Medical Examiner: Dr Piyush Goyal
M.B.B.S. D.M.R.L.
Reg. No - 017003 Name Medical Examiner _____



Jash Goyal
M.B.S., D.M.R.D.
RMS Reg. No.-017903

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B-51, Ganesh Nagar, Near Metro Pillar No. 109-110, New Sanganer Road, Jaipur
Tele : 0141-2293346, 4049787, 9887049787
Website : www.drgoyalspathlab.com E-mail : drgoyalpiyush@gmail.com



Date :- 16/03/2024 12:02:30
NAME :- Mr. NIRDOSH
Sex / Age :- Male 32 Yrs 6 Mon 5 Days
Company :- MediWheel

Patient ID :- 12236378
Ref. By Doctor:-BOB
Lab/Hosp :-

Final Authentication : 16/03/2024 17:13:56

BOB PACKAGE BELOW 40MALE

X RAY CHEST PA VIEW:

Both lung fields appears clear.
Bronchovascular markings appear normal.
Trachea is in midline.
Both the hilar shadows are normal.
Both the C.P.angles is clear.
Both the domes of diaphragm are normally placed.
Bony cage and soft tissue shadows are normal.
Heart shadows appear normal.

Impression :- Normal Study

(Please correlate clinically and with relevant further investigations)

Dr. NAVNEET AGARWAL (MD, DNB RADIO-DIAGNOSIS, MNAMS)
EX-SR NEURO-RADIOLOGY AIIMS NEW DELHI
(RMC No. 33613 / 14911)

*** End of Report ***

Page No: 1 of 1

Dr. Piyush Goyal
(D.M.R.D.) BILAL

Transcript by,

Dr. Piyush Goyal
M.B.B.S., D.M.R.D.
RMC Reg No. 017996

Dr. Ashish 
MBBS, MD (Radio-Diagnosis)
Fetal Medicine Consultant
FMF ID - 260517 | RMC No 22430

Dr. Abhishek Jain
MBBS, DNB, (Radio-Diagnosis)
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RMC No. 33613/14911

Dr. Poorvi Malik
MBBS, MD, DNB (Radio Diagnosis)
RMC No. 21505



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Sex / Age :- Male 32 Yrs 6 Mon 5 Days

Lab/Hosp :-

Company :- MediWheel

Sample Type :- EDTA

Sample Collected Time 16/03/2024 12:06:37

Final Authentication : 16/03/2024 14:11:38

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
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BOB PACKAGE BELOW 40MALE

GLYCOSYLATED HEMOGLOBIN (HbA1C)

6.2 H %

Non-diabetic: < 5.7
Pre-diabetics: 5.7-6.4
Diabetics: = 6.5 or higher
ADA Target: 7.0
Action suggested: > 6.5

Method:- HPLC

Instrument name: ARKRAY's ADAMS Lite HA 8380V, JAPAN.

Test Interpretation:

HbA1C is formed by the condensation of glucose with n-terminal valine residue of each beta chain of HbA to form an unstable Schiff base. It is the major fraction, constituting approximately 80% of HbA1c. Formation of glycosylated hemoglobin (GHb) is essentially irreversible and the concentration in the blood depends on both the lifespan of the red blood cells (RBC) (120 days) and the blood glucose concentration. The GHb concentration represents the integrated values for glucose over the period of 6 to 8 weeks. GHb values are free of day to day glucose fluctuations and are unaffected by recent exercise or food ingestion. Concentration of plasma glucose concentration in GHb depends on the time interval, with more recent values providing a larger contribution than earlier values. The interpretation of GHb depends on RBC having a normal life span. Patients with hemolytic disease or other conditions with shortened RBC survival exhibit a substantial reduction of GHb. High GHb have been reported in iron deficiency anemia. GHb has been firmly established as an index of long term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. The absolute risk of retinopathy and nephropathy are directly proportional to the mean of HbA1C. Genetic variants (e.g. HbS trait, HbC trait), elevated HbF and chemically modified derivatives of hemoglobin can affect the accuracy of HbA1c measurements. The effects vary depending on the specific Hb variant or derivative and the specific HbA1c method.

Ref by ADA 2020

MEAN PLASMA GLUCOSE

131 H mg/dL

Non Diabetic < 100 mg/dL
Prediabetic 100- 125 mg/dL
Diabetic 126 mg/dL or Higher

Method:- Calculated Parameter

AJAYSINGH
Technologist

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RMC No. 17975/008828

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
HAEMOGARAM			
HAEMOGLOBIN (Hb)	13.9	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	6.93	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	65.5	%	40.0 - 80.0
LYMPHOCYTE	30.3	%	20.0 - 40.0
EOSINOPHIL	1.2	%	1.0 - 6.0
MONOCYTE	2.6	%	2.0 - 10.0
BASOPHIL	0.4	%	0.0 - 2.0
NEUT#	4.54	10 ³ /uL	1.50 - 7.00
LYMPH#	2.10	10 ³ /uL	1.00 - 3.70
EO#	0.08	10 ³ /uL	0.00 - 0.40
MONO#	0.18	10 ³ /uL	0.00 - 0.70
BASO#	0.03	10 ³ /uL	0.00 - 0.10
TOTAL RED BLOOD CELL COUNT (RBC)	5.21	x10 ⁶ /uL	4.50 - 5.50
HEMATOCRIT (HCT)	45.10	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	86.5	fL	83.0 - 101.0
MEAN CORP HB (MCH)	26.7 L	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	30.9 L	g/dL	31.5 - 34.5
PLATELET COUNT	227	x10 ³ /uL	150 - 410
RDW-CV	14.4 H	%	11.6 - 14.0
MENTZER INDEX	16.60		

The Mentzer index is used to differentiate iron deficiency anemia from beta thalassemia trait. If a CBC indicates microcytic anemia, these are two of the most likely causes, making it necessary to distinguish between them.
If the quotient of the mean corpuscular volume divided by the red blood cell count is less than 13, thalassemia is more likely. If the result is greater than 13, then iron-deficiency anemia is more likely.

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
Erythrocyte Sedimentation Rate (ESR)	54 H	mm/hr.	00 - 13

(ESR) Methodology : Measurement of ESR by cells aggregation.

Instrument Name : Independent form Hematocrit value by Automated Analyzer (Roller-20)

Interpretation : ESR test is a non-specific indicator of inflammatory disease and abnormal protein states.

The test is used to detect, follow course of a certain disease (e.g-tuberculosis, rheumatic fever, myocardial infarction

Levels are higher in pregnancy due to hyperfibrinogenaemia.

The "3-figure ESR " >100 value nearly always indicates serious disease such as a serious infection, malignant paraproteinaemia (CBC); Methodology : TLC, DLC Fluorescent Flow cytometry, HB SLS method, TRBC, PCV, PLT Hydrodynamically focused Impedance and MCH, MCV, MCHC, MENTZER INDEX. are calculated. Instrument Name: Sysmex 6 part fully automatic analyzer XN-L, Japan

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Method:- Enzymatic Endpoint Method	191.67	mg/dl	Desirable <200 Borderline 200-239 High > 240
TRIGLYCERIDES Method:- GPO-PAP	246.68 H	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
DIRECT HDL CHOLESTEROL Method:- Direct clearance Method	30.99	mg/dl	Low < 40 High > 60
DIRECT LDL CHOLESTEROL Method:- Direct clearance Method	119.57	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Method:- Calculated	49.34	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method:- Calculated	6.18 H		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Method:- Calculated	3.86 H		0.00 - 3.50
TOTAL LIPID Method:- CALCULATED	699.21	mg/dl	400.00 - 1000.00
<small>TOTAL CHOLESTEROL InstrumentName:Randox Rx Imola Interpretation: Cholesterol measurements are used in the diagnosis and treatment of lipid lipoprotein metabolism disorders.</small>			
<small>TRIGLYCERIDES 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.</small>			
<small>DIRECT HDL CHOLESTEROL InstrumentName:Randox Rx Imola 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.</small>			
<small>DIRECT LDL CHOLESTEROL InstrumentName:Randox Rx Imola Interpretation: Accurate measurement of LDL-Cholesterol is of vital importance in therapies which focus on lipid reduction to prevent atherosclerosis or reduce its progress and to avoid plaque rupture.</small>			
<small>TOTAL LIPID AND VLDL ARE CALCULATED</small>			

SURENDRAXHANGA

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIVER PROFILE WITH GGT			
SERUM BILIRUBIN (TOTAL) Method:- Colorimetric method	0.53	mg/dl	Up to - 1.0 Cord blood <2 Premature < 6 days <16 Full-term < 6 days= 12 1month - <12 months <2 1-19 years <1.5 Adult - Up to - 1.2 Ref-(ACCP 2020)
SERUM BILIRUBIN (DIRECT) Method:- Colorimetric Method	0.15	mg/dL	Adult - Up to 0.25 Newborn - <0.6 >- 1 month - <0.2
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.38	mg/dl	0.30-0.70
SGOT Method:- IFCC	37.7 H	U/L	Men- Up to - 37.0 Women - Up to - 31.0
SGPT Method:- IFCC	62.7 H	U/L	Men- Up to - 40.0 Women - Up to - 31.0
SERUM ALKALINE PHOSPHATASE Method:- AMP Buffer	82.40	IU/L	30.00 - 120.00
SERUM GAMMA GT Method:- IFCC	81.50 H	U/L	11.00 - 50.00
SERUM TOTAL PROTEIN Method:- Biuret Reagent	7.62	g/dl	6.40 - 8.30
SERUM ALBUMIN Method:- Bromocresol Green	4.46	g/dl	3.80 - 5.00
SERUM GLOBULIN Method:- CALCULATION	3.16	gm/dl	2.20 - 3.50
A/G RATIO	1.41		1.30 - 2.50

Total Bilirubin Methodology: Colorimetric method InstrumentName:Random Rx Inida Interpretation: An increase in bilirubin concentration in the serum occurs in toxic or infectious diseases of the liver e.g. hepatitis B or obstruction of the bile duct and in these incompatible babies. High levels of unconjugated bilirubin indicate that too much haemoglobin is being destroyed or that the liver is not actively treating the haemoglobin it is receiving.

AST Aspartate Aminotransferase Methodology: IFCC InstrumentName:Random Rx Inida Interpretation: Elevated levels of AST can signal myocardial infarction, hepatic disease, muscular dystrophy and organ damage. Although heart muscle is found to have the most activity of the enzyme, significant activity has also been seen in the brain, liver, gastric mucosa, adipose tissue and kidneys of humans.

ALT Alanine Aminotransferase Methodology: IFCC InstrumentName:Random Rx Inida Interpretation: The enzyme ALT has been found to be in highest concentrations in the liver, with decreasing concentrations found in kidney, heart, skeletal muscle, pancreas, spleen and lung tissue respectively. Elevated levels of the transaminase can indicate myocardial infarction, hepatic disease, muscular dystrophy and organ damage.

