भारत सरकार

GOVERNMENT OF INDIA

செந்தில் நாதன் முத்துமாணிக்கம்

Senthil Nathan Muthumanickam

பிறந்த நாள் / DOB : 06/05/1990

ஆண் / MALE

7625 1780 1737

ஆதார் - சாதாரண மனிதனின் அதிகாரம்

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CLOUD 36 BILDING SHOP NO 8 PLOT NO 6 SEC11, Palm Beach Rd, Jijamata Nagar, Sector 11, Ghansoli, Navi
Lat: 19.119245
Lon: 72.9936473
24/02/2024 09:47:10 AM GMT+05:30

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X II

MEDICAL EXAMINATION FORM

Confidential without Prejudice Report. To Be Filled In Strictly By the Physician/Diagnostic Center

PART I: GENERAL DETAILS

NAME OF THE PATIENT: Nathan Senthil

D.O.B: 6/5/1990 Age: 33 Sex: M Phone number: 8148715445

PART II: MEDICAL EXAMINATION REPORT (Strictly to be filled by Medical Examiner)

(Kindly tick wherever applicable)

A. PERSONAL HISTORY:

1. Previous history if any:

Disease	Yes/No	Medicine & Surgery Details	Disease	Yes/No	Medicine & Surgery Details
Diabetes Mellitus	No (bracketed for all)		Cancer	No (bracketed for all)	
Hypertension			Tumor/Benign		
IHD			Genital urinary disorder		
Stroke			Rheumatic joint diseases or symptoms		
Surgeries			Asthma		
Tuberculosis			Pulmonary Disease		
Congenital Disease			Anemia		
Arrhythmia			Bleeding disease or Disorder.		
Aids (HIV)			Mental Stress		

2. Habits:

Diet	Mixed	Alcohol	No	Tobacco/Smoking	No	Medicine	

3. Major complaints/Relevant past history if any: N/A

4. Previous Illness (Hospitalization Investigation, consultation): N/A

5. Family history: N/A

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B. MEDICAL EXAMINERS FINDING AND ASSESMENT: (Please answer each question and where appropriate provide particulars. You are asked not to give any information to the person, assured, about the results

1. Anthropometry:

Height	162 cm	Weight	68.30 kg	BMI	

2. Vital Parameters:

(i)

Respiratory Rate	22	Pulse Rate	97 bpm

(ii) Blood Pressure (Three consecutive Reading):

Systolic	120	120	120
Diastolic	70	70	70
Further readings at 10 minute interval if the first reading exceeds 140/90	mmhg	mmhg	mmhg

3. Skin

Is there is any evidence of:

Chronic Ulcer:	☐ YES	☑ NO		Eczema	☐ YES	☑ NO	
Swelling	☐ YES	☑ NO		Varicose Veins	☐ YES	☑ NO	
Skin Discoloration	☐ YES	☑ NO		Psoriasis	☐ YES	☑ NO	

Any Other skin problem and specific location describe ______

EXAMINATION FINDINGS DETAILS

4. Cardiovascular System: S1S2

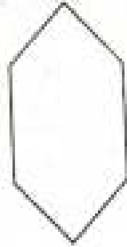
5. Genito-Urinary System:

6. Respiratory System: AeBe Clear

7. Gastro-Entrology System:

(a) Oropharyngeal:

(b) Abdomen: Soft.



Evidence of Hernia, Hydrocele, Fissure, Fistula & piles,

If yes, please describe

8. Nervous System: Conicious, Well Oriented

9. Eye Check-up Report Attached

10. ENT Ⓝ

12. For Female Clients Only: N/A

1. Is there any disease of breast? ______
2. (I) Is there any evidence of pregnancy? ______

   (II) If Pregnant, are any complications to be expected? ______
3. Do you suspect any disease of uterus, cervix of ovaries? ______
4. Any menstrual complaints? ______

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C. SUMMARY of the examination findings:

Positive Findings if any: (Please Specify)

Advice:

Conclusion on the fitness of the client: Clinically & Medically Fit

D. DOCTOR'S DECLARATION:

I confirm that I have examined this CLIENT and the findings stated above are true and correct to the best of my knowledge.

