

Dr. Vimmi Goel
MBBS, MD (Internal Medicine)
Sr. Consultant Non Invasive Cardiology
Reg. No. MMC-20141010113

Preventive Health Check up
KIMS Kingsway Hospitals
Nagpur
Phone No.: 7499913052

**KIMS-KINGSWAY
HOSPITALS**

Name: Mrs. Runali Dharmakar Date: 27/11/24

Age: 34y Sex: WF Weight: 45 Kg Height: 153.7 Inc BMI: 19.0

BP: 108/62 mmHg Pulse: 83/m bpm RBS: _____ mg/dl

SPO2: 99% LMP - 27/11/24



CLINICAL DIAGNOSTIC LABORATORY DEPARTMENT OF PATHOLOGY

Patient Name : Mrs. Runali Dhamankar	Age / Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324072418/KH63988	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 27-Jan-24 09:53 am	Report Date : 27-Jan-24 11:16 am

HAEMOGRAM

Parameter	Specimen	Results	Biological Reference	Method
Haemoglobin	Blood	7.0	12.0 - 15.0 gm%	Photometric
Haematocrit(PCV)		24.5	36.0 - 46.0 %	Calculated
RBC Count		4.04	3.8 - 4.8 Millions/cumm	Photometric
Mean Cell Volume (MCV)		61	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		17.3	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		26.5	31.5 - 35.0 g/l	Calculated
RDW		18.7	11.5 - 14.0 %	Calculated
Platelet count		334	150 - 450 10 ³ /cumm	Impedance
WBC Count		3100	4000 - 11000 cells/cumm	Impedance
<u>DIFFERENTIAL COUNT</u>				
Neutrophils		55.4	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes		37.6	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils		2.5	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes		4.5	2 - 10 %	Flow Cytometry/Light microscopy
Basophils		0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		1717.4	2000 - 7000 /cumm	Calculated



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF PATHOLOGY

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Parameter	Specimen	Results	Biological Reference Method
Absolute Lymphocyte Count		1165.6	1000 - 4800 /cumm
Absolute Eosinophil Count		77.5	20 - 500 /cumm
Absolute Monocyte Count		139.5	200 - 1000 /cumm
Absolute Basophil Count		0	0 - 100 /cumm
PERIPHERAL SMEAR			
Microcytosis		Microcytosis	Calculated
Hypochromasia		++(11%-20%)	
Anisocytosis		Hypochromia	Calculated
		+(11%-20%)	
Target Cells		Anisocytosis	Calculated
Oval Macrocytes		++(11%-20%)	
WBC		+	
Platelets		Leukopenia	Microscopy
ESR		Adequate	
		23	Automated
		*** End Of Report ***	Westergren's Method

Suggested Clinical Correlation * If necessary, please discuss
Verified By : : 11100354
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Page 2 of 2

DR. VAIDHEE NAIK, MBBS, MD
CONSULTANT PATHOLOGIST





CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. Runali Dhamankar
Age / Gender : 34 Y(s)/Female
Bill No / UMR No : BIL2324072418/KH63988
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 27-Jan-24 09:53 am
Report Date : 27-Jan-24 11:21 am

Parameter	Specimen	Results	Biological Reference	Method
Fasting Plasma Glucose	Plasma	88	< 100 mg/dl	GOD/POD, Colorimetric
Post Prandial Plasma Glucose		101	< 140 mg/dl	GOD/POD, Colorimetric
GLYCOSYLATED HAEMOGLOBIN (HBA1C)				
HBA1c		4.9	Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPIC

*** End Of Report ***

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**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY**

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Received Dt : 27-Jan-24 09:53 am
Age /Gender : 34 Y(s)/Female
Referred By : Dr. Vimmi Goel MBBS,MD
Report Date : 27-Jan-24 11:27 am