Alkaline Phosphatase Methodology: AMP Buffer InstrumentName:Random Rx Inida Interpretation: Measurements of alkaline phosphatase are of use in the diagnosis, treatment and investigation of hepatobiliary disease and in bone disease associated with increased osteoblastic activity. Alkaline phosphatase is also used in the diagnosis of parathyroid and renal disease.

TOTAL PROTEIN Methodology: Biuret Reagent InstrumentName:Random Rx Inida Interpretation: Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone masses as well as other metabolic or nutritional disorders.

ALBUMIN (ALB) Methodology: Bromocresol Green InstrumentName:Random Rx Inida Interpretation: Albumin measurements are used in the diagnosis and treatment of numerous diseases involving primarily the liver or kidneys. Globulin & A/G ratio is calculated.

Instrument Name: Random Rx Inida Interpretation: Elevations in GGT levels are more and more pronounced than those with other liver enzymes in cases of obstructive jaundice and alcoholic consumption. 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)

SURENDRAKHANGA

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Sample Collected Time 16/03/2024 12:06:37

Final Authentication : 15/03/2024 13:07:37

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
TOTAL THYROID PROFILE			
SERUM TOTAL T3 Method:- Chemiluminescence(Competitive immunoassay)	1.030	ng/ml	0.970 - 1.690
SERUM TOTAL T4 Method:- Chemiluminescence(Competitive immunoassay)	8.780	ug/dl	6.530 - 13.210
SERUM TSH ULTRA Method:- Enhanced Chemiluminescence Immunoassay	1.840	μIU/mL	0.350 - 5.500

Interpretation: Triiodothyronine (T3) contributes to the maintenance of the euthyroid state. A decrease in T3 concentration of up to 50% occurs in a variety of clinical situations, including acute and chronic disease. Although T3 results alone cannot be used to diagnose hypothyroidism, T3 concentration may be more sensitive than thyroxine (T4) for hyperthyroidism. Consequently, the total T3 assay can be used in conjunction with other assays to aid in the differential diagnosis of thyroid disease. T3 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, Free T3 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake, or T4 uptake can be used with the total T3 result to calculate the free T3 index and estimate the concentration of free T3.

Interpretation: The measurement of Total T4 aids in the differential diagnosis of thyroid disease. While >99.9% of T4 is protein-bound, primarily to thyroxine-binding globulin (TBG), it is the free fraction that is biologically active. In most patients, the total T4 concentration is a good indicator of thyroid status. T4 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, free T4 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake may be used with the total T4 result to calculate the free T4 index (FT4I) and estimate the concentration of free T4. Some drugs and some nonthyroidal patient conditions are known to alter TT4 concentrations in vivo.

Interpretation: TSH stimulates the production of thyroxine (T4) and triiodothyronine (T3) by the thyroid gland. The diagnosis of overt hypothyroidism by the finding of a low total T4 or free T4 concentration is readily confirmed by a raised TSH concentration. Measurement of low or undetectable TSH concentrations may assist the diagnosis of hyperthyroidism, where concentrations of T4 and T3 are elevated and TSH secretion is suppressed. These have the advantage of discriminating between the concentrations of TSH observed in thyrotoxicosis, compared with the low, but detectable, concentrations that occur in subclinical hyperthyroidism. The performance of this assay has not been established for neonatal specimens. Some drugs and some nonthyroidal patient conditions are known to alter TSH concentrations in vivo.

INTERPRETATION

PREGNANCY	REFERENCE RANGE FOR TSH IN μIU/mL (As per American Thyroid Association)
1st Trimester	0.10-2.50
2nd Trimester	0.20-3.00
3rd Trimester	0.30-3.00

MUKESH SINGH
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Sample Type > URINE

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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)	6.5		5.0 - 7.5
Method:- Reagent Strip(Double indicator blue reaction)			
SPECIFIC GRAVITY	1.025		1.010 - 1.030
Method:- Reagent Strip(bromthymol blue)			
PROTEIN	NIL		NIL
Method:- Reagent Strip (Sulphosalicylic acid test)			
GLUCOSE	NIL		NIL
Method:- Reagent Strip (Glu.Oxidase Peroxidase Benedict)			
BILIRUBIN	NEGATIVE		NEGATIVE
Method:- Reagent Strip (Azo-coupling reaction)			
UROBILINOGEN	NORMAL		NORMAL
Method:- Reagent Strip (Modified cherlich reaction)			
KETONES	NEGATIVE		NEGATIVE
Method:- Reagent Strip (Sodium Nitroprusside) Rothera's			
NITRITE	NEGATIVE		NEGATIVE
Method:- Reagent Strip (Diazotization reaction)			
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		ABSENT

VIJENDRAMEENA
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Sample Type :- KOx/Na FLUORIDE-F, KOx/Na Bile Acid, Urea, Creatinine, Glucose, HbA1c, Lipid Profile, Vitamin B12, Vitamin D3, Vitamin E, Vitamin K, Vitamin C, Vitamin B6, Vitamin B1, Vitamin B2, Vitamin B3, Vitamin B5, Vitamin B7, Vitamin B9, Vitamin B10, Vitamin B11, Vitamin B12, Vitamin B13, Vitamin B14, Vitamin B15, Vitamin B16, Vitamin B17, Vitamin B18, Vitamin B19, Vitamin B20, Vitamin B21, Vitamin B22, Vitamin B23, Vitamin B24, Vitamin B25, Vitamin B26, Vitamin B27, Vitamin B28, Vitamin B29, Vitamin B30, Vitamin B31, Vitamin B32, Vitamin B33, Vitamin B34, Vitamin B35, Vitamin B36, Vitamin B37, Vitamin B38, Vitamin B39, Vitamin B40, Vitamin B41, Vitamin B42, Vitamin B43, Vitamin B44, Vitamin B45, Vitamin B46, Vitamin B47, Vitamin B48, Vitamin B49, Vitamin B50, Vitamin B51, Vitamin B52, Vitamin B53, Vitamin B54, Vitamin B55, Vitamin B56, Vitamin B57, Vitamin B58, Vitamin B59, Vitamin B60, Vitamin B61, Vitamin B62, Vitamin B63, Vitamin B64, Vitamin B65, Vitamin B66, Vitamin B67, Vitamin B68, Vitamin B69, Vitamin B70, Vitamin B71, Vitamin B72, Vitamin B73, Vitamin B74, Vitamin B75, Vitamin B76, Vitamin B77, Vitamin B78, Vitamin B79, Vitamin B80, Vitamin B81, Vitamin B82, Vitamin B83, Vitamin B84, Vitamin B85, Vitamin B86, Vitamin B87, Vitamin B88, Vitamin B89, Vitamin B90, Vitamin B91, Vitamin B92, Vitamin B93, Vitamin B94, Vitamin B95, Vitamin B96, Vitamin B97, Vitamin B98, Vitamin B99, Vitamin B100

Final Authentication : 16/03/2024 16:05:57

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
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FASTING BLOOD SUGAR (Plasma)
Method:- GOD PAP

103.8

mg/dl

75.0 - 115.0

Impaired glucose tolerance (IGT)

111 - 125 mg/dL

Diabetes Mellitus (DM)

> 126 mg/dL

Instrument Name: Randox Rx Imola **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

111.7

mg/dl

70.0 - 140.0

Instrument Name: Randox Rx Imola **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.

SERUM CREATININE
Method:- Colorimetric Method

0.72

mg/dl

Men - 0.6-1.30
Women - 0.5-1.20

SERUM URIC ACID
Method:- Enzymatic colorimetric

5.40

mg/dl

Men - 3.4-7.0
Women - 2.4-5.7

AJAYSINGH, SURENDRAXHANGA

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HAEMATOLOGY

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

BLOOD GROUP ABO

"B" POSITIVE

BLOOD GROUP ABO Methodology : Haemagglutination reaction Kit Name : Monoclonal agglutinating antibodies (Span clone).

URINE SUGAR (FASTING)
Collected Sample Received

Nil

Nil

AJAYSINGH, VIJENDRAMEENA
Technologist

Page No: 11 of 12



Dr. Rashmi Bakshi
MBBS, MD (Path)
RMC No. 17975/008828

Dr. Goyal's

Path Lab & Imaging Centre

B-51, Ganesh Nagar, Near Metro Piller No. 109-110, New Sanganeer Road,
Sodala, Jaipur-302019

Tele : 0141-2293346, 4049787, 9887049787

Website: www.drgoyalspathlab.com | E-mail: drgoyalpiyush@gmail.com

Date :- 16/03/2024 12:02:30

Patient ID :-12236378



NAME :- Mr. NIRDOSH

Ref. By Dr:- BOB

Sex / Age :- Male 32 Yrs 6 Mon 5 Days

Lab/Hosp :-

Company :- MediWheel

Sample Type :- PLAIN/SERUM

Sample Collected Time 16/03/2024 12:06:37

Final Authentication : 16/03/2024 13:50:16

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
BLOOD UREA NITROGEN (BUN)	9.1	mg/dl	0.0 - 23.0