1. Name of the Medical Examiner: Dr. Anand Gaur

Signature of the Medical Examiner: [signature]

DR. ANAND PRAKASH GAUR
MBBS, [illegible], CCEBDM
(Consulting Physician)
MMC Reg. No.
2005/02/0965

Stamp of the Medical Examiner

Registration Number

Date of medicals conducted: 24/2/24

Place: Ghansoli

2. Name of the Client:

Signature of the Client:

NOTE: NAME AND SIGNATURE OF MEDICAL EXAMINER AND THE CLIENT IS MANDATORY ON THIS FORM

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Nathan m senthil 15.02.2024 2:21:32

Male
33 Years

QRS :	68 ms
QT / QTcBaz :	348 / 404 ms
PR :	94 ms
P :	70 ms
RR / PP :	740 / 740 ms
P / QRS / T :	46 / 85 / 60 degrees

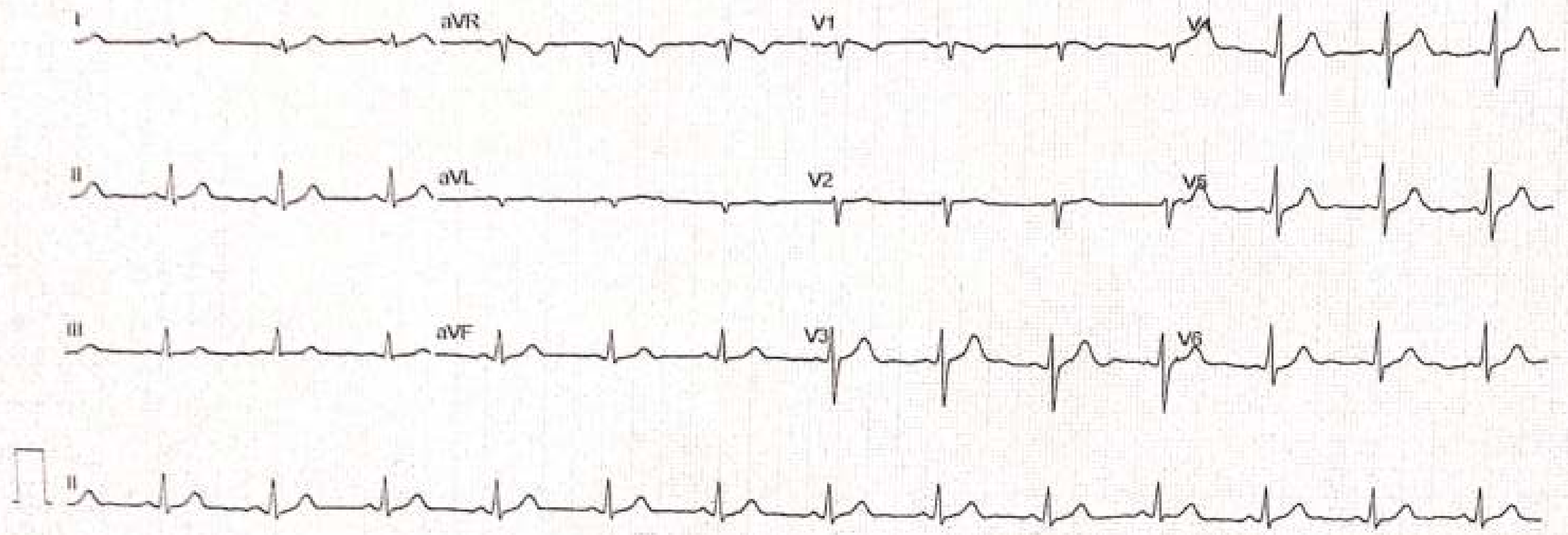
Sinus rhythm with short PR
Otherwise normal ECG

