

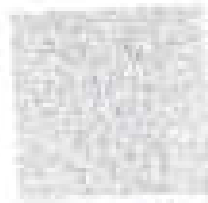
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Tilak

DR. TILAK DEDHIA
M.D.S.
REG. No. 2011/07/2287

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MER- MEDICAL EXAMINATION REPORT

Date of Examination	10/8/2024	
NAME	Mr. Kundan Kumar	
W.A	38 Gender	Male
HEIGHT	174 cm	75 kg
BP		130/80 mmHg
ECG	WNL	
X Ray	Normal	
Visual Checkup	(R) 6/6	(L) 6/6
Present Complaints	Normal colour vision KID = HTN ∴ 4 months on ff	
Details of Past ailments (if any)	NO	
Comments / Advice (if any is physically fit)	He is physically fit	

Tilak
DR. TILAK DEDHIA
 M.B.B.S.
 REG. No. 2311/07/2287

Signature with Stamp of Medical Examiner



Patient : MR KUNDAN KUMAR

M/38 Y

10-Aug-24

Ref By : Dr ARCOFEMI HEALTHCARE LT

No : 12

COMPLETE BLOOD COUNT WITH ESR

Test	Value	Normal Range	Units
HEMOGLOBIN	11.4	13.3 - 18.0	gms/dl
R.B.C. COUNT	4.07	4.30 - 6.50	millions/cmm
PCV	35.1	40.0 - 54.0	%
MCV	86.2	76.0 - 96.0	fl
MCH	28.0	27.0 - 32.0	pg
MCHC	32.5	30.0 - 35.0	g/dl
RDW	15.2	11.5 - 14.5	%
W.B.C. COUNT	6320	4,000-11,000	cells/cmm
Differential Count :			
Neutrophils	62	45 - 70	%
Lymphocytes	34	20 - 45	%
Eosinophils	00	1 - 6	%
Monocytes	04	1 - 10	%
Basophils	00	0 - 1	%
PLATELET COUNT	179,000	150,000 - 450,000	cells/cmm
PLATELETS ON SMEAR	Adequate		
R.B.C. MORPHOLOGY	Hypochromasia (+), Microcytosis (+), Anisocytosis (+)		
W.B.C. MORPHOLOGY	Normal		
E.S.R. (Westergren)	14	0 - 20	mm/hr

U.R. done on Fully Automated Urine H100 Cell Counter.


Dr. Arcofemi
M.D. Pathology



Patient : MR KUNDAN KUMAR M/38 Y 10-Aug-24
Ref By : Dr ARCOFEMI HEALTHCARE LT No : 12

BLOOD SUGAR

Test	Value	Normal Range	Units
FASTING BLOOD SUGAR:	92	70-110	mg/dl
Urine Sugar	Absent		
Urine Ketones	Absent		

POST PRANDIAL BLOOD SUGAR:	106	70-140	mg/dl
Urine Sugar (2 hrs)	Absent		
Urine Ketones (2 Hrs)	Absent		

METHOD: Glucose Oxidase Peroxidase (GOD/POD)

American Diabetes Association (ADA 2011) Blood Glucose Level Criteria:

FASTING GLUCOSE LEVEL:

Normal glucose tolerance :- 100 mg %
Impaired Fasting Glucose :- 100 - 125 mg %
Prediagnosed diagnosis :- 126 mg % (on two different occasions)
diabetes mellitus

POST LUNCH GLUCOSE LEVEL:

Normal glucose tolerance :- <140 mg %
Impaired Glucose Tolerance :- 140 - 199 mg %
Prediagnosed diagnosis :- 200 mg % (on two different occasions)
diabetes mellitus

URINE SUGAR INTERPRETATION :- (approx.)

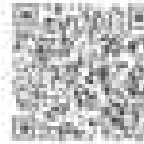
Trace :- 0.1 g/dl
+ :- 0.25 g/dl
++ :- 0.5 g/dl
+++ :- 1.0 g/dl
++++ :- 1.5 g/dl




Dr. Sahakar Bhandar
M.D. (Pathology)



Patient Name : MR. SUNDAS SOMAYE
Age / Gender : 38 Years / Male
Patient ID : U000110002
Referrer : Radwave Diagnostics LLP



Collection Time^o : Aug 10, 2024, 05:25 PM
Receiving Time : Aug 10, 2024, 05:40 PM
Reporting Time : Aug 10, 2024, 07:19 PM

Sample ID



W30154100

Glycosylated Haemoglobin (HbA1c)

Sample Type : Whole Blood

TEST	RESULT	UNITS	REFERENCE RANGES
HbA1c	5.6	%	4.1 - 5.7
Mean Glucose Level	114	mg/dL	upto 140

HbA1c - DEGREE OF GLUCOSE CONTROL
5.7% - 6.4% - Prediabetic
6.5% - Diabetic

INTERPRETATION

Glycosylated haemoglobin accumulates within the red blood cells and exists in this form throughout the lifespan of red cells. Thus, single HbA1c value taken every 2-3 months, serves over those months. The measurement of HbA1c has been used as an index of metabolic control of diabetes during the preceding 2-3 months providing physician with an objective to look at the patient's diabetes control. HbA1c is not affected by factors like intake of carbohydrates, timing of antidiabetic drugs and daily activities.

*** END OF REPORT ***

DR. YAGYESH R. SHAH
M.B.B.S., DNB (PATH)
Consultant Pathologist



Patient : MR KUNDAN KUMAR

MSBY

10-Aug-24

Ref By : Dr ARCOPMI HEALTHCARE LT

No : 12

LIPID PROFILE

Test	Value	Normal Range	Units
Total Cholesterol	134	130-210	mg/dl
Triglycerides	109	25-150	mg/dl
HDL Cholesterol	48	35-80	mg/dl
VLDL Cholesterol	22	5-30	mg/dl
LDL Cholesterol	84	80-110	mg/dl
TC:HDL Ratio	2.2	0.0-4.5	
LDL:HDL Ratio	1.8	0.0-3.5	

NOTE: Various cholesterol levels recommended targets by NCEP (National Cholesterol Education Program) (May-2001).

CHOLESTEROL

Desirable < 200 mg/dl
Borderline High 200-239 mg/dl
High >= 240 mg/dl

TRIGLYCERIDES

Desirable < 150 mg/dl
Borderline High 150-199 mg/dl
High 200-499 mg/dl

HDL CHOLESTEROL