*** End of Report ***

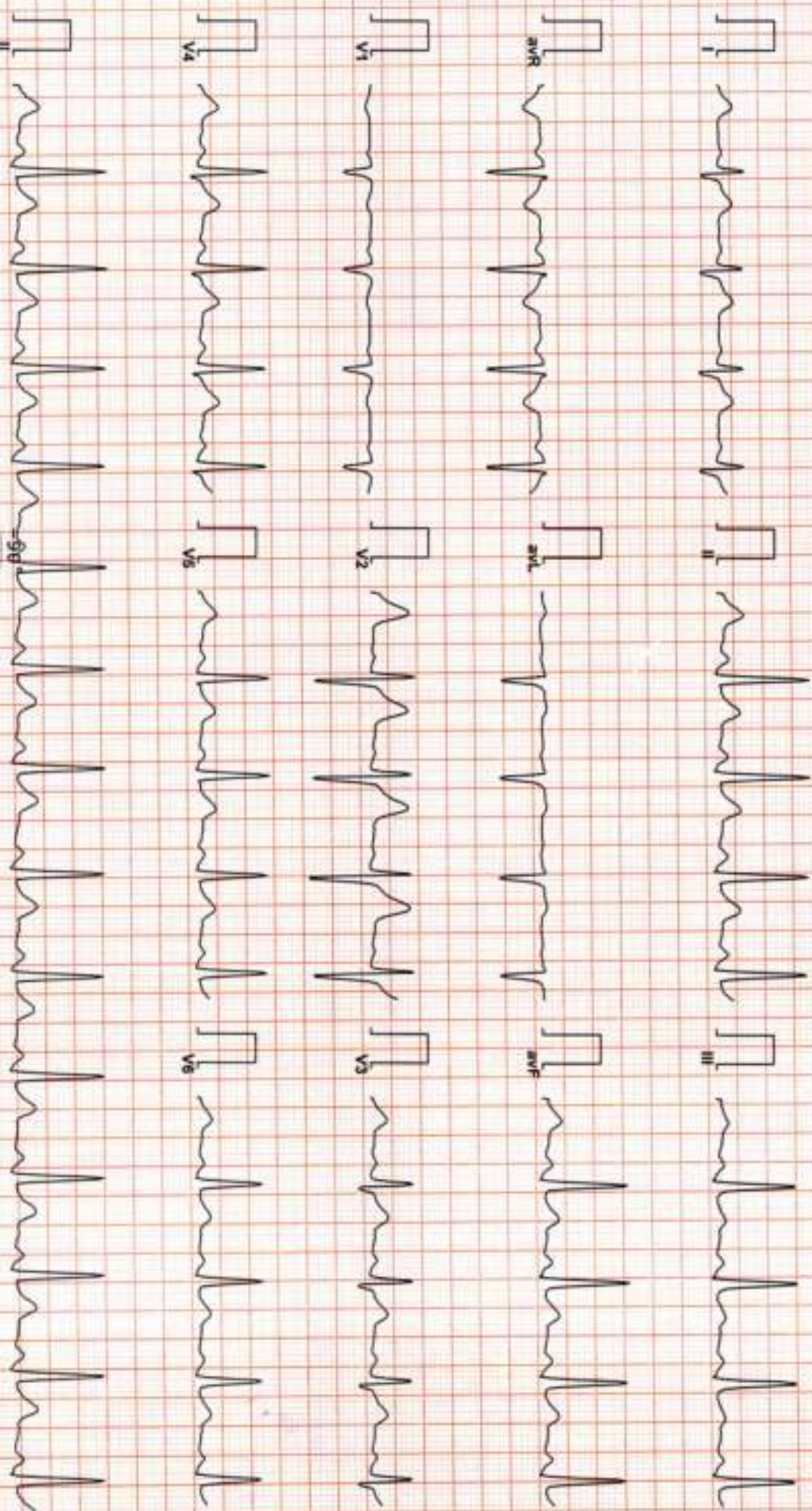
SURENDRAKHANGA

Page No: 12 of 12



Dr. Rashmi Bakshi
MBBS, MD (Path)
RMC No. 17975/008828

4803 / MR NIRDOSH / 32 Yrs / M/ Non Smoker
Heart Rate : 86 bpm / Tested On : 16-Mar-24 13:23:42 / HF 0.05 Hz - LF 35 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s
/ Refd By: BOB



Vent. Rate : 86 bpm
PR Interval : 158 ms
QRS Duration: 96 ms
QT/QTc Int : 352/398 ms
P-QRS-T axis: 73.00° 84.00° 53.00°

180°



Axis

R 84.00° P 73.00°

Reported By:

Top HV

Dr. Naresh Kumar Moh...
MBBS, D.P. (Cardiology)
DE.M. (C.V.)

DR. GOYALS PATH LAB & IMAGING CENTRE

SODALA JAIPUR RAJ. EMAIL:

863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / NonSmoker
 Date: 16 / 03 / 2024 01:24:19 PM Refd By : BOB Examined By:

Report



Stage	Time	Duration	Speed(mph)	Elevation	METs	Rate	% THR	BP	RPP	PVC	Comments
Supine	00:11	0:11	01.1	00.0	01.0	000	0%	120/80	000	00	
Standing	00:31	0:20	01.1	00.0	01.0	061	43%	120/80	097	00	
HV	00:59	0:28	01.1	00.0	01.0	107	57%	120/80	128	00	
Warm Up	01:19	0:20	01.1	00.0	01.0	093	49%	120/80	111	00	
ExStart	02:02	0:43	01.0	00.0	01.0	099	53%	120/80	118	00	
BRUCE Stage 1	05:02	3:00	01.7	10.0	04.7	132	70%	128/82	168	00	
BRUCE Stage 2	08:02	3:00	02.5	12.0	07.1	155	82%	136/86	210	00	
PeakEX	10:03	2:01	03.4	14.0	09.2	175	93%	140/90	245	00	
Recovery	11:03	1:00	00.0	00.0	01.2	144	77%	140/90	201	00	
Recovery	12:03	2:00	00.0	00.0	01.0	117	62%	138/88	161	00	
Recovery	13:03	3:00	00.0	00.0	01.0	119	63%	136/86	161	00	
Recovery	14:03	4:00	00.0	00.0	01.0	111	59%	136/86	150	00	
Recovery	14:06	4:03	00.0	00.0	01.0	111	59%	136/86	150	00	

FINDINGS :

Exercise Time : 08:01
 Max HR Attained : 175 bpm 93% of Target 188
 Max BP Attained : 140/90 (mm/Hg)
 Max Workload Attained : 9.2 Good response to induced stress
 Test End Reasons : Test Complete, Heart Rate Achieved

REPORT :

Dr. Mareeh Kumar Mohanika
 RMO No. 35703
 RMO IN ESCORTS

MFMS, DIP (P), M (ESCORTS),
 D.F.M. (RCSF-UK)

TM7 is Negative for RMI

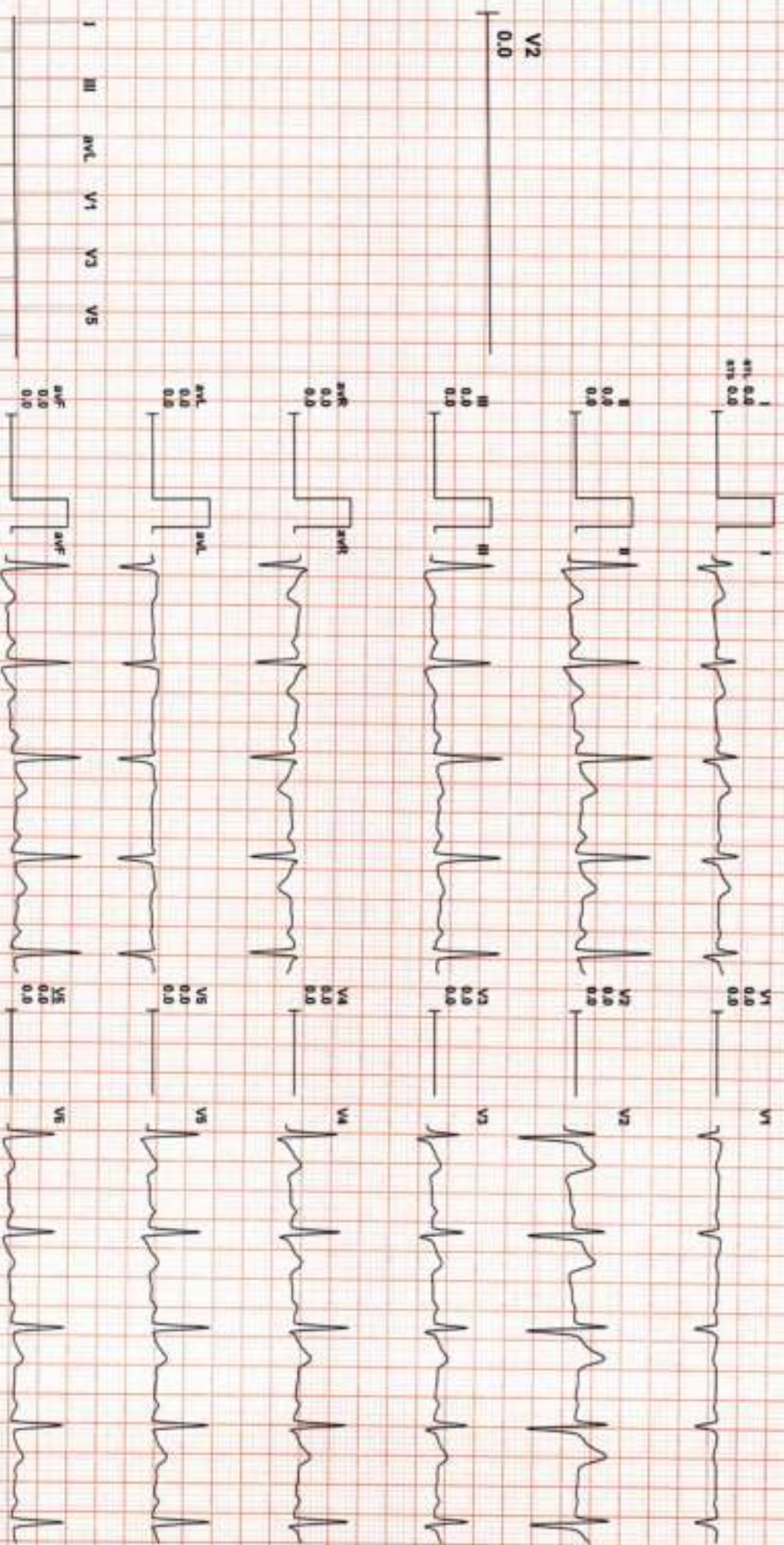


863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 0

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.0V @ bpm 0% of THR BP: 120/80 mmHg Raw ECG/ BLC Ov/ Natch Ov/ HF 0.05 Hz/ LF 35 Hz