Location:
Room:
Order Number:
Indication:
Medication 1:
Medication 2:
Medication 3:

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

81 bpm
-- / -- mmHg

DR. ANAND PRAKASH ... UR
MBBS, ... EEDM
(... Physician)
... Reg. No.
20?5/02/0965



GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 60 Hz 4x2.5x3_25_R1 Unconfirmed 1/1

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help@healthledger.co.in
+91 916 907 5555

HEALTH LEDGER
DIAGNOSTICS

Ophthalmology Case Paper

Reg. No. : ____________ Date: 24/02/2024

Patient Name Mr.Mrs: Nathan Senthil

Age 33 Sex M Addresss: ____________

Mobile No: 8148716445

Systemic Illness:	NAD
Allergies:	No allergies

	Right Eye	Left Eye
Color Vision	N	N
Distance	6/6 N c̄ glasses	6/6 N c̄ glasses
Near	NG	NG

Doctor's Sign and Stamp

DR. ANAND PRAKASH GAUR
CCMH, CCEBDM
(Consulting Physician)
Reg. No.
2005/02/0965

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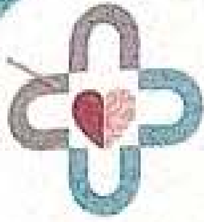

Credence
Care Hospital Pvt. Ltd.

RAMAN CT SCAN & DIAGNOSTIC CENTER

Name: Mr. Nathan Senthil **Age/Sex:33Y/Male**

Date: 24/02/2024

2 D Echocardiography & color Doppler Study

FINDINGS:

- No left ventricle regional wall motion abnormality.
- No left ventricle diastolic dysfunction.
- No left ventricle wall hypertrophy. No LV dilation.
- Normal left ventricle systolic function. LVEF apprx-60%.
- No mitral regurgitation.
- No aortic regurgitation.
- No TR. No pulmonary hypertension.
- Cardiac valves are structurally normal.
- Normal size of cardiac chambers.
- Intact IAS & IVS.
- No LV clot/vegetation/pericardial effusion.
- Normal RV systolic function. No hepatic congestion.

Conclusion:

Normal 2D echo & color Doppler Study.

DR. KUMAR RAJEEV
M.D.(Med),DNB(Cardiology)

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Name: Mr. Nathan Senthil **Age/Sex:33Y/Male**

Date: 24/02/2024

2D Measurements:

LA	35 mm
AORTIC ROOT	28 mm
EF SLOPE	90 mm/sec
LVIDD	40 mm
LVIDS	29 mm
IVS(D)	09 mm
PW(D)	09 mm
RVID	28 mm
LVEF	60%

Doppler study:

AV max -	1.1 m/sec	E vel	0.9 m/sec
PV max -	0.9 m/sec	A vel	0.7 m/sec
PASP		E/A	1.3

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JUMBO DIAGNOSTIC CENTER

THE DIAGNOSTIC SPECIALISTS

Patient Name	: SENTHIL MUTHUMANICKAM	Patient ID:4780
Age /Gender : 30 yrs/MALE		Date : 24/02/2024

X-RAY CHEST PA

Plain P.A. Radiograph of chest shows :-
The hilar shadows are normal in size, position and density.
Both Cardiophrenic and Costophrenic angles are clear.
The Cardiac silhoutte is within normal limits.
Aortic shadow is normal.
Restofthevisualizedmediastinumshadowsarenormal.
Both domes of diaphragms arenormal.
The visualised bony thorax is normal.

CONCLUSION :

NO SIGNIFICANT ABNORMALITY DETECTED

DR. NikunjKothia
MBBS, DMRD Reg-2009093218

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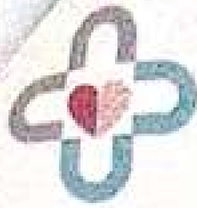

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RAMAN CT SCAN & DIAGNOSTIC CENTER

PATIENT'S NAME	MR. NATHAN SENTHIL	AGE :- 33 y/M
REFERRED BY	CREDENCE CARE HOSPITAL	DATE :24/02/2024

USG WHOLE ABDOMEN

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

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

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

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

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

Urinary Bladder is empty.

