

**PHYSICAL EXAMINATION REPORT**

Patient Name	Hannant Asolkar	Sex/Age	M/54
Date	28/10/23	Location	Thane

**History and Complaints**

Nil

**EXAMINATION FINDINGS:**

Height (cms):	165	Temp (0c):	
Weight (kg):	88	Skin:	
Blood Pressure	140/90	Nails:	
Pulse	76/min	Lymph Node:	

②  
 Eczematous Patches on legs (f)  
 NAD

**Systems :**

Cardiovascular:

Respiratory:

Genitourinary:

GI System:

CNS:

**Impression:**

- BSL < Pp (Impaired) . ↑ HbA1c (Pre Diabetic)  
 - ↑ TG's, ↓ HDL, ↑ Non HDL.  
 - Cholelithiasis . 1 LVH .

**Advice:**

- Low Fat, Low sugar Diet.
- Reg. Exercise.
- Repeat sugar Profile, Lipid Profile, USG after 6 Months.
- Monitor B.P.

- |     |                                      |
|-----|--------------------------------------|
| 1)  | Hypertension:                        |
| 2)  | IHD                                  |
| 3)  | Arrhythmia                           |
| 4)  | Diabetes Mellitus                    |
| 5)  | Tuberculosis                         |
| 6)  | Asthama                              |
| 7)  | Pulmonary Disease                    |
| 8)  | Thyroid/ Endocrine disorders         |
| 9)  | Nervous disorders                    |
| 10) | GI system                            |
| 11) | Genital urinary disorder             |
| 12) | Rheumatic joint diseases or symptoms |
| 13) | Blood disease or disorder            |
| 14) | Cancer/lump growth/cyst              |
| 15) | Congenital disease                   |
| 16) | Surgeries                            |
| 17) | Musculoskeletal System               |

Nil

Nil

PA/RA: Nil

**PERSONAL HISTORY:**

- |    |            |
|----|------------|
| 1) | Alcohol    |
| 2) | Smoking    |
| 3) | Diet       |
| 4) | Medication |

No. mixed.

No.

*[Signature]*  
**Dr. Manasee Kulkarni**  
 M.B.B.S  
 2005/0019439  
 31/10/20



Date:- 28/10/23  
 Name:- Harshvardhan Ashokrao  
 CID: 233  
 Sex / Age: M / 54

DOB - 17/10/1969

**EYE CHECK UP**

Chief complaints: RCW

Systemic Diseases: All

Past history: All

Unaided Vision: 032 6/6 HVBC 24/6

Aided Vision: 032 6/6 HVBC 46

Refraction:

(Right Eye)

(Left Eye)

	Sph	Cyl	Axis	Vn	Sph	Cyl	Axis	Vn
Distance								
Near								

Colour Vision: Normal / Abnormal

Remark: RCW over Spect

MR. PRAKASH KUDVA  
 SR. OPTOMETRIST



CID : 2330120071  
Name : MR.ASOLKAR HANUMANT RAMCHANDRA  
Age / Gender : 54 Years / Male  
Consulting Dr. : -  
Reg. Location : G B Road, Thane West (Main Centre)

Collected : 28-Oct-2023 / 10:17  
Reported : 28-Oct-2023 / 13:01

**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**

**CBC (Complete Blood Count), Blood**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
<b>RBC PARAMETERS</b>			
Haemoglobin	15.8	13.0-17.0 g/dL	Spectrophotometric
RBC	5.19	4.5-5.5 mil/cmm	Elect. Impedance
PCV	46.0	40-50 %	Measured
MCV	88.5	80-100 fl	Calculated
MCH	30.5	27-32 pg	Calculated
MCHC	34.4	31.5-34.5 g/dL	Calculated
RDW	15.6	11.6-14.0 %	Calculated
<b>WBC PARAMETERS</b>			
WBC Total Count	5270	4000-10000 /cmm	Elect. Impedance
<b>WBC DIFFERENTIAL AND ABSOLUTE COUNTS</b>			
Lymphocytes	19.0	20-40 %	
Absolute Lymphocytes	1001.3	1000-3000 /cmm	Calculated
Monocytes	8.3	2-10 %	
Absolute Monocytes	437.4	200-1000 /cmm	Calculated
Neutrophils	68.9	40-80 %	
Absolute Neutrophils	3631.0	2000-7000 /cmm	Calculated
Eosinophils	3.6	1-6 %	
Absolute Eosinophils	189.7	20-500 /cmm	Calculated
Basophils	0.2	0.1-2 %	
Absolute Basophils	10.5	20-100 /cmm	Calculated
Immature Leukocytes	-		
WBC Differential Count by Absorbance & Impedance method/Microscopy.			
<b>PLATELET PARAMETERS</b>			
Platelet Count	227000	150000-400000 /cmm	Elect. Impedance
MPV	8.6	6-11 fl	Calculated
PDW	10.3	11-18 %	Calculated
<b>RBC MORPHOLOGY</b>			
Hypochromia	-		
Microcytosis	-		