4X 0 ms Post J

ExTime: 00:00 1.1 mph 0.0%
25 mm/Sec. 1.9 Cm/mV



REMARKS:
I II aVR aVL V1 V2 V3 V4 V5 V6



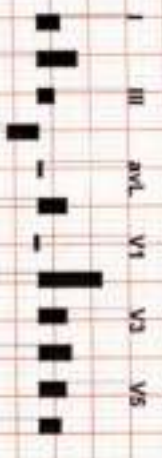
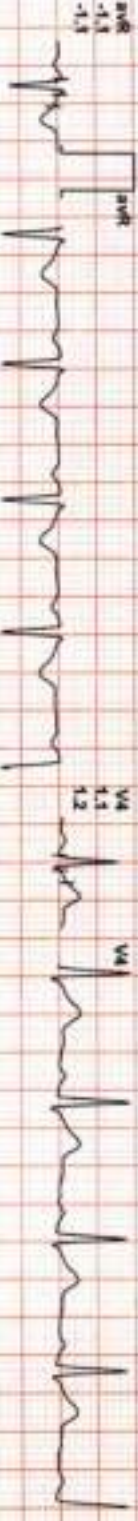
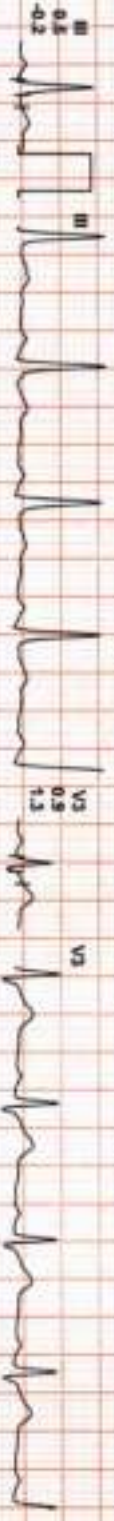
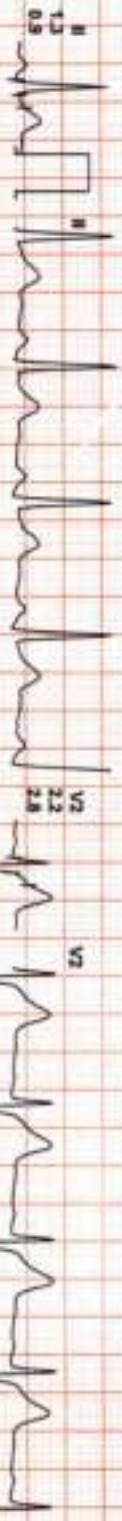
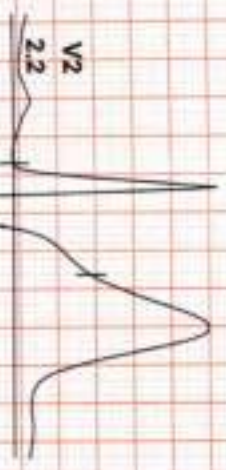
863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 81

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.0/ 81 bpm 43% of THR BP: 120/80 mmHg Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/ LF 35 Hz

ExTime: 00:00 1.1 mph, 0.0%

4X 80 mS Post J

25 mm/Sec 1.0 Cm/mV



REMARKS: I II aVR aVL aVF V1 V2 V3 V4 V5

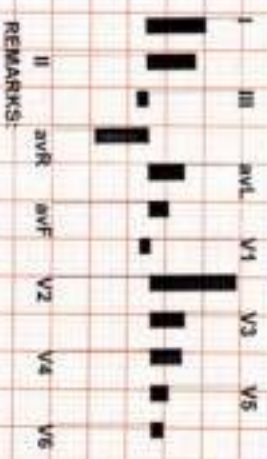
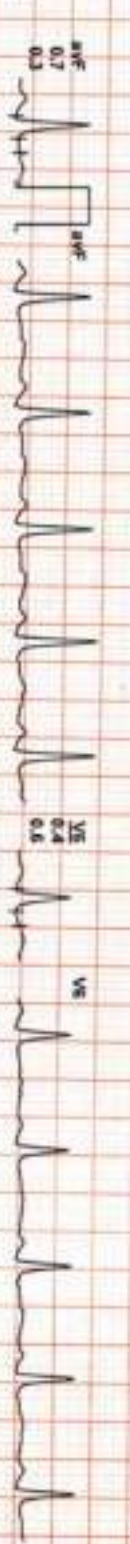
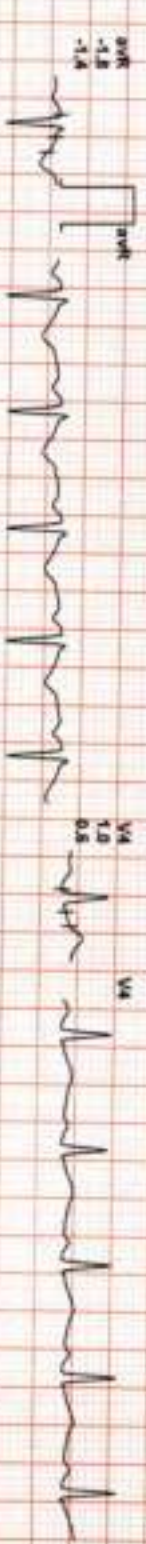


863 (113) / MR NIRDOSH / 32 Yrs / M / O Cris / 0 Kg / HR : 107

Date: 16/03/2024 01:24:19 PM METS: 1.8L 107 bpm 67% of THR BP: 120/80 mmHg Raw ECG/ BLC Onv Notch Onv HF 0.05 Hz/ L/F 35 Hz

4X 80 mm Post J

ExTime: 00:00 1.1 mph, 0.0% 28 mm/sec, 1.0 Cm/mv



REMARKS:

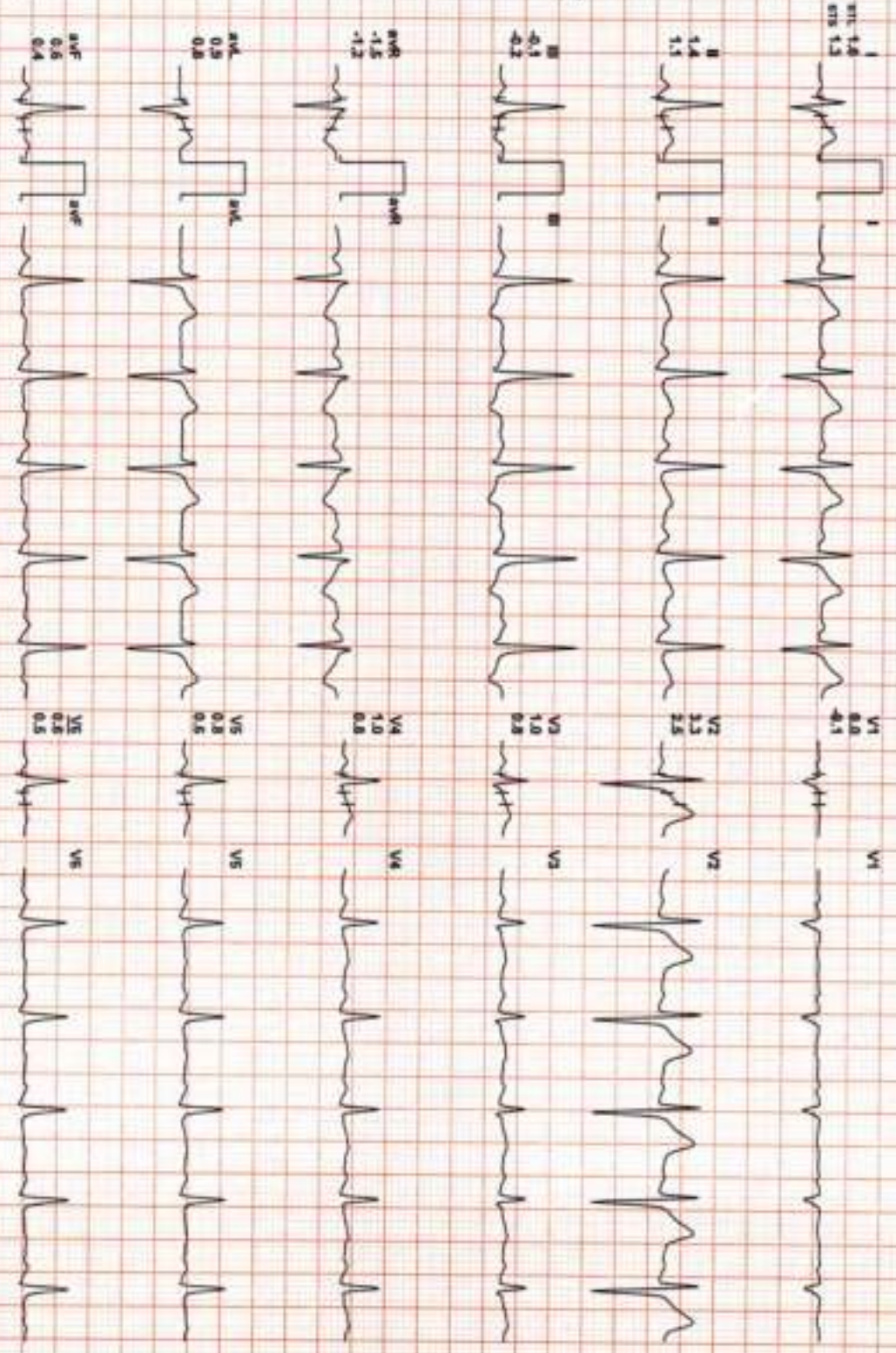
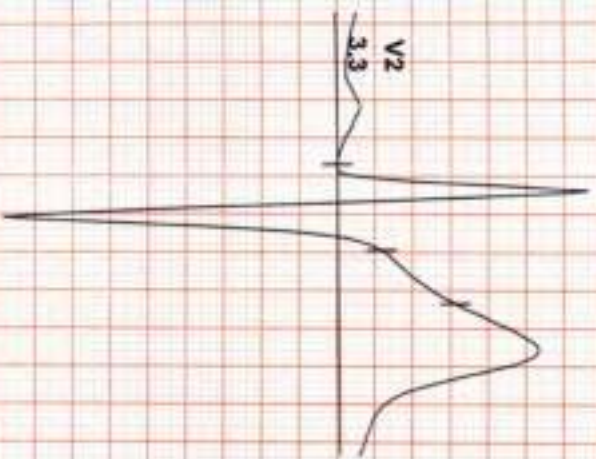


863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 93

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.07 93 bpm 49% of THR BP: 120/80 mmHg Raw ECG/ BLC On/ Notch On/ H_F 0.05 Hz/LF 35 Hz

4X 30 ms Post J

ExTime: 00:00 1.1 mph, 0.0%
25 mm/Sec. 1.4 Cm/mV



REMARKS:

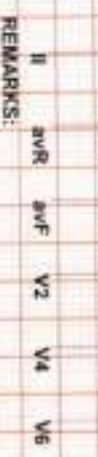


863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Crms / 0 Kg / HR : 99

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.0/ 99 bpm 53% of THR BP: 120/80 mmHg Raw ECG BLC On/ Notch On/ HF 0.05 Hz/ LF 35 Hz