PROSTATE is normal in size, shape and echotexture.

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

IMPRESSION –

- **No significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

DR SAGAR GARGE
CONSULTANT RADIOLOGIST

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Patient Name : MR. NATHAN SENTHIL		**Age / Gender**	: 33 Years / Male
Referral Doctor: HEALTH CHRCK UP		**Collection Date**	: 24/02/2024 11:49 AM
Pt.Type / ID : OPD/ 620		**Reporting Date**	: 24/02/2024 03:49 PM

Complete Blood Count (CBC)

Test Description	Value(s)	Unit	Reference Range
Hemoglobin	14.9	gms/dl	13 - 16
RBC Count	4.82	mil./cmm	4.5 - 6.5
Haematocrit (HCT)	43.0	%	40 - 54
RBC Indices			
MCV	89.21	fL	80 - 100
MCH	30.91	pg	27 - 34
MCHC	34.65	gm/dl	32 - 36
RDW-CV	12.0	%	11 - 16
Total WBC Count	8600	/uL	4000 - 10000
DIFFERENTIAL COUNT			
Neutrophil	65	%	40 - 70
Lymphocytes	30	%	20 - 40
Eosinophil	02	%	1 - 6
Monocytes	03	%	2 - 8
Basophils	00	%	0 - 1
Platelet Indices			
Platelet Count	310000	/cmm.	150000 - 450000
RBC Morphology	Normocytic Normochromic		
WBC Morphology	Within Normal Limits		
Platelet	Adequate on smear		

Done on fully Automated cell counter-ERBA H360

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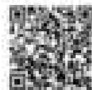

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JUMBO DIAGNOSTIC CENTER
THE DIAGNOSTIC SPECIALISTS

Patient Name : MR. NATHAN SENTHIL
Referral Doctor: HEALTH CHRCK UP
Pt.Type / ID : OPD/ 620

Age / Gender : 33 Years / Male
Collection Date : 24/02/2024 11:49 AM
Reporting Date : 24/02/2024 03:49 PM

ESR (ERYTHROCYTE SEDIMENTATION RATE)

Test Description	Value(s)	Unit	Reference Range
Erythrocyte Sedimentation Rate Wintrobe method	08	mm/hr	< 15

Interpretation: It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

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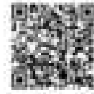

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Referral Doctor: HEALTH CHRCK UP | **Collection Date** : 24/02/2024 11:49 AM
Pt.Type / ID : OPD/ 620 | **Reporting Date** : 24/02/2024 03:49 PM

BLOOD GROUP (BG)

Test Description	Value(s)	Unit	Reference Range
Sample Type : WHOLE BLOOD EDTA			
Blood Group :	B Rh Positive		

METHOD : Monoclonal blood grouping (Agglutination test) by slide method

KIT : Span diagnostics.

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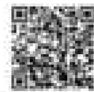

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Age / Gender : 33 Years / Male
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Reporting Date : 24/02/2024 03:49 PM

BLOOD GLUCOSE LEVEL (FASTING & POST PRANDIAL)

Test Description	Value(s)	Unit	Reference Range
Glucose Fasting (Plasma)	89.0	mg/dl	70 - 110
Glucose Urine	Absent		
Glucose PP (Plasma)	110.0	mg/dl	90 - 150

Interpretation : Fasting Blood Sugar more than 126 mg/dl on more than one occasion can indicate Diabetes Mellitus.