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Macrocytosis -  
Anisocytosis -  
Poikilocytosis -  
Polychromasia -  
Target Cells -  
Basophilic Stippling -  
Normoblasts -  
Others Normocytic, Normochromic  
WBC MORPHOLOGY -  
PLATELET MORPHOLOGY -  
COMMENT -

Specimen: EDTA Whole Blood

ESR, EDTA WB-ESR 6 2-20 mm at 1 hr. Sedimentation

\*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD G B Road Lab, Thane West  
\*\*\* End Of Report \*\*\*



*J. Mujawar*

Dr. IMRAN MUJAWAR  
M.D ( Path )  
Pathologist

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Reported : 28-Oct-2023 / 17:49

**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
GLUCOSE (SUGAR) FASTING, Fluoride Plasma	106.7	Non-Diabetic: < 100 mg/dl Impaired Fasting Glucose: 100-125 mg/dl Diabetic: >= 126 mg/dl	Hexokinase
GLUCOSE (SUGAR) PP, Fluoride Plasma PP/R	196.1	Non-Diabetic: < 140 mg/dl Impaired Glucose Tolerance: 140-199 mg/dl Diabetic: >= 200 mg/dl	Hexokinase
Urine Sugar (Fasting)	Absent	Absent	
Urine Ketones (Fasting)	Absent	Absent	
Urine Sugar (PP)	Absent	Absent	
Urine Ketones (PP)	Absent	Absent	

\*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD G B Road Lab, Thane West  
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*J. Mujawar*

**Dr.IMRAN MUJAWAR**  
M.D ( Path )  
Pathologist





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Collected : 28-Oct-2023 / 10:17  
Reported : 28-Oct-2023 / 18:30

**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**  
**KIDNEY FUNCTION TESTS**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
BLOOD UREA, Serum	25.1	19.29-49.28 mg/dl	Calculated
BUN, Serum	11.7	9.0-23.0 mg/dl	Urease with GLDH
CREATININE, Serum	0.85	0.73-1.18 mg/dl	Enzymatic
Note: Kindly note in change in reference range w.e.f. 07-09-2023			
eGFR, Serum	103	(ml/min/1.73sqm) Normal or High: Above 90 Mild decrease: 60-89 Mild to moderate decrease: 45-59 Moderate to severe decrease: 30-44 Severe decrease: 15-29 Kidney failure: <15	Calculated
Note: eGFR estimation is calculated using 2021 CKD-EPI GFR equation w.e.f 16-08-2023			
TOTAL PROTEINS, Serum	7.6	5.7-8.2 g/dL	Biuret
ALBUMIN, Serum	4.4	3.2-4.8 g/dL	BCG
GLOBULIN, Serum	3.2	2.3-3.5 g/dL	Calculated
A/G RATIO, Serum	1.4	1 - 2	Calculated
URIC ACID, Serum	6.9	3.7-9.2 mg/dl	Uricase/ Peroxidase
PHOSPHORUS, Serum	2.6	2.4-5.1 mg/dl	Phosphomolybdate
CALCIUM, Serum	9.4	8.7-10.4 mg/dl	Arsenazo
SODIUM, Serum	138	136-145 mmol/l	IMT
POTASSIUM, Serum	5.1	3.5-5.1 mmol/l	IMT
CHLORIDE, Serum	103	98-107 mmol/l	IMT

