

Dr. Vimmi Goel  
 MBBS, MD (Internal Medicine)  
 Sr. Consultant Non Invasive Cardiology  
 Reg. No: MMC- 2014/01/0113

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

Medi-Wheel  
 Plo → Hiranghad  
**KIMS-KINGSWAY  
 HOSPITALS**

Name: Mr. Sagar Petar. Date: 13/01/24

Age: 41y Sex: M/F Weight: 76.4 kg Height: 170.3 inc BMI: 26.3

BP: 150/100 mmHg Pulse: 100 bpm RBS: \_\_\_\_\_ mg/dl  
 SpO2 - 98%

- 41/M
- Syrr. HT  
 (Metosartan 50 OD)
  - Smoker 2 cigs/d
  - Alcohol - 90 ml/d.
  - FH - DM+ (Elder Brother)
  - NIDDM (new)  
 FBS - 259  
 PMBS - 362  
 HbA1c - 9.7
  - Dyslipidemia  
 TG - 214  
 LDL - 129
  - Fatty Liver
  - 2D - Mild LM
  - ECG - T ↓  
 Hb - 17.7  
 O/E

STOP SMOKING  
 ✓ ALCOHOL

Adv.

- Dietician Referral
- TMT (after BP control)
- 1. T. Gemer - 1 1 1  
 (Before meals)
- 2. T. Metosartan 50 2 X X  
~~ABR~~ A/D
- 3. T. Amloz 5 1 X X  
 ABR
- 4. T. Roseday F X 1 1  
 (90) A/D
- 5. ~~Roap~~ T. Elosprin 75 X 1 X  
A/L

Jr<sup>o</sup>  
 Chem  
 in  
 PIA X

• R/A 15d E F & PIMBS

**DR. VIMMI GOEL**



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mr. SAGAR RETAR	<b>Age /Gender</b> : 41 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324069414/UMR2324033712	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 13-Jan-24 08:23 am	<b>Report Date</b> : 13-Jan-24 10:32 am

**HAEMOGRAM**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Haemoglobin	Blood	<del>17.7</del>	13.0 - 17.0 gm%	Photometric
Haematocrit(PCV)		<del>52.1</del>	40.0 - 50.0 %	Calculated
RBC Count		<del>5.97</del>	4.5 - 5.5 Millions/cumm	Photometric
Mean Cell Volume (MCV)		87	83 - 101 fl	Calculated
Mean Cell Haemoglobin (MCH)		29.7	27 - 32 pg	Calculated
Mean Cell Haemoglobin Concentration (MCHC)		34.0	31.5 - 35.0 g/l	Calculated
RDW		<b>15.0</b>	11.5 - 14.0 %	Calculated
Platelet count		285	150 - 450 10 <sup>3</sup> /cumm	Impedance
WBC Count		8700	4000 - 11000 cells/cumm	Impedance
<b><u>DIFFERENTIAL COUNT</u></b>				
Neutrophils		58.2	50 - 70 %	Flow Cytometry/Light microscopy
Lymphocytes		34.7	20 - 40 %	Flow Cytometry/Light microscopy
Eosinophils		2.0	1 - 6 %	Flow Cytometry/Light microscopy
Monocytes		5.1	2 - 10 %	Flow Cytometry/Light microscopy
Basophils		0.0	0 - 1 %	Flow Cytometry/Light microscopy
Absolute Neutrophil Count		5063.4	2000 - 7000 /cumm	Calculated



**CLINICAL DIAGNOSTIC LABORATORY**  
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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Absolute Lymphocyte Count		3018.9	1000 - 4800 /cumm	Calculated
Absolute Eosinophil Count		174	20 - 500 /cumm	Calculated
Absolute Monocyte Count		443.7	200 - 1000 /cumm	Calculated
Absolute Basophil Count		0	0 - 100 /cumm	Calculated

**PERIPHERAL SMEAR**

RBC		Normochromic		
Anisocytosis		Normocytic		
WBC		Anisocytosis		
Platelets		+(Few)		
<b>E S R</b>		As Above		
		Adequate		
		02	0 - 15 mm/hr	

Automated  
Westergren's Method

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

Suggested Clinical Correlation \* If neccessary, Please discuss

Verified By : : 11100245

Test results related only to the item tested.