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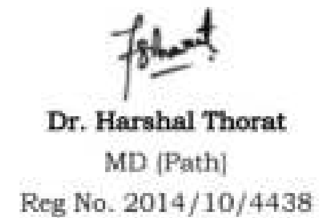

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620

Age / Gender : 33 Years / Male
Collection Date : 24/02/2024 11:49 AM
Reporting Date : 24/02/2024 03:49 PM

GLYCOSYLATED HAEMOGLOBIN (GHB / HBA1c)

Test Description	Value(s)	Unit	Reference Range
HbA1c H.P.L.C	5.8	%	Below 6.0% - Normal Value 6.0% - 7.0% - Good Control 7.0% - 8.0% - Fair Control 8.0% - 10% - Unsatisfactory Control Above 10% - Poor Control

Interpretation: Glycosylated Haemoglobin is acurate and true index of the " Mean Blood Glucose Level in the body for the previous 2-3 months.HbA1c is an indicator of glycemic control. HbA1c represent average glycemia over the past six to eight weeks. Glycation ofhemoglobin occurs the entire 120 days life span of the red blood cell, but with in this 120 days. Recent glycemia has the largestinfluence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in themouth before sampling, 25% in the month before that, and the remaining 25% in months 2-4.

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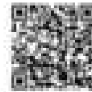
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Collection Date : 24/02/2024 11:49 AM
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LIPID PROFILE

Test Description	Value(s)	Unit	Reference Range
Total Cholesterol	150.0	mg/dl	Low < 125 Desirable : < 200 Borderline High : 201 - 240 High : > 240
Triglycerides	98.0	mg/dl	Low < 25 Normal : < 150 Borderline High : 151 - 199 High : > 200
HDL Cholesterol	41.0	mg/dl	<35 Low >80 High
Non HDL Cholesterol	109.00	mg/dl	Desirable : < 130 Boderline high : 130 - 159 High : > 160
LDL Cholesterol	89.40	mg/dl	Low < 85 Optimal : <100 Near/Above Optimal : 101 - 129 Borderline High : 130 - 159 High : >160
VLDL Cholesterol	19.60	mg/dl	Below 40
TOTAL CHOL/HDL Ratio	3.66	-	Desirable/Low Risk : 3.3 - 4.4 Borderline/Middle Risk : 4.5 - 7.1 Elevated/High Risk : 7.2 - 11.0
LDL/HDL Ratio	2.18	-	Desirable/Low Risk : 0.5 - 3.0 Borderline/Middle Risk : 3.1 - 6.0 Elevated/High Risk : >6.1
Appearance of Serum	Clear		

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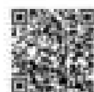
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620

Age / Gender : 33 Years / Male
Collection Date : 24/02/2024 11:49 AM
Reporting Date : 24/02/2024 03:49 PM

THYROID FUNCTION TEST (TFT)

Test Description	Value(s)	Unit	Reference Range
TOTAL TRIIODOTHYRONINE (T3) Competitive Chemi Luminescent Immuno Assay	130.0	ng/dl	60 - 181
TOTAL THYROXINE (T4) Competitive Chemi Luminescent Immuno Assay	5.6	µg/dL	4.5 - 12.6
THYROID STIMULATING HORMONE (TSH) SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY	2.1	uIU/mL	0.3 - 5.5

SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY

Reference range for < 18 years

TEST	1 - 3 D	4 - 30 D	31 - 60 D	61 D - 12 M	1 - 5 Y	6 - 10 Y	11 - 14 Y	15 - 18 Y
TSH	0.1-9.2	0.2-8.5	0.2-7.8	0.30-5.9	0.4-4.8	0.5-4.7	0.5-4.6	0.6-4.5
T3	41.7-272.1	48.2-272.1	54.7-272.1	76.8-272.1	89.2-246.7	87.2-218.1	86.6-199.8	85.3-188.8
T4	4.9-15.8	5-15.3	5.2-14.8	5.7-13.3	5.7-11.7	5.4-10.7	5.2-10	5.1-9.6
FT3	1.5-5.3	1.6-5.2	1.6-5.1	1.8-4.8	2-4.5	2.1-4.4	2.3-4.4	2.3-4.3
FT4	0.84-2.08	0.85-1.98	0.85-1.89	0.89-1.62	0.89-1.48	0.85-1.46	0.84-1.45	0.84-1.45