\*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD SDRL, Vidyavihar Lab  
\*\*\* End Of Report \*\*\*



*Dr. Vrushali Shroff*

**Dr.VRUSHALI SHROFF**  
M.D.(PATH)  
Pathologist





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Reported : 28-Oct-2023 / 14:15

**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**

**GLYCOSYLATED HEMOGLOBIN (HbA1c)**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
Glycosylated Hemoglobin (HbA1c), EDTA WB - CC	6.1	Non-Diabetic Level: < 5.7 % Prediabetic Level: 5.7-6.4 % Diabetic Level: >= 6.5 %	HPLC
Estimated Average Glucose (eAG), EDTA WB - CC	128.4	mg/dl	Calculated

**Intended use:**

- In patients who are meeting treatment goals, HbA1c test should be performed at least 2 times a year
- In patients whose therapy has changed or who are not meeting glycemic goals, it should be performed quarterly
- For microvascular disease prevention, the HbA1C goal for non pregnant adults in general is Less than 7%.

**Clinical Significance:**

- HbA1c, Glycosylated hemoglobin or glycated hemoglobin, is hemoglobin with glucose molecule attached to it.
- The HbA1c test evaluates the average amount of glucose in the blood over the last 2 to 3 months by measuring the percentage of glycosylated hemoglobin in the blood.

**Test Interpretation:**

- The HbA1c test evaluates the average amount of glucose in the blood over the last 2 to 3 months by measuring the percentage of Glycosylated hemoglobin in the blood.
- HbA1c test may be used to screen for and diagnose diabetes or risk of developing diabetes.
- To monitor compliance and long term blood glucose level control in patients with diabetes.
- Index of diabetic control, predicting development and progression of diabetic micro vascular complications.

**Factors affecting HbA1c results:**

**Increased in:** High fetal hemoglobin, Chronic renal failure, Iron deficiency anemia, Splenectomy, Increased serum triglycerides, Alcohol ingestion, Lead/opiate poisoning and Salicylate treatment.

**Decreased in:** Shortened RBC lifespan (Hemolytic anemia, blood loss), following transfusions, pregnancy, ingestion of large amount of Vitamin E or Vitamin C and Hemoglobinopathies

**Reflex tests:** Blood glucose levels, CGM (Continuous Glucose monitoring)

**References:** ADA recommendations, AACC, Wallach's interpretation of diagnostic tests 10th edition.

\*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD G B Road Lab, Thane West  
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*Dr. Imran Mujawar*

**Dr. IMRAN MUJAWAR**  
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Pathologist





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Reported : 28-Oct-2023 / 15:06

**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**  
**PROSTATE SPECIFIC ANTIGEN (PSA)**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
TOTAL PSA, Serum	0.284	<4.0 ng/ml	CLIA

**Clinical Significance:**

- PSA is detected in the serum of males with normal, benign hyper-plastic, and malignant prostate tissue.
- Monitoring patients with a history of prostate cancer as an early indicator of recurrence and response to treatment.
- Prostate cancer screening 4.The percentage of Free PSA (FPSA) in serum is described as being significantly higher in patients with BPH than in patients with prostate cancer. 5.Calculation of % free PSA (ie. FPSA/TPSA x 100 ), has been suggested as way of improving the differentiation of BPH and Prostate cancer.

**Interpretation:**

**Increased In-** Prostate diseases,Cancer,Prostatitis, Benign prostatic hyperplasia, Prostatic ischemia, Acute urinary retention, Manipulations like Prostatic massage, Cystoscopy, Needle biopsy, Transurethral resection,Digital rectal examination, Radiation therapy, Indwelling catheter, Vigorous bicycle exercise, Drugs (e.g., testosterone), Physiologic fluctuations. Also found in small amounts in other cancers (sweat and salivary glands, breast, colon, lung, ovary) and in Skene glands of female urethra and in term placenta ,Acute renal failure, Acute myocardial infarction,

**Decreased In-** Ejaculation within 24-48 hours, Castration, Antiandrogen drugs (e.g., finasteride), Radiation therapy, Prostatectomy, PSA falls 17% in 3 days after lying in hospital, Artfactual (e.g., improper specimen collection; very high PSA levels).Finasteride (5- $\alpha$ -reductase inhibitor) reduces PSA by 50% after 6 months in men without cancer.