LIPID PROFILE

Parameter	Specimen	Results	Method
Total Cholesterol	Serum	124	Enzymatic/CHE/CHO/PO D)
Triglycerides		33	Enzymatic
HDL Cholesterol Direct		41	(Lpase/GK/GPO/POD) Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		71.61	Enzymatic
VLDL Cholesterol		7	Calculated
Tot Chol/HDL Ratio		3	Calculation
Inlitate therapeutic			
CHD OR CHD risk equivalent		>100	LDC-C
Multiple major risk factors conferring 10 yrs CHD risk>20%		>130	<100
Two or more additional major risk factors,10 yrs CHD risk <20%		>160	<130
No additional major risk or one additional major risk factor		>190,optional at 160-189	<160
*** End Of Report ***			
Consider Drug therapy			
		>130, optional at 100-129	

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**Dr. VAIDEHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST**



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. Runali Dharamkar **Age / Gender** : 34 Y(s)/Female
Bill No/ UMR No : BL2324072418/K/H63988 **Referred By** : Dr. Vimmi Goel MBBS, MD
Received Dt : 27-Jan-24 09:53 am **Report Date** : 27-Jan-24 11:27 am

Parameter	Specimen	Result Values	Biological Reference	Method
RFT				
Blood Urea	Serum	14	15.0 - 36.0 mg/dl	Urease with indicator dye
Creatinine		0.47	0.52 - 1.04 mg/dl	Enzymatic (creatinine amidohydrolase)
GFR		128.0	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		144	136 - 145 mmol/L	Direct ion selective electrode
Potassium		4.15	3.5 - 5.1 mmol/L	Direct ion selective electrode
THYROID PROFILE				
T3		1.21	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		1.38	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.06	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence
*** End Of Report ***				

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DR. VAIDHEE NAIK, MBBS, MD



CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. Runali Dhamankar
Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : BIL2324072418/KH63988
Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 27-Jan-24 09:53 am
Report Date : 27-Jan-24 11:27 am

LIVER FUNCTION TEST(LFT)

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Total Bilirubin	Serum	0.45	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		0.25	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.20	0.1 - 1.1 mg/dl	Duel wavelength spectrophotometric
Alkaline Phosphatase		53	38 - 126 U/L	PNPP/AMP buffer
SGPT/ALT		26	13 - 45 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		33	13 - 35 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		7.55	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.30	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.26	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.32		

*** End Of Report ***

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DR. VAIDHEE NAIK, MBBS,MD
CONSULTANT PATHOLOGIST



CLINICAL DIAGNOSTIC LABORATORY

DEPARTMENT OF PATHOLOGY

Patient Name : Mrs. Runali Dhamankar

Bill No/ UMR No : BIL2324072418/KH63988

Received Dt : 27-Jan-24 10:26 am

Age /Gender : 34 Y(s)/Female

Referred By : Dr. Vimmi Goel MBBS, MD

Report Date : 27-Jan-24 12:56 pm

Parameter Specimen Results

Method

URINE MICROSCOPY

PHYSICAL EXAMINATION

Volume Urine 20 ml
 Appearance Pale yellow
 Colour Clear

CHEMICAL EXAMINATION

Reaction (pH) Urine 5.0
 Specific gravity 1.005
 Urine Protein Negative

Indicators
 Ion concentration
 protein error of pH
 Indicator

Sugar Negative
 Bilirubin Negative
 Ketone Bodies Negative

GOD/POD
 Diazonium
 Legal's est Principle

Nitrate Negative
 Urobilinogen Negative

Ehrlich's Reaction

MICROSCOPIC EXAMINATION

Epithelial Cells Urine 0-1
 R.B.C. Absent 0 - 4 /hpf
 Pus Cells 0-1 0 - 4 /hpf
 Casts 0 - 1 0 - 4 /hpf
 Crystals Absent
 USF (URINE SUGAR FASTING) Absent

Manual

Urine Glucose

Urine

Negative

STRUP

*** End Of Report ***

Suggested Clinical Correlation * If necessary, Please discuss

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Dr. VAIDHEE NALK, MBBS, MD

CONSULTANT PATHOLOGIST

44, Parkwada Bhawan, Kinsowak, Nandur - 440 001, Maharashtra, India.