4X 40 ms Post J

ExTime: 00:00 1.0 mph, 0.0%
25 mm/sec, 1.0 Cm/mV

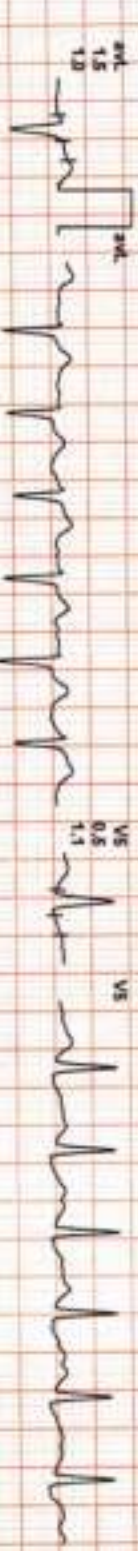
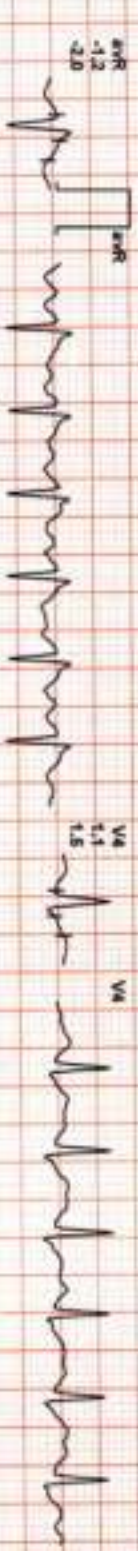
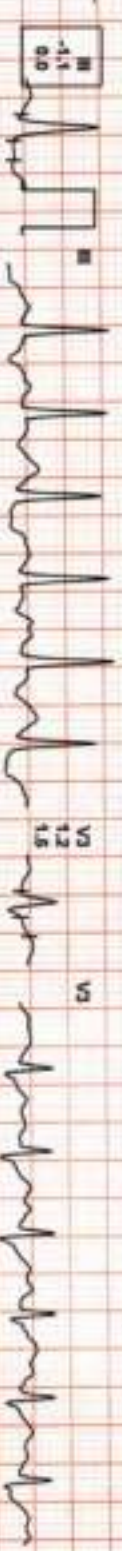
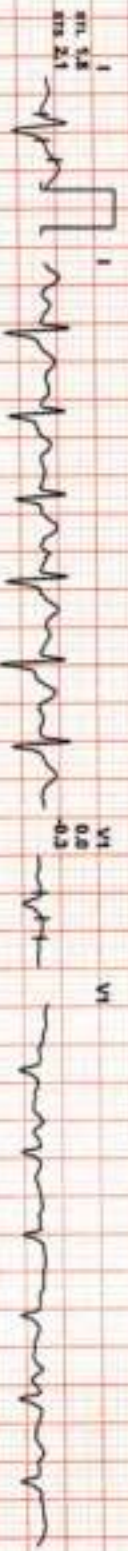


REMARKS:



4X 80 MS Post J

EXTime: 03:00 1.7 mph, 10.0%
25 minutes, 1.0 Gramiv



REMARKS:



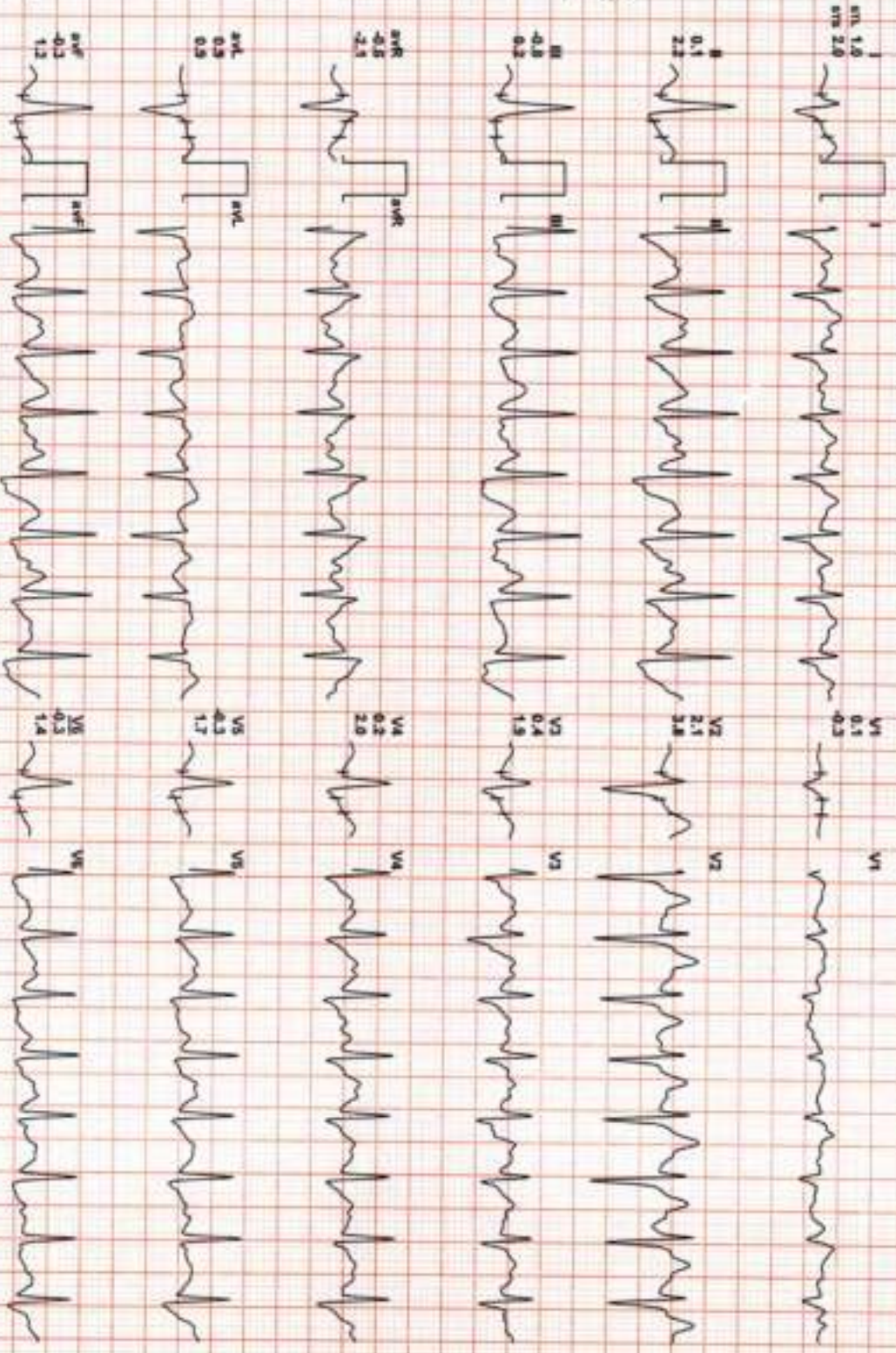
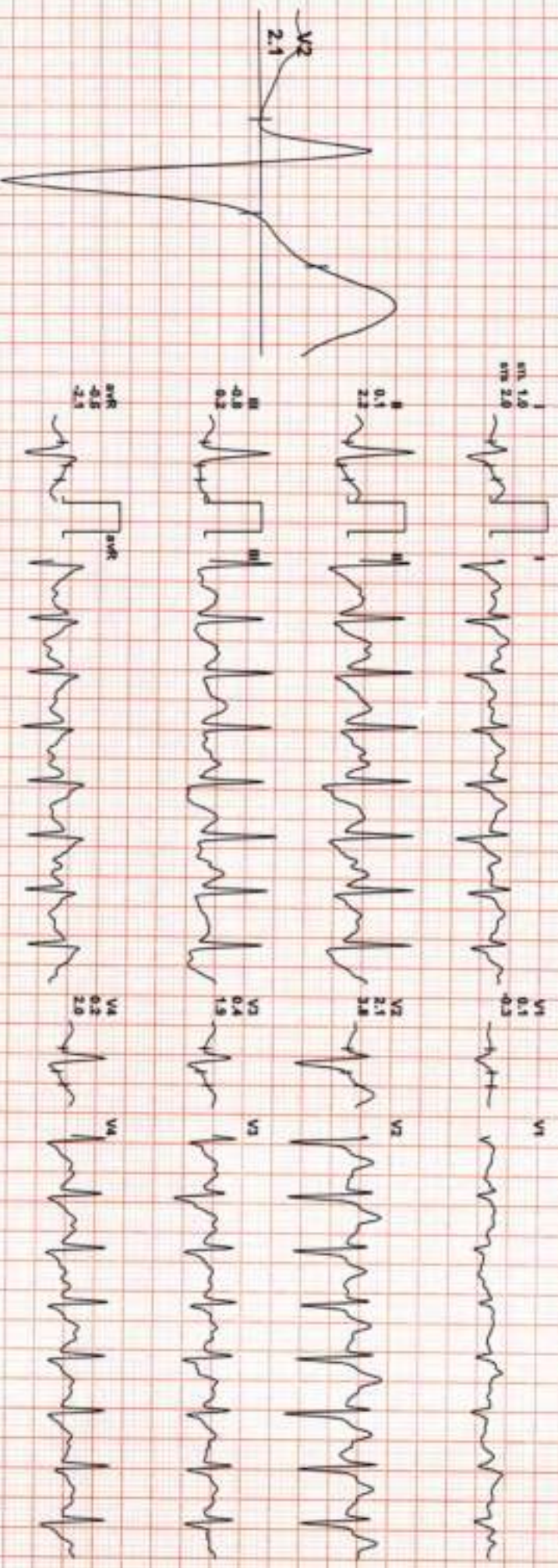
863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cris / 0 Kg / HR : 155

Date: 16 / 03 / 2024 01:24:19 PM METS: 7.1 / 165 bpm 82% of THR BP- 138/86 mmHg Raw ECG/ BLC On Notch On HF 0.05 Hz/LF 35 Hz

ExTime: 06:00 2.5 mph, 12.0%

4X 60 ms/Post J

25 mm/Sec, 1.0 Cm/mV



REMARKS:

I II III aVR aVL aVF V1 V2 V3 V4 V5 V6



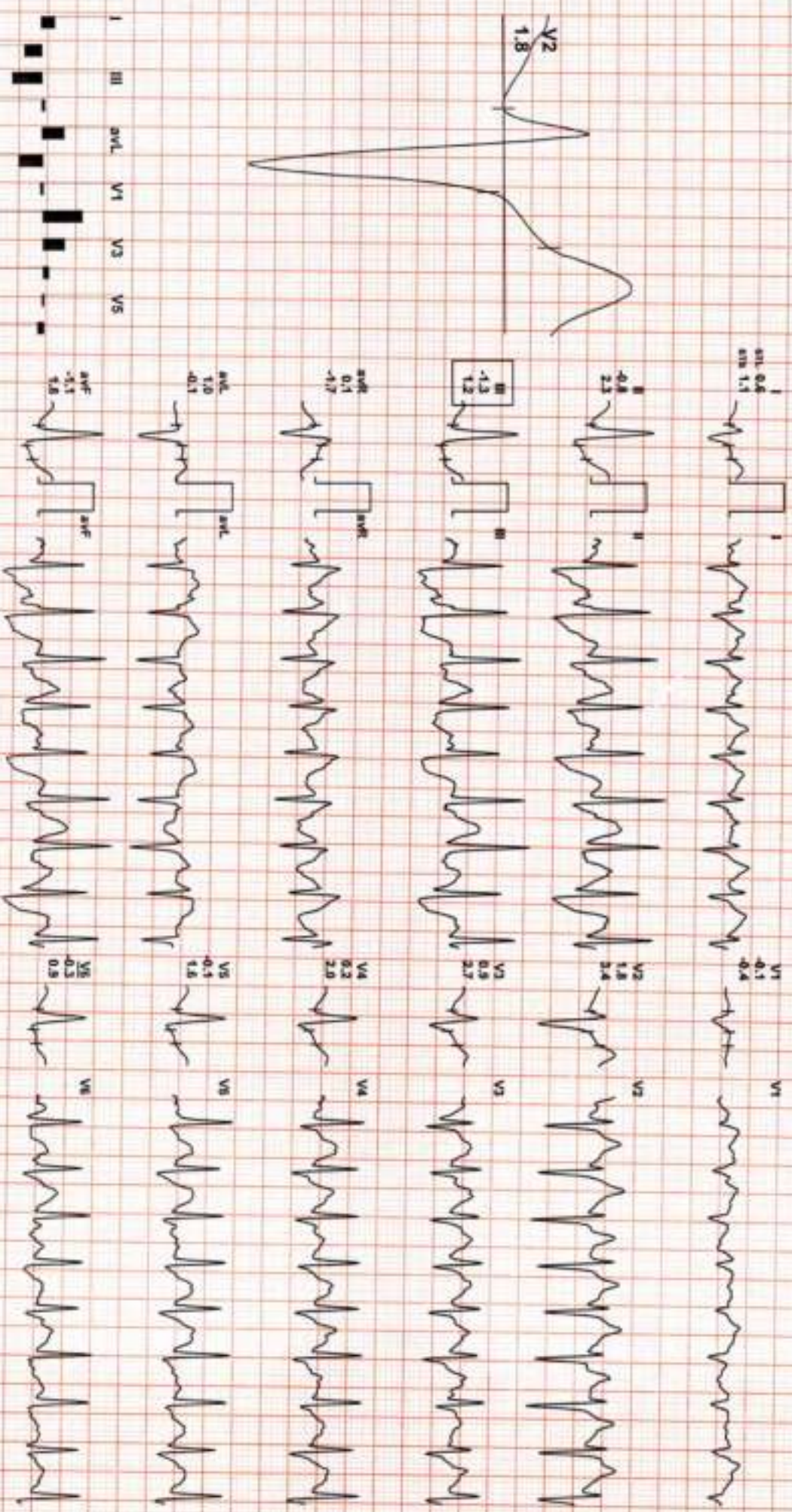
863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 175

Date: 16 / 03 / 2024 01:24:19 PM METS: 9.2/ 175 bpm 95% of THR BP: 140/90 mmHg Raw ECG BLC On Notch On HF 0.05 Hz/LF 35 Hz

ExTime: 08:01 3.4 mph, 14.0%

4X 60 mm Post J

25 mm/Sec. 1.8 Cm/mV



REMARKS: I II aVR aVL aVF V1 V2 V3 V4 V5 V6



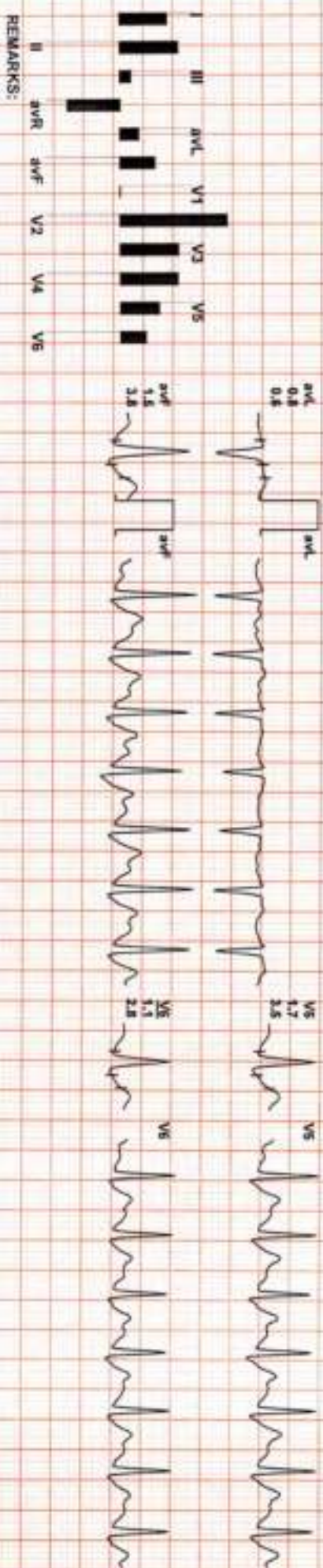
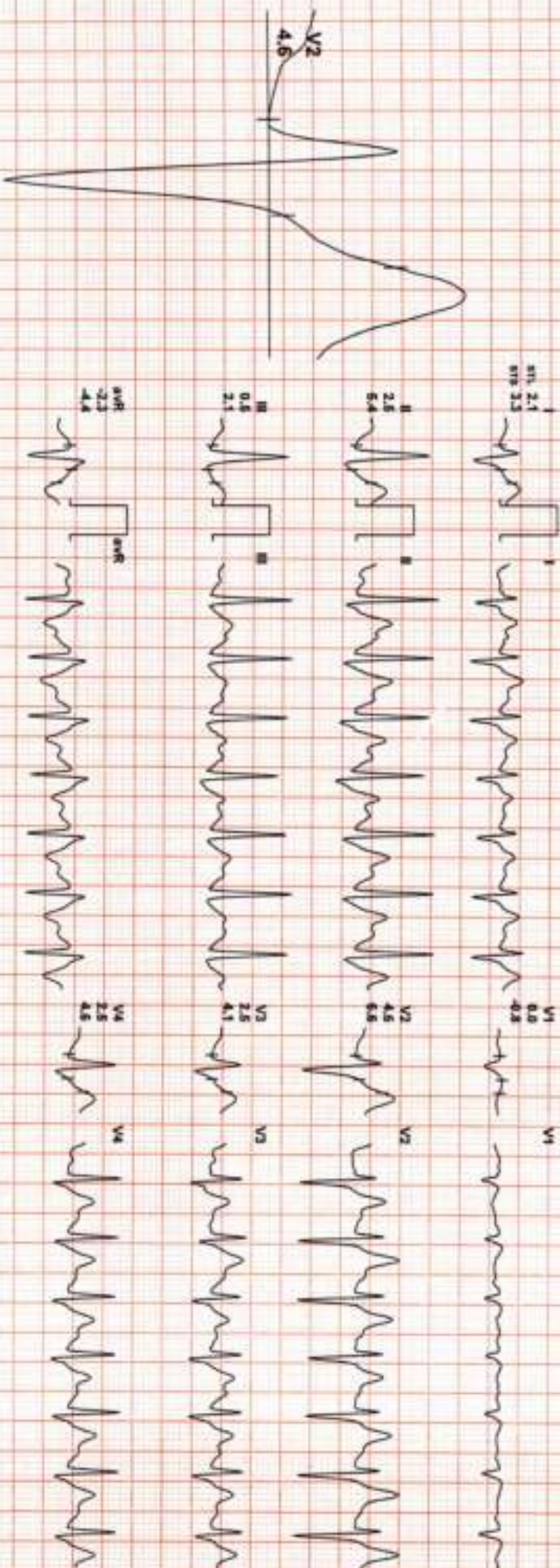
863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 144

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.2/ 144 bpm 77% of THR BP: 140/90 mmHg Raw ECG/ BLC Onv Notch Onv HF 0.05 Hz/ LF 35 Hz

ExTime: 08:01 0.0 mph, 0.0%

4X 60 ms Post J

25 mm/Sec. 1.8 Cm/mV



REMARKS:



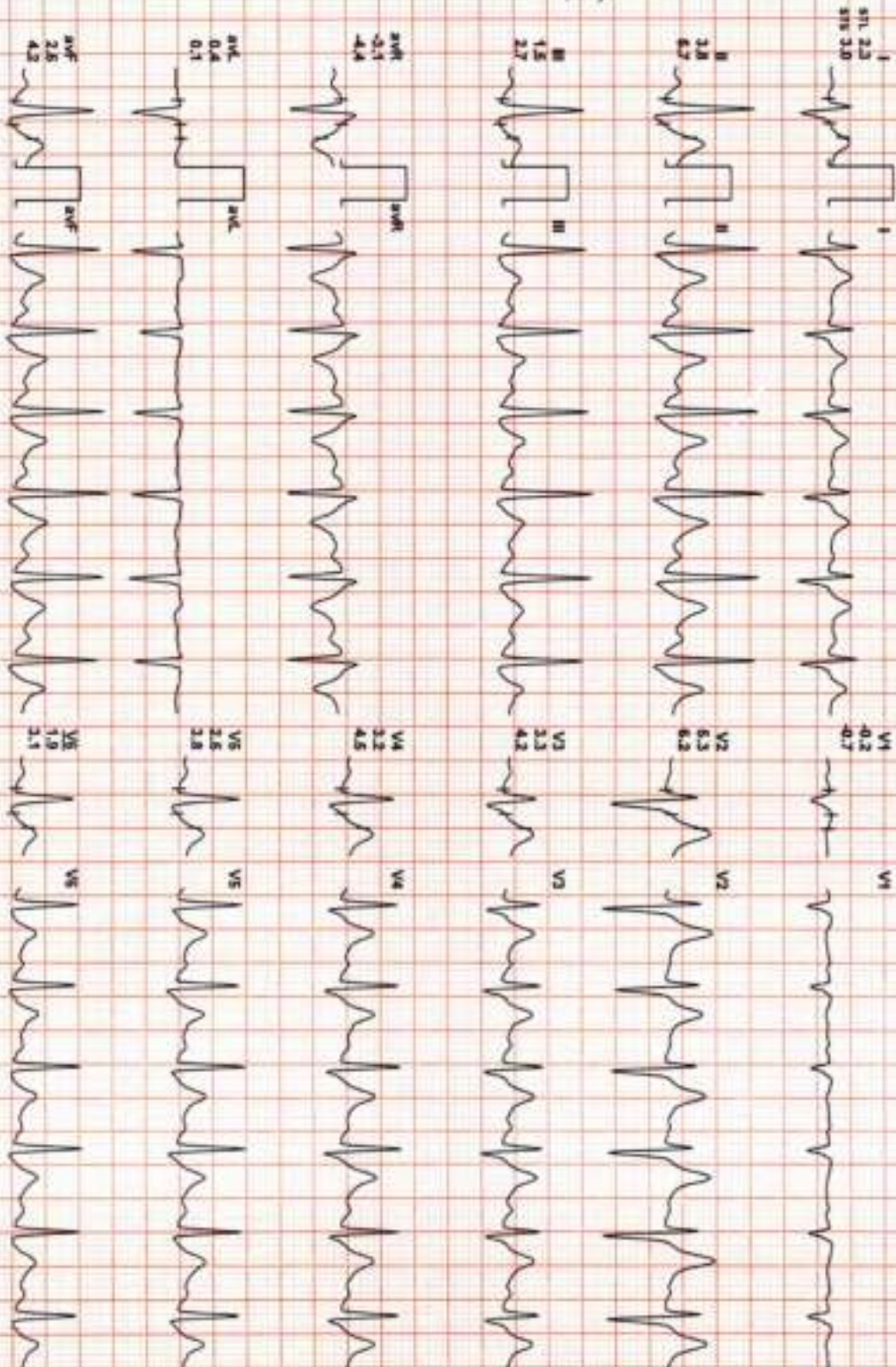
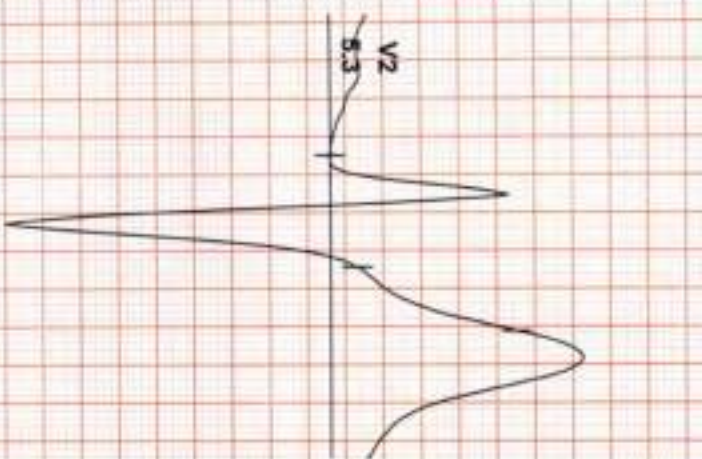
863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 117