Reflex Tests: % FREE PSA , USG Prostate

**Limitations:**

- tPSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of croneous medical interpretations. If there is a change in the tPSA assay procedure used while monitoring therapy, then the tPSA values obtained upon changing over to the new procedure must be confirmed by parallelmeasurements with both methods. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels.
- Patients who have been regularly exposed to animals or have received immunotherapy or diagnostic procedures utilizing immunoglobulins or immunoglobulin fragments may produce antibodies, e.g. HAMA, that interferes with immunoassays.
- PSA results should be interpreted in light of the total clinical presentation of the patient, including: symptoms, clinical history, data from additional tests, and other appropriate information.
- Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of prostate cancer.

**Reference:**

- Wallach's Interpretation of diagnostic tests
- Total PSA Pack insert

\*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD SDRL, Vidyavihar Lab  
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*Anupa*

**Dr.ANUPA DIXIT**  
M.D.(PATH)  
Consultant Pathologist & Lab Director





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Reported : 28-Oct-2023 / 15:00

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**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**  
**URINE EXAMINATION REPORT**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
<b>PHYSICAL EXAMINATION</b>			
Color	Pale yellow	Pale Yellow	-
Reaction (pH)	Acidic (6.5)	4.5 - 8.0	Chemical Indicator
Specific Gravity	1.030	1.010-1.030	Chemical Indicator
Transparency	Slight hazy	Clear	-
Volume (ml)	40	-	-
<b>CHEMICAL EXAMINATION</b>			
Proteins	Absent	Absent	pH Indicator
Glucose	Absent	Absent	GOD-POD
Ketones	Absent	Absent	Legals Test
Blood	Absent	Absent	Peroxidase
Bilirubin	Absent	Absent	Diazonium Salt
Urobilinogen	Normal	Normal	Diazonium Salt
Nitrite	Absent	Absent	Griess Test
<b>MICROSCOPIC EXAMINATION</b>			
Leukocytes(Pus cells)/hpf	1-2	0-5/hpf	
Red Blood Cells / hpf	Absent	0-2/hpf	
Epithelial Cells / hpf	2-3		
Casts	Absent	Absent	
Crystals	Absent	Absent	
Amorphous debris	Absent	Absent	
Bacteria / hpf	4-5	Less than 20/hpf	
Others	-		

Interpretation: The concentration values of Chemical analytes corresponding to the grading given in the report are as follows:

- Protein ( 1+ = 25 mg/dl , 2+ =75 mg/dl , 3+ = 150 mg/dl , 4+ = 500 mg/dl )
- Glucose(1+ = 50 mg/dl , 2+ =100 mg/dl , 3+ =300 mg/dl , 4+ =1000 mg/dl )
- Ketone (1+ =5 mg/dl , 2+ = 15 mg/dl , 3+ = 50 mg/dl , 4+ = 150 mg/dl )

Reference: Pack inert

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Reported : 28-Oct-2023 / 16:22

**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**  
**BLOOD GROUPING & Rh TYPING**

PARAMETER	RESULTS
ABO GROUP	B
Rh TYPING	Positive

NOTE: Test performed by Semi- automated column agglutination technology (CAT)

Specimen: EDTA Whole Blood and/or serum

**Clinical significance:**  
ABO system is most important of all blood group in transfusion medicine

**Limitations:**

- ABO blood group of new born is performed only by cell (forward) grouping because allo antibodies in cord blood are of maternal origin.
- Since A & B antigens are not fully developed at birth, both Anti-A & Anti-B antibodies appear after the first 4 to 6 months of life. As a result, weaker reactions may occur with red cells of newborns than of adults.
- Confirmation of newborn's blood group is indicated when A & B antigen expression and the isoagglutinins are fully developed at 2 to 4 years of age & remains constant throughout life.
- Cord blood is contaminated with Wharton's jelly that causes red cell aggregation leading to false positive result
- The Hh blood group also known as Oh or Bombay blood group is rare blood group type. The term Bombay is used to refer the phenotype that lacks normal expression of ABH antigens because of inheritance of hh genotype.