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

**CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**

**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mr. SAGAR RETAR  
**Bill No/ UMR No** : BIL2324069414/UMR2324033712  
**Received Dt** : 13-Jan-24 08:22 am

**Age /Gender** : 41 Y(s)/Male  
**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Report Date** : 13-Jan-24 10:11 am

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
Fasting Plasma Glucose	Plasma	259	< 100 mg/dl	GOD/POD,Colorimetric
Post Prandial Plasma Glucose		362	< 140 mg/dl	GOD/POD, Colorimetric
<b>GLYCOSYLATED HAEMOGLOBIN (HbA1c)</b>		<b>9.7</b>		
HbA1c			Non-Diabetic : <= 5.6 % Pre-Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %	HPLC

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

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

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Phone: +91 0712 6789100

CIN : U74999MH2018PTC303510



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

<b>Patient Name</b> : Mr. SAGAR RETAR	<b>Age / Gender</b> : 41 Y(s)/Male
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**LIPID PROFILE**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Total Cholesterol	Serum	<b>208</b> < 200 mg/dl	Enzymatic(CHE/CHO/POD)
Triglycerides		<b>214</b> < 150 mg/dl	Enzymatic (Lipase/GK/GPO/POD)
HDL Cholesterol Direct		47 > 40 mg/dl	Phosphotungstic acid/mgcl-Enzymatic (microslide)
LDL Cholesterol Direct		<b>129.87</b> < 100 mg/dl	Enzymatic
VLDL Cholesterol		<b>43</b> < 30 mg/dl	Calculated
Tot Chol/HDL Ratio		4 3 - 5	Calculation

<u>Intiate therapeutic</u>	<u>Consider Drug therapy</u>	<u>LDC-C</u>
CHD OR CHD risk equivalent	>100 >130, optional at 100-129	<100
Multiple major risk factors conferring 10 yrs CHD risk >20%		
Two or more additional major risk factors, 10 yrs CHD risk <20%	>130 10 yrs risk 10-20 % >130	<130
No additional major risk or one additional major risk factor	>160 >190, optional at 160-189	<160

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

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



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF BIOCHEMISTRY**

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**Age / Gender** : 41 Y(s)/Male  
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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
<b>THYROID PROFILE</b>				
T3	Serum	1.41	0.55 - 1.70 ng/ml	Enhanced chemiluminescence
Free T4		<b>1.73</b>	0.80 - 1.70 ng/dl	Enhanced Chemiluminescence
TSH		1.90	0.50 - 4.80 uIU/ml	Enhanced chemiluminescence
PSA (Total)		0.337	< 4 ng/ml	Enhanced chemiluminenscence

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

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**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF BIOCHEMISTRY**

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<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Biological Reference</u>	<u>Method</u>
<b>LIVER FUNCTION TEST(LFT)</b>				
Total Bilirubin	Serum	0.96	0.2 - 1.3 mg/dl	Azobilirubin/Dyphylline
Direct Bilirubin		<b>0.61</b>	0.1 - 0.3 mg/dl	Calculated
Indirect Bilirubin		0.35	0.1 - 1.1 mg/dl	Dual wavelength spectrophotometric
Alkaline Phosphatase		<b>191</b>	38 - 126 U/L	pNPP/AMP buffer
SGPT/ALT		<del>24</del>	10 - 40 U/L	Kinetic with pyridoxal 5 phosphate
SGOT/AST		33	15 - 40 U/L	Kinetic with pyridoxal 5 phosphate
Serum Total Protein		<b>8.51</b>	6.3 - 8.2 gm/dl	Biuret (Alkaline cupric sulphate)
Albumin Serum		4.74	3.5 - 5.0 gm/dl	Bromocresol green Dye Binding
Globulin		3.77	2.0 - 4.0 gm/dl	Calculated
A/G Ratio		1.26		