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.0/ 117 bpm 62% of THR BP: 138/88 mmHg Raw ECG/ BLC On Notch On HF 0.05 Hz/LF 35 Hz

EXTime: 08:01 0.0 mph, 0.0%

4X 70 ms Post J

25 mm/sec - 1.0 Cm/mV



REMARKS:



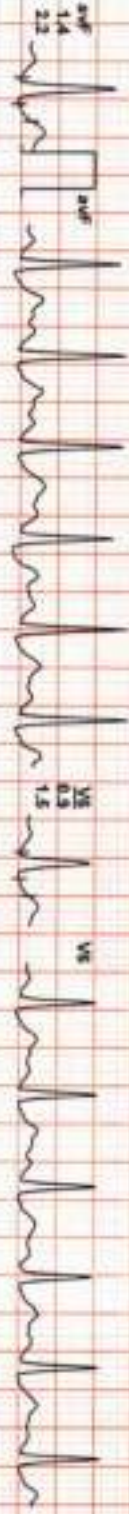
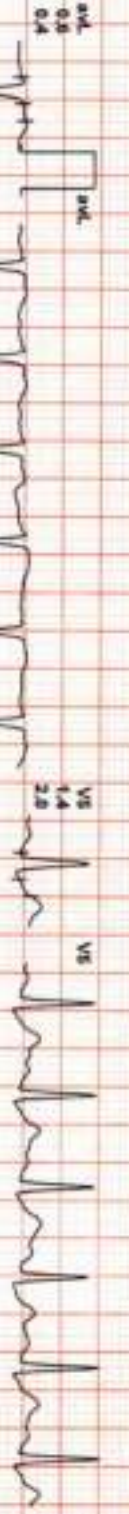
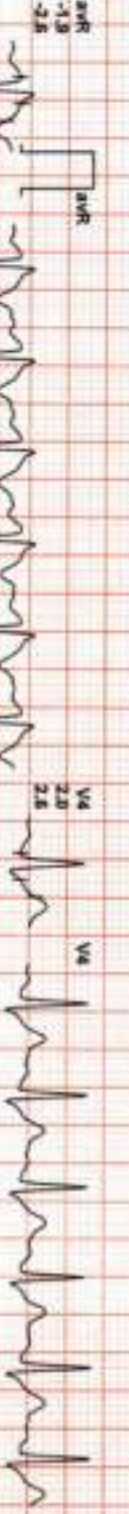
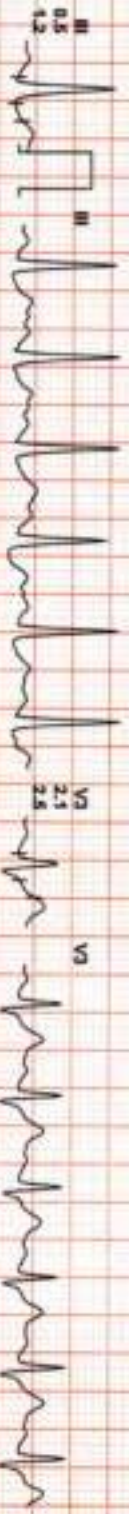
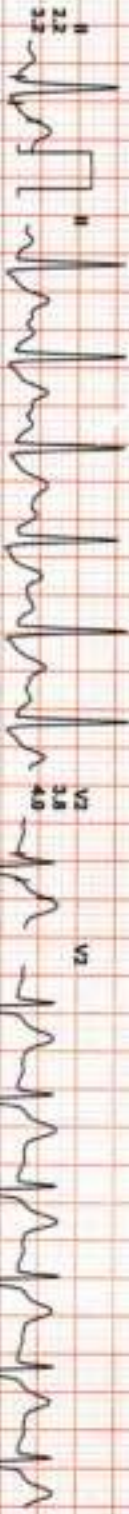
863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 119

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.6/ 119 bpm 63% of THR BP: 136/86 mmHg Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/ LF 35 Hz

EXTime: 08:01 0.0 mph, 0.0%

4X 80 ms/Post J

25 mm/Sec. 1.0 Cm/mV



REMARKS:

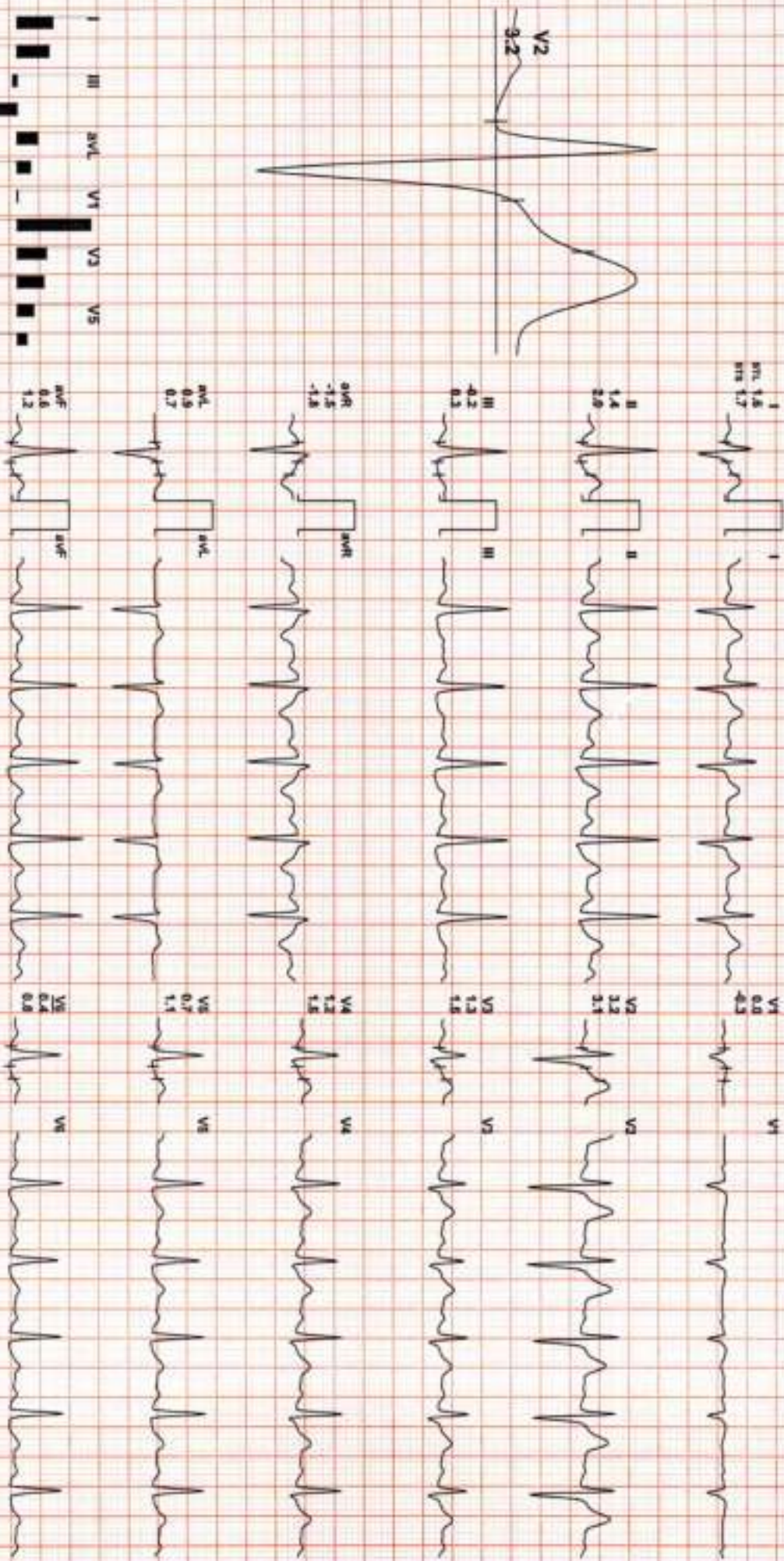


863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 111

Date: 16 / 03 / 2024 01:24:19 PM METS: 1.01 111 bpm 99% of THR BP: 136/86 mmHg Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/ LF 35 Hz

4X 80 ms Post J

ExTime: 08:01 0.0 mph, 0.0%
25 mm/sec, 1.2 Cm/mV



REMARKS:



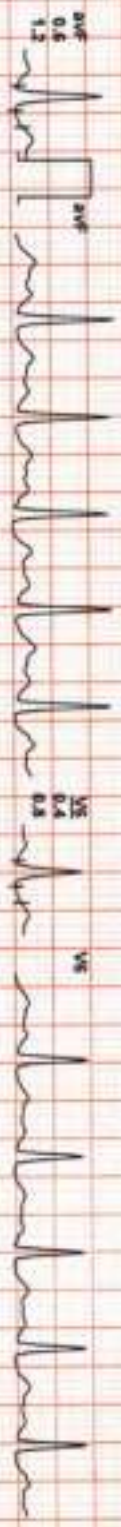
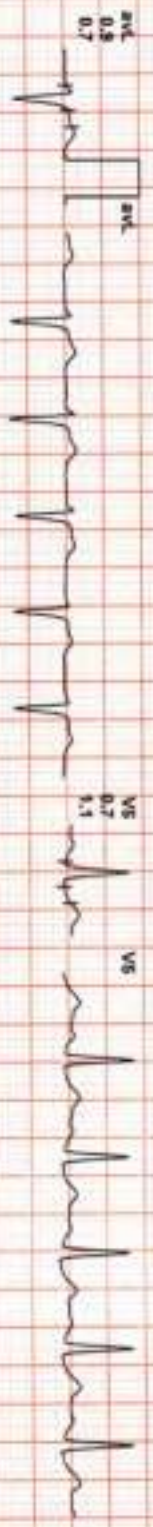
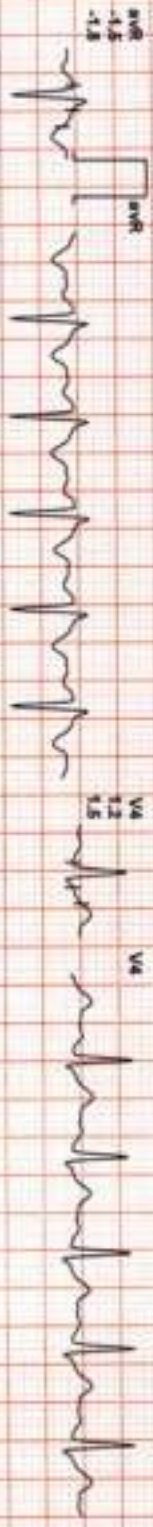
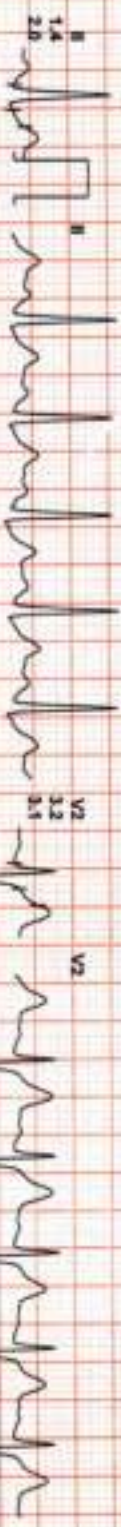
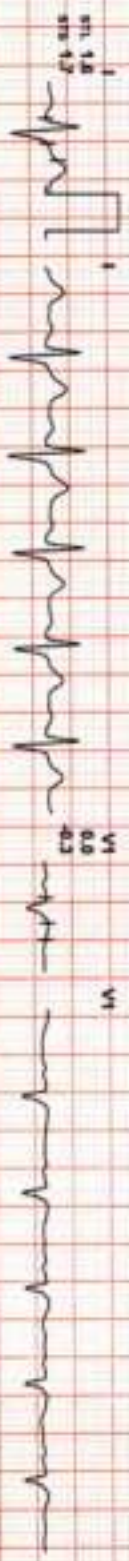
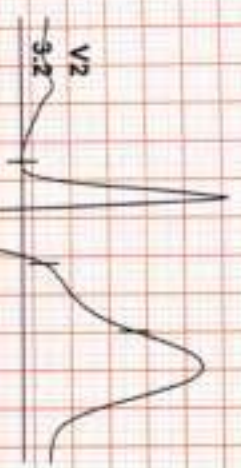
863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 111

Date: 16 / 03 / 2024 01:24:10 PM METS: 1.0/ 111 bpm 59% of THR BP: 136/86 mmHg Raw ECG/ BLC ON/ Naich ON/ HF 0.05 Hz/ LF 35 Hz

EXTime: 08:01 0.0 mph, 0.0%

4X 80 ms Post J

25 mm/Sec. 1.0 Cm/mV



REMARKS:



863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 87

Date: 16 / 03 / 2024 01:24:19 PM I

II

III

aVR

aVL

aVF

V1

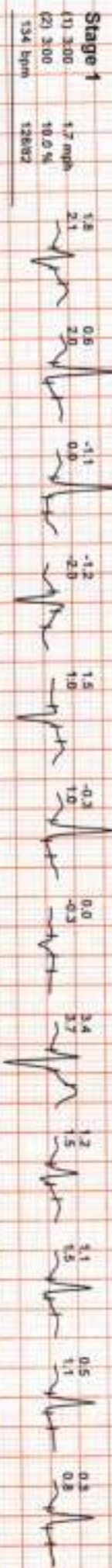
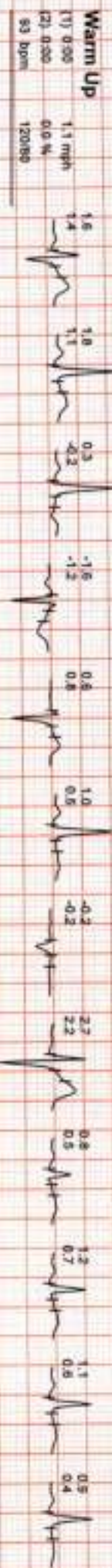
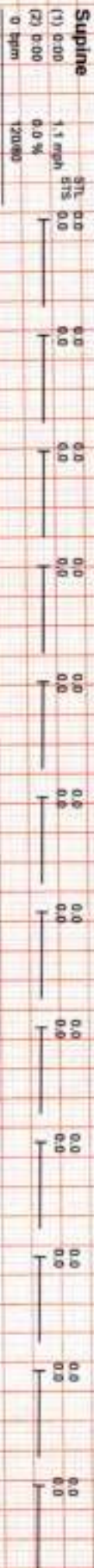
V2

V3

V4

V5

V6





863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 87

Date: 16 / 03 / 2024 01:24:19 PM I II III

aVR

aVL

aVF

V1

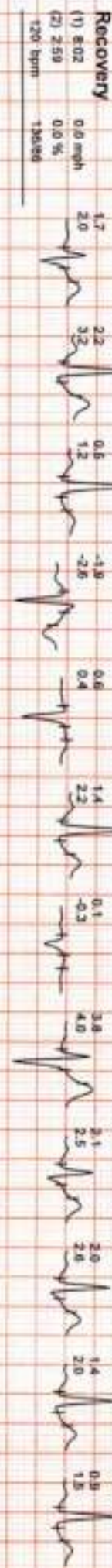
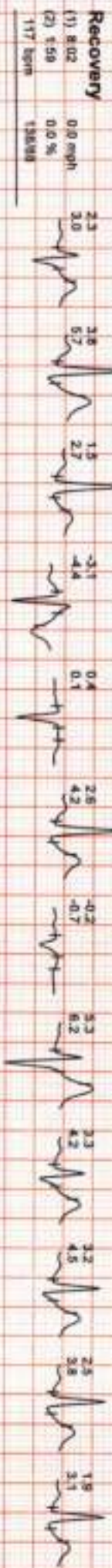
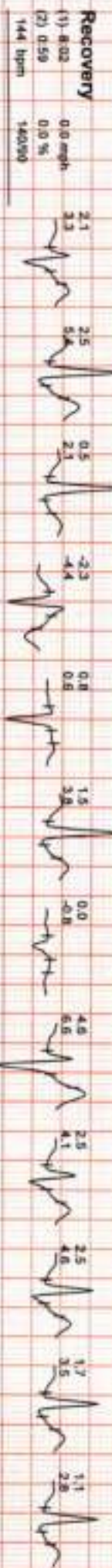
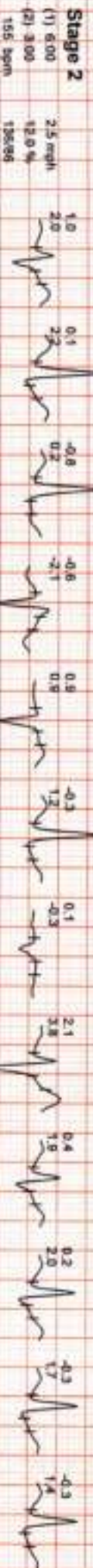
V2

V3

V4

V5

V6



DR. GOYALS PATH LAB & IMAGING CENTRE

Average



863 (113) / MR NIRDOSH / 32 Yrs / M / 0 Cms / 0 Kg / HR : 87

Date: 16 / 03 / 2024 01:24:19 PM I

II

III

AVR

AVL

AVF

V1

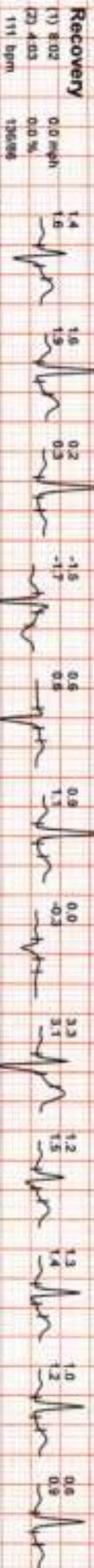
V2

V3

V4

V5

V6



Recovery

(T) 8.02 0.0 mV
(D) 4.03 0.0 %
111 bpm 13sec





Date :- 16/03/2024 12:02:30
NAME :- Mr. NIRDOSH
Sex / Age :- Male 32 Yrs 6 Mon 5 Days
Company :- MediWheel

Patient ID :-12236378
Ref. By Doctor:-BOB
Lab/Hosp:-

Final Authentication : 16/03/2024 16:01:43

BOB PACKAGE BELOW 40MALE

USG WHOLE ABDOMEN

Liver is enlarged in size (~ 15.8 cm). Echo-texture is bright No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is partially distended grossly normal. 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 (~ 12.3 cm) Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

Urinary bladder is well distended and showing smooth wall with normal thickness. Urinary bladder does not show any calculus or mass lesion.

Prostate is enlarged in size (~ 27 gms) with normal echo-texture and outline. No enlarged nodes are visualised. No retro-peritoneal lesion is identified. No significant free fluid is seen in peritoneal cavity.

IMPRESSION:

- * Mild hepatomegaly with grade II fatty changes.
- * Mild splenomegaly.
- * Mild prostatomegaly.

Needs clinical correlation.

*** End of Report ***


AHSAN

Transcript by.

Page No: 1 of 1

Dr. Piyush Goyal
M.B.B.S., D.M.R.D.
RMC Reg No. 017999

Dr. Ashish Choudhary
MBBS, MD (Radio Diagnosis)
Fetal Medicine Consultant
FMF ID - 260517 | RMC No 22430


Dr. Abhishek Jain
MBBS, DNB, (Radio-Diagnosis)
RMC No. 21987

Dr. Navneet Agarwal
MD, DNB (Radio Diagnosis)
RMC No. 33613/14911

Dr. Poorvi Malik
MBBS, MD, DNB (Radio Diagnosis)
RMC No. 21505