**References:**

1. Denise M Harmening, Modern Blood Banking and Transfusion Practices- 6th Edition 2012. F.A. Davis company, Philadelphia
2. AABB technical manual

\*Sample processed at SUBURBAN DIAGNOSTICS (INDIA) PVT. LTD G B Road Lab, Thane West  
\*\*\* End Of Report \*\*\*



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**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**  
**LIPID PROFILE**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
CHOLESTEROL, Serum	178.0	Desirable: <200 mg/dl Borderline High: 200-239mg/dl High: >=240 mg/dl	CHOD-POD
TRIGLYCERIDES, Serum	199.8	Normal: <150 mg/dl Borderline-high: 150 - 199 mg/dl High: 200 - 499 mg/dl Very high:>=500 mg/dl	Enzymatic colorimetric
HDL CHOLESTEROL, Serum	33.3	Desirable: >60 mg/dl Borderline: 40 - 60 mg/dl Low (High risk): <40 mg/dl	Elimination/ Catalase
NON HDL CHOLESTEROL, Serum	144.7	Desirable: <130 mg/dl Borderline-high:130 - 159 mg/dl High:160 - 189 mg/dl Very high: >=190 mg/dl	Calculated
LDL CHOLESTEROL, Serum	104.1	Optimal: <100 mg/dl Near Optimal: 100 - 129 mg/dl Borderline High: 130 - 159 mg/dl High: 160 - 189 mg/dl Very High: >= 190 mg/dl	Calculated
VLDL CHOLESTEROL, Serum	40.6	< /= 30 mg/dl	Calculated
CHOL / HDL CHOL RATIO, Serum	5.3	0-4.5 Ratio	Calculated
LDL CHOL / HDL CHOL RATIO, Serum	3.1	0-3.5 Ratio	Calculated

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\*\*\* End Of Report \*\*\*



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**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**  
**THYROID FUNCTION TESTS**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
Free T3, Serum	5.5	3.5-6.5 pmol/L	ECLIA
Free T4, Serum	16.6	11.5-22.7 pmol/L	ECLIA
sensitiveTSH, Serum	1.35	0.35-5.5 microIU/ml	ECLIA

**Interpretation:**

A thyroid panel is used to evaluate thyroid function and/or help diagnose various thyroid disorders.

**Clinical Significance:**

- 1)TSH Values between high abnormal upto15 microIU/ml should be correlated clinically or repeat the test with new sample as physiological factors can give falsely high TSH.
- 2)TSH values may be transiently altered because of non thyroidal illness like severe infections,liver disease, renal and heart severe burns, trauma and surgery etc.

TSH	FT4 / T4	FT3 / T3	Interpretation
High	Normal	Normal	Subclinical hypothyroidism, poor compliance with thyroxine, drugs like amiodarone, Recovery phase of non-thyroidal illness, TSH Resistance.
High	Low	Low	Hypothyroidism, Autoimmune thyroiditis, post radio iodine Rx, post thyroidectomy, Anti thyroid drugs, tyrosine kinase inhibitors & amiodarone, amyloid deposits in thyroid, thyroid tumors & congenital hypothyroidism.
Low	High	High	Hyperthyroidism, Graves disease, toxic multinodular goiter, toxic adenoma, excess iodine or thyroxine intake, pregnancy related (hyperemesis gravidarum, hydatiform mole)
Low	Normal	Normal	Subclinical Hyperthyroidism, recent Rx for Hyperthyroidism, drugs like steroids & dopamine), Non thyroidal illness.
Low	Low	Low	Central Hypothyroidism, Non Thyroidal Illness, Recent Rx for Hyperthyroidism.
High	High	High	Interfering anti TPO antibodies, Drug interference: Amiodarone, Heparin, Beta Blockers, steroids & anti epileptics.