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JUMBO DIAGNOSTIC CENTER

THE DIAGNOSTIC SPECIALISTS

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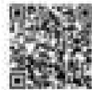
Pt.Type / ID : OPD/	620	**Reporting Date**	: 24/02/2024 03:49 PM

URIC ACID

Test Description	Value(s)	Unit	Reference Range
Uric Acid	5.0	mg/dl	3.5 - 7.2



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BLOOD UREA NITROGEN

Test Description	Value(s)	Unit	Reference Range
BUN* Serum,Calculated	9.0	mg/dL	7 - 18.0

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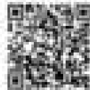

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CREATININE

Test Description	Value(s)	Unit	Reference Range
CREATININE Jaffe IDMS	0.8	mg/dl	0.7 - 1.4

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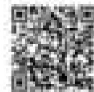
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BUN/CREATININE RATIO

Test Description	Value(s)	Unit	Reference Range
BUN/CREATININE RATIO	11.3	Mg/dL	5 - 20

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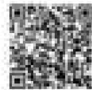
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620

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Collection Date : 24/02/2024 11:49 AM
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LIVER FUNCTION TEST (LFT)

Test Description	Value(s)	Unit	Reference Range
Bilirubin Total	0.72	mg/dL	0.3 - 1.5
Bilirubin Direct	0.32	mg/dL	0.0 - 0.5
Bilirubin Indirect	0.4	mg/dL	0.2 - 0.9
SGOT (AST)	21.0	U/L	0 - 45
SGPT (ALT)	29.0	U/L	0 - 45
Alkaline Phosphatase	192.0	U/L	80 - 306
Protein Total	6.7	g/dL	6 - 8
Albumin	3.6	g/dL	3.2 - 5.0
Globulin	3.10	g/dL	2.5 - 3.3
A/G Ratio	1.16	-	1.0 - 2.1

Checked By

Authenticity Check

Dr. Harshal Thorat
MD (Path)
Reg No. 2014/10/4438

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JUMBO DIAGNOSTIC CENTER
THE DIAGNOSTIC SPECIALISTS

Patient Name : MR. NATHAN SENTHIL
Referral Doctor: HEALTH CHRCK UP
Pt.Type / ID : OPD/ 620

Age / Gender : 33 Years / Male
Collection Date : 24/02/2024 11:49 AM
Reporting Date : 24/02/2024 03:49 PM

GAMMA GT

Test Description	Value(s)	Unit	Reference Range
Gamma Glutaryl Trans Peptidase	12.0	U/L	5 - 40

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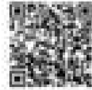
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JUMBO DIAGNOSTIC CENTER
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Patient Name : MR. NATHAN SENTHIL	**Age / Gender** : 33 Years / Male
Referral Doctor: HEALTH CHRCK UP	**Collection Date** : 24/02/2024 11:49 AM
Pt.Type / ID : OPD/ 620	**Reporting Date** : 24/02/2024 03:49 PM

URINE ROUTINE REPORT

Test Description	Value(s)	Unit	Reference Range
	Physical Examination		
Quantity	**20**	ml	-
Colour	Pale Yellow		Pale yellow/Yellow
Appearance	Slightly Hazy		Clear
Specific Gravity	1.010		1.005-1.030
pH	Acidic		Acidic
Deposit	Absent		Absent
	Chemical Examination		
Protein	Trace		Absent
Sugar	Absent		Absent
Ketones	Absent		Absent
Bile Salt	Absent		Absent
Bile Pigment	Absent		Absent
Urobilinogen	Normal		Normal
	Microscopic Examination (/hpf)		
Pus Cell	Occasional		Upto 5
Epithelial Cells	1-2		Upto 5
Red Blood Cells	Absent		Absent
Casts	Absent		Absent
Crystals	Absent		Absent
Bacteria	Absent		Absent

END OF REPORT

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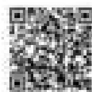
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