Phone: +91 0712 6789100

CIN: U74999MH2018PTCG303510



**CLINICAL DIAGNOSTIC LABORATORY
DEPARTMENT OF IMMUNO HAEMATOLOGY**

Patient Name : Mrs. Runali Dhamankar	Age /Gender : 34 Y(s)/Female
Bill No / UMR No : BIL2324072418/KH63988	Referred By : Dr. Vimmi Goel MBBS,MD
Received Dt : 27-Jan-24 09:53 am	Report Date : 27-Jan-24 11:46 am

BLOOD GROUPING AND RH

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>
BLOOD GROUP.	EDTA Whole Blood & Plasma/ Serum	"AB"
Rh (D) Typing.		" Positive "(+Ve) *** End Of Report ***

Gel Card Method

Suggested Clinical Correlation * If necessary, please discuss
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**DR. VAIDHEE NALK, MBBS,MD
CONSULTANT PATHOLOGIST**

DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE

NAME	Runali Dhawanekar	STUDY DATE	27-01-2024 10:44:38
AGE/SEX	34Y 7M 2D / F	HOSPITAL NO.	KIK63988
ACCESSION NO.	BLI3324072418-10	MODALITY	DX
REPORTED ON	27-01-2024 11:17	REFERRED BY	Dr. Vinod Goel

X-RAY CHEST PA VIEW

Both the lung fields are clear.

Heart and Aorta are normal

✓ hilar shadows appear normal

Diaphragm domes and CP angles are clear.

Bony cage is normal

IMPRESSION:

No pleuro-parenchymal abnormality seen.



Dr. R.R. KHANDELWAL

SENIOR CONSULTANT

MD, RADIODIAGNOSIS [MMC-55870]

N.B.: This is only a professional opinion and not the final diagnosis. Radiological investigations are subject to variations due to technical limitations.
Hence, correlation with clinical findings and other investigations should be carried out to know true nature of illness.

NAME OF PATIENT:	RUNALI DHAMANKAR	AGE & SEX:	34 YRS/F
UMR NO	KH63988	BILL NO:	23524072418
REF BY:	DR VIMMI GOEL	DATE:	27/01/2024

USG ABDOMEN AND PELVIS

LIVER is normal in size and echotexture. No evidence of any focal lesion seen. Intrahepatic biliary radicals are not dilated. PORTAL VEIN and CBD are normal in course and caliber.

GALL BLADDER is physiologically distended. No stones or sludge seen within it. Wall thickness is within normal limits.

Visualized head and body of PANCREAS is normal in shape, size and echotexture. SPLEEN is normal in size, shape and echotexture. No focal lesion seen.

Both KIDNEYS are normal in shape, size and echotexture. No evidence of calculus or hydronephrosis seen. URETERS are not dilated.

URINARY BLADDER is well distended. No calculus or mass lesion seen. Uterus is anteverted and normal.

No focal myometrial lesion seen. Endometrial echo-complex appear normal. No adnexal mass lesion seen.

There is no free fluid or abdominal lymphadenopathy seen.

IMPRESSION: USG reveals,
No significant visceral abnormality seen.



DR. R.R. KHANDELWAL
SENIOR CONSULTANT
MD RADIO DIAGNOSIS [MMC-55870]

2D ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT

Patient Name : Mrs. Runal Dhankar
 Age : 34 years / Female
 UMR : KH63988
 Date : 27/01/2024
 Done by : Dr. Vimmi Goel
 ECG : NSR, WNL
 Blood pressure: 108/62 mm Hg (Right arm, Supine position)
 BSA : 1.38 m²

Impression:

Normal chambers dimensions
No RWMA of LV at rest
Good LV systolic function, LVEF 59%
Normal LV diastolic function
E/A is 1.5
E/E' is 8.8 (Normal filling pressure)
Valves are normal
Trivial MR
Trivial TR, No pulmonary hypertension
IVC is normal in size and collapsing well with respiration
No clots or pericardial effusion
IAS aneurysm seen with concavity towards LA

Comments:

Sector echocardiography was performed in various conventional views (PLAX, SSAX, AP4 CH and 5 CH views), LV size normal. There is no RWMA of LV seen at rest. Good LV systolic function. LVEF 59%. Normal LV diastolic function. E Velocity is 128 cm/s, A Velocity is 86 cm/s. E/A is 1.5. Valves are normal. Trivial MR. Trivial TR. No Pulmonary Hypertension. IVC pericardial effusion seen.
 E' at medial mitral annulus is 13.7 cm/sec & at lateral mitral annulus is 14.3 cm/sec. E/E' is 8.8 (Average).