**Diurnal Variation:**TSH follows a diurnal rhythm and is at maximum between 2 am and 4 am , and is at a minimum between 6 pm and 10 pm. The variation is on the order of 50 to 206%. Biological variation:19.7%(with in subject variation)

**Reflex Tests:**Anti thyroid Antibodies,USG Thyroid ,TSH receptor Antibody. Thyroglobulin, Calcitonin

**Limitations:**

1. Samples should not be taken from patients receiving therapy with high biotin doses (i.e. >5 mg/day) until atleast 8 hours following the last biotin administration.
2. Patient samples may contain heterophilic antibodies that could react in immunoassays to give falsely elevated or depressed results. this assay is designed to minimize interference from heterophilic antibodies.

**Reference:**

- 1.O.koulouri et al. / Best Practice and Research clinical Endocrinology and Metabolism 27(2013)
- 2.Interpretation of the thyroid function tests, Dayan et al. THE LANCET . Vol 357
- 3.Tietz ,Text Book of Clinical Chemistry and Molecular Biology -5th Edition
- 4.Biological Variation:From principles to Practice-Callum G Fraser (AACC Press)



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**MEDIWHEEL FULL BODY HEALTH CHECKUP MALE ABOVE 40/2D ECHO**  
**LIVER FUNCTION TESTS**

PARAMETER	RESULTS	BIOLOGICAL REF RANGE	METHOD
BILIRUBIN (TOTAL), Serum	0.51	0.3-1.2 mg/dl	Vanadate oxidation
BILIRUBIN (DIRECT), Serum	0.18	0-0.3 mg/dl	Vanadate oxidation
BILIRUBIN (INDIRECT), Serum	0.33	<1.2 mg/dl	Calculated
TOTAL PROTEINS, Serum	7.6	5.7-8.2 g/dL	Biuret
ALBUMIN, Serum	4.4	3.2-4.8 g/dL	BCG
GLOBULIN, Serum	3.2	2.3-3.5 g/dL	Calculated
A/G RATIO, Serum	1.4	1 - 2	Calculated
SGOT (AST), Serum	21.7	<34 U/L	Modified IFCC
SGPT (ALT), Serum	31.5	10-49 U/L	Modified IFCC
GAMMA GT, Serum	32.9	<73 U/L	Modified IFCC
ALKALINE PHOSPHATASE, Serum	67.9	46-116 U/L	Modified IFCC

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\*\*\* End Of Report \*\*\*



*Dr. Vrushali Shroff*

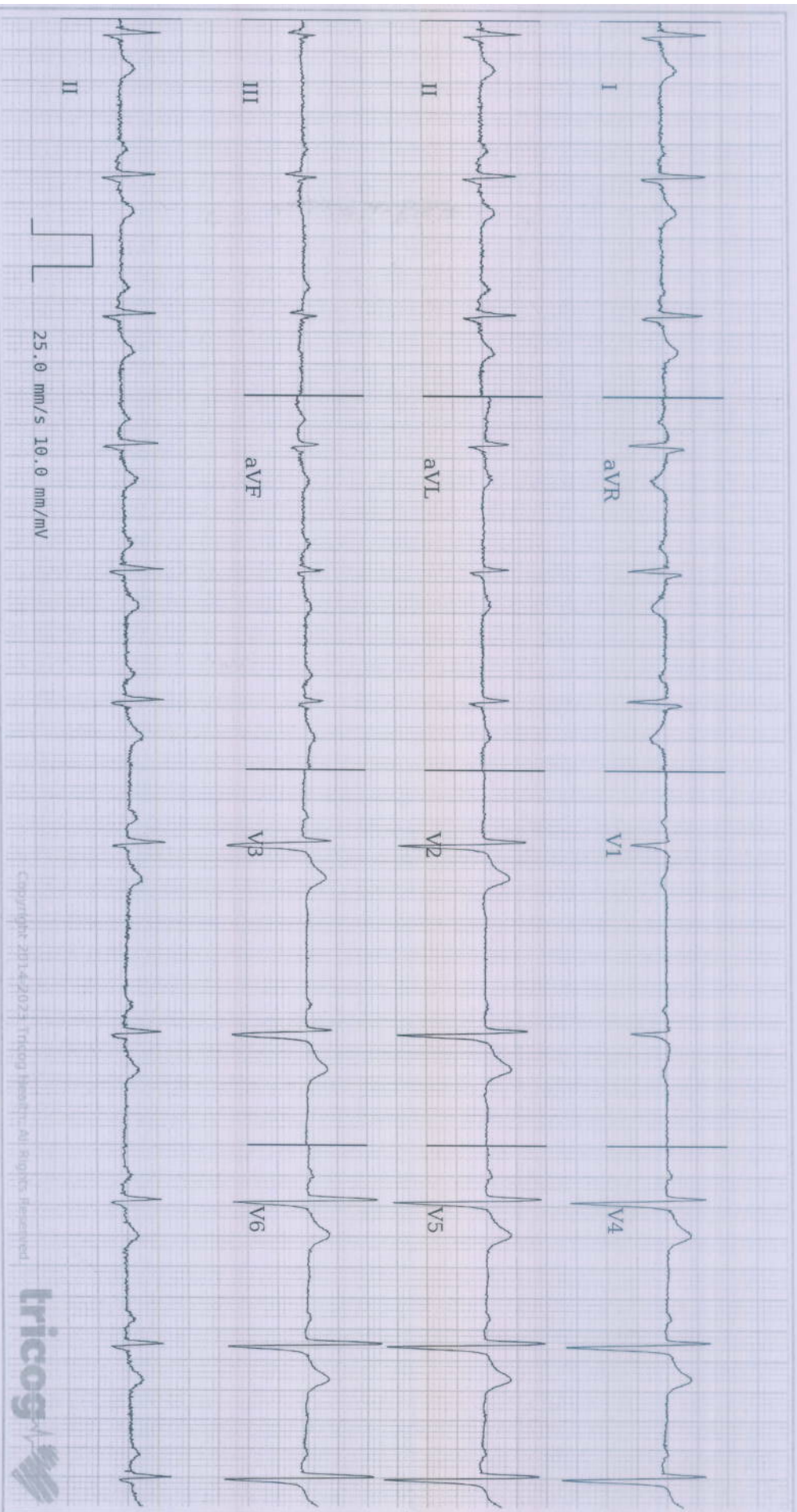
**Dr.VRUSHALI SHROFF**  
M.D.(PATH)  
Pathologist



Patient Name: ASOLKAR HANUMANT  
RAMCHANDRA  
Patient ID: 2330120071

**SUBURBAN DIAGNOSTICS - G B ROAD, THANE WEST**

Date and Time: 28th Oct 23 11:58 AM



25.0 mm/s 10.0 mm/mV

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Age **54** NA NA  
years months days

Gender **Male**

Heart Rate **64bpm**

Patient Vitals

BP: 140/90 mmHg

Weight: 88 kg

Height: 165 cm

Pulse: NA

Spo2: NA

Resp: NA

Others:

Measurements

QRSD: 98ms

QT: 366ms

QTcB: 377ms

PR: 176ms

P-R-T: 56° 31° 35°

REPORTED BY

DR SHAILAJA PILLAI  
MBBS, MD Physician  
MD Physician  
49972

ECG Within Normal Limits: Sinus Rhythm, Sinus Arrhythmia Seen. Please correlate clinically.

Disclaimer: 1) Analysis in this report is based on ECG alone and should be used in an adjunct to clinical history, symptoms, and results of other invasive and non-invasive tests and must be interpreted by a qualified physician. 2) Patient vitals are as reported by the clinician and not derived from the ECG.



CID : 2330120071  
Name : Mr ASOLKAR HANUMANT  
RAMCHANDRA  
Age / Sex : 54 Years/Male  
Ref. Dr :  
Reg. Location : G B Road, Thane West Main Centre  
Reg. Date : 28-Oct-2023  
Reported : 28-Oct-2023 / 14:59

Use a QR Code Scanner  
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### X-RAY CHEST PA VIEW

Both lung fields are clear.  
Both costo-phrenic angles are clear.  
The cardiac size and shape are within normal limits.  
The domes of diaphragm are normal in position and outlines.  
The skeleton under review appears normal.

#### IMPRESSION:

**NO SIGNIFICANT ABNORMALITY IS DETECTED.**

-----End of Report-----

*G. R. Fartade*

Dr.GAURAV FARTADE  
MBBS, DMRE  
Reg No -2014/04/1786  
Consultant Radiologist

[Click here to view images <<ImageLink>>](#)



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Ref. Dr :  
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Reg. Date : 28-Oct-2023  
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**USG WHOLE ABDOMEN**

**LIVER:** Liver appears normal in size(13.9 cm) and *shows increased echorefectivity*. There is no intra-hepatic biliary radical dilatation. No evidence of any focal lesion.

**GALL BLADDER:** *Gall bladder is distended ,Shows few GB calculi largest measuirng 7 to 8 mm.*No peri-cholecystic collection seen.

**PORTAL VEIN:** Portal vein is normal. **CBD:** CBD is normal.

**PANCREAS:** Pancreas appears normal in echotexture. There is no evidence of any focal lesion or calcification. Pancreatic duct is not dilated.

**KIDNEYS:** Right kidney measures 10.1 x 4.6 cm. Left kidney measures 10.2 x 4.7 cm. Both kidneys are normal in shape and echotexture. Corticomedullary differentiation is maintained. There is no evidence of any hydronephrosis, hydroureter or calculus.

**SPLEEN:** Spleen is normal in size, shape and echotexture. No focal lesion is seen.

**URINARY BLADDER:** Urinary bladder is distended and normal. Wall thickness is within normal limits.

**PROSTATE:** Prostate is normal in size and echotexture and measures 2.7 x 2.9 x 3.7 cm in dimension and 16 cc in volume. No evidence of any focal lesion. Median lobe does not show significant hypertrophy.

No free fluid or significant lymphadenopathy is seen.

Click here to view images <http://3.111.232.119/iRISViewer/NeoradViewer?AccessionNo=2023102809560816>





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**IMPRESSION:**

**CHOLELITHIASIS WITHOUT CHOLECYSTITIS.**

**Advice: Clinical co-relation, further evaluation and follow up.**

Note: Investigations have their limitations. Solitary radiological investigations never confirm the final diagnosis. They only help in diagnosing the disease in correlation to clinical symptoms and other related tests. USG is known to have inter-observer variations. Further/follow-up imaging may be needed in some cases for confirmation / exclusion of diagnosis.

-----End of Report-----

**Dr Gauri Varma**  
**Consultant Radiologist**  
**MBBS / DMRE**  
**MMC- 2007/12/4113**

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Page no 2 of 2

REG NO : 2330120071	SEX : MALE
NAME : MR. HANUMANT RAMCHANDRA ASOLKAR	AGE : 54 YRS
REF BY : -----	DATE : 28.10.2023

**2D ECHOCARDIOGRAPHY**

**M - MODE FINDINGS:**

LVIDD	52	mm
LVIDS	30	mm
LVEF	60	%
IVS	14	mm
PW	10	mm
AO	15	mm
LA	33	mm

**2D ECHO:**

- All cardiac chambers are normal in size
- Left ventricular contractility : Normal
- Regional wall motion abnormality : Absent.
- Systolic thickening : Normal. LVEF = 60%
- Mitral, tricuspid , aortic , pulmonary valves are : Normal.
- Great arteries : Aorta and pulmonary artery are : Normal .
- Inter - arterial and inter - ventricular septum are intact .
- Pulmonary veins , IVC , hepatic veins are normal.
- No pericardial effusion . No intracardiac clots or vegetation.

**OUR PRESENCE**

022-6170-0000



**PATIENT NAME : MR.HANUMANT RAMCHANDRA ASOLKAR**

**COLOR DOPPLER:**

- Mitral valve doppler – E- 0.9 m/s, A- 0.4 m/s.
- Mild TR.
- No aortic / mitral regurgitation. Aortic velocity 1.4 m/s, PG 8.1 mmHg
- No significant gradient across aortic valve.
- No diastolic dysfunction.

**IMPRESSION:**

- **MILD CONCENTRIC HYPERTROPHY OF LV**
- **NO REGIONAL WALL MOTION ABNORMALITY AT REST.**
- **NORMAL LV SYSTOLIC FUNCTION.**

-----End of the Report-----



**DR.YOGESH KHARCHE**  
**DNB(MEDICINE) DNB (CARDIOLOGY)**  
**CONSULTANT INTERVENTIONAL CARDIOLOGIST.**