**URINE SUGAR**

**Urine Glucose** 4+ (Approx 1000mg/dl)  
\*\*\* End Of Report \*\*\*

Suggested Clinical Correlation \* If necessary, Please discuss  
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**Dr. VAIDEHEE NAIK, MBBS,MD  
CONSULTANT PATHOLOGIST**



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mr. SAGAR RETAR **Age /Gender** : 41 Y(s)/Male  
**Bill No/ UMR No** : BIL2324069414/UMR2324033712 **Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 13-Jan-24 08:23 am **Report Date** : 13-Jan-24 10:11 am

**RFT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
Blood Urea	Serum	<b>14</b>	19.0 - 43.0 mg/dl	Urease with indicator dye
Creatinine		<b>0.56</b>	0.66 - 1.25 mg/dl	Enzymatic ( creatinine amidohydrolase)
GFR		127.0	>90 mL/min/1.73m square.	Calculation by CKD-EPI 2021
Sodium		<b>133</b>	136 - 145 mmol/L	Direct ion selective electrode
Potassium		<b>5.23</b>	3.5 - 5.1 mmol/L	Direct ion selective electrode

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

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





**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF PATHOLOGY**

<b>Patient Name</b> : Mr. SAGAR RETAR	<b>Age / Gender</b> : 41 Y(s)/Male
<b>Bill No/ UMR No</b> : BIL2324069414/UMR2324033712	<b>Referred By</b> : Dr. Vimmi Goel MBBS,MD
<b>Received Dt</b> : 13-Jan-24 08:32 am	<b>Report Date</b> : 13-Jan-24 12:49 pm

**URINE MICROSCOPY**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
<b><u>PHYSICAL EXAMINATION</u></b>			
Volume	Urine	30 ml	
Colour.		Pale yellow	
Appearance		Clear	Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
Reaction (pH)		6.5	4.6 - 8.0 Indicators
Specific gravity		1.010	1.005 - 1.025 ion concentration
Urine Protein		Negative	Negative protein error of pH indicator
Sugar		4+ (Approx 1000mg/dl)	Negative GOD/POD
Bilirubin		Negative	Negative Diazonium
Ketone Bodies		Negative	Negative Legal's est Principle
Nitrate		Negative	Negative
Urobilinogen		Normal	Normal Ehrlich's Reaction
<b><u>MICROSCOPIC EXAMINATION</u></b>			
Epithelial Cells		2-4	0 - 4 /hpf
R.B.C.		Absent	0 - 4 /hpf
Pus Cells		0-1	0 - 4 /hpf



**CLINICAL DIAGNOSTIC LABORATORY  
DEPARTMENT OF PATHOLOGY**

**Patient Name** : Mr. SAGAR RETAR  
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**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 13-Jan-24 08:32 am  
**Report Date** : 13-Jan-24 12:49 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	<u>Method</u>
Casts		Absent	Absent
Crystals		Absent	
*** End Of Report ***			

Suggested Clinical Correlation \* If necessary, Please discuss

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



**CLINICAL DIAGNOSTIC LABORATORY**  
**DEPARTMENT OF IMMUNO HAEMATOLOGY**

**Patient Name** : Mr. SAGAR RETAR  
**Age / Gender** : 41 Y(s)/Male  
**Bill No/ UMR No** : BIL2324069414/UMR2324033712  
**Referred By** : Dr. Vimmi Goel MBBS,MD  
**Received Dt** : 13-Jan-24 08:23 am  
**Report Date** : 13-Jan-24 11:15 am

**BLOOD GROUPING AND RH**

<u>Parameter</u>	<u>Specimen</u>	<u>Results</u>	
BLOOD GROUP.	EDTA Whole Blood & Plasma/ Serum	" O "	Gel Card Method
Rh (D) Typing.		" Positive "(+Ve)	

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

Suggested Clinical Correlation \* If necessary, Please discuss

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

**DEPARTMENT OF RADIOLOGY & IMAGING SCIENCE**

NAME	SAGAR RETAR	STUDY DATE	13-01-2024 09:23:09
AGE/SEX	41Y / M	HOSPITAL NO.	UMR2324033712
ACCESSION NO.	BIL2324069414-17	MODALITY	DX
REPORTED ON	13-01-2024 12:22	REFERRED BY	Dr. Vimmi Goel

**X-RAY CHEST PA VIEW**

Both the lung fields are clear.

Heart and Aorta are normal.

Both 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]**

PATIENT NAME:	MR. SAGAR RETAR	AGE /SEX:	41Y/M
UMR NO:	2324033712	BILL NO:	2324069414
REF BY	DR. VIMMI GOEL	DATE:	13/01/2024

**USG WHOLE ABDOMEN**

LIVER is normal in size, shape and shows mild increase in 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 sludge or calculus seen.  
Wall thickness is within normal limits.

PANCREAS is normal in shape, size and echotexture.

SPLEEN is normal in shape, size 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.

BLADDER is partially distended. No calculus or mass lesion seen.

Prostate is normal in size, shape and echotexture.

There is no free fluid or abdominal lymphadenopathy seen.

**IMPRESSION:**

- Mild hepatic fatty infiltration.
- No other significant abnormality seen.

**Suggest clinical correlation / further evaluation.**



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

**2D ECHOCARDIOGRAPHY AND COLOR DOPPLER REPORT**

Patient Name : Mr. Sagar Retar  
 Age : 41 years / Male  
 UMR : UMR2324033712  
 Date : 13/01/2024  
 Done by : Dr. Vimmi Goel  
 ECG : NSR, Minor ST-T changes  
 Blood pressure: 150/100 mm Hg (Right arm, Supine position)  
 BSA : 1.99 m<sup>2</sup>

**Impression: Hypertensive Heart Disease**

**Normal chambers dimensions**  
**Mild left ventricular hypertrophy**  
**No RWMA of LV at rest**  
**Good LV systolic function, LVEF 70%**  
**LV diastolic dysfunction, Grade I (E<A)**  
**E/A is 0.7**  
**E/E' is 7.1 (Normal filling pressure)**  
**Valves are normal**  
**No pulmonary hypertension**  
**IVC is normal in size and collapsing well with respiration**  
**No clots or pericardial effusion**

**Comments:**

Sector echocardiography was performed in various conventional views (PLAX, SSAX, AP4 CH and 5 CH views). LV size normal. Mild left ventricular hypertrophy. There is no RWMA of LV seen at rest. Good LV systolic function. LVEF 70%. LV diastolic dysfunction, Grade I (E<A). E Velocity is 57 cm/s, A Velocity is 73 cm/s. E/A is 0.7. Valves are normal. No Pulmonary Hypertension. IVC normal in size and collapsing well with respiration. Pericardium is normal. No clots or pericardial effusion seen. E' at medial mitral annulus is 6.4 cm/sec & at lateral mitral annulus is 10.6 cm/sec. E/E' is 7.1 (Average).

**M Mode echocardiography and dimension:**

	Normal range (mm)		Observed (mm)
	(adults)	(children)	
Left atrium	19-40	7-37	37
Aortic root	20-37	7-28	30
LVIDd	35-55	8-47	40
LVIDs	23-39	6-28	29
IVS (d)	6-11	4-8	12
LVPW (d)	6-11	4-8	12
LVEF %	~ 60%	~60%	12
Fractional Shortening			70%
			40%

P.T.O

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

13-Jan-24 8:47:58 AM

KIMS-KINGSWAY HOSPITALS

PBC DEPT.

MR. SAGAR RETAR

Male

41 Years

Rate 78 . Sinus rhythm.....normal P axis, V-rate 50-99  
 . Borderline low voltage, extremity leads.....all extremity leads <0.6mV  
 PR 157 . Abnormal R-wave progression, early transition.....QRS area>0 in V2  
 QRS 105 . Abnormal T, consider ischemia, lateral leads.....T <-0.20mV, I aVL V5 V6  
 QT 380  
 QTc 433

--AXIS--

P 36

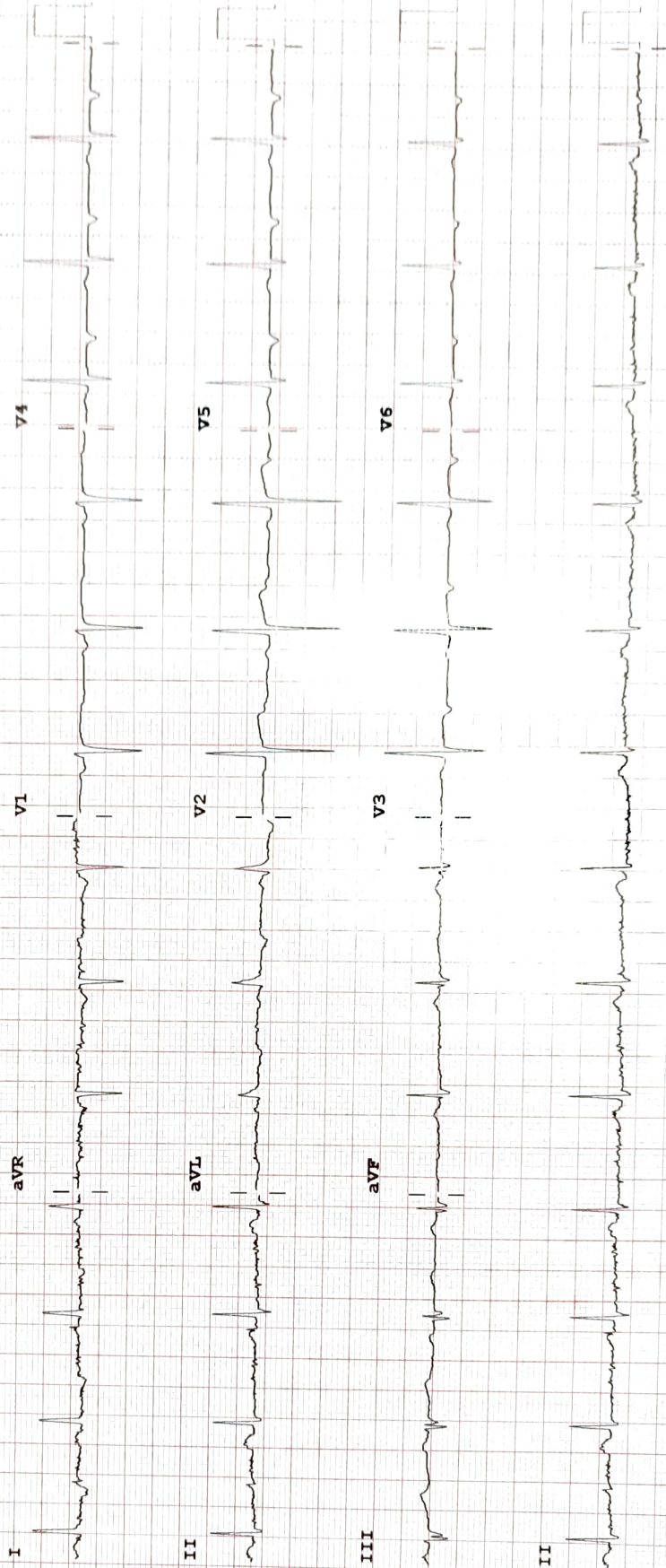
QRS -2

T 139

12 Lead; Standard Placement

- ABNORMAL ECG -

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?

PHILIPS

REORDER # M2483A