M Mode echocardiography and dimension:

	Normal range (mm) (adults) (children)	Observed (mm)
Left atrium	19-40	29
Aortic root	20-37	21
LVIDd	35-55	41
LVIDs	23-39	25
IVS (d)	6-11	09
LVPW (d)	6-11	09
LVEF %	~ 60%	59%
Fractional Shortening	~ 60%	28%

P.T.O


Dr. Vimmi Goel
MD, Sr. Consultant
Non-invasive Cardiology

34 Years

MRS RUNALI DHAMANKAR
Female

27-Jan-24 12:30:44 PM

KIMS-KINGSWAY HOSPITALS

PHC DEPT.

Rate 76 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Baseline wander in lead(s) V1,V6

PR 156
QRSD 87
QT 373
QTc 420

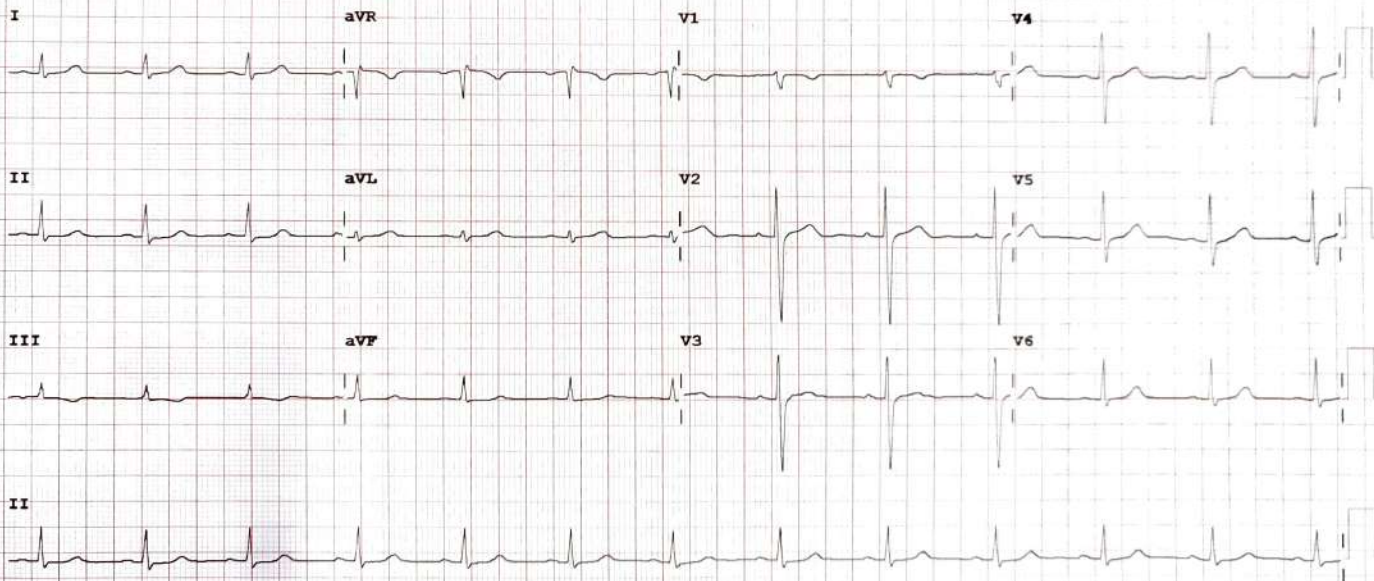
--AXIS--

P 21
QRS 52
T 10

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50~ 0.50-150 Hz W 100B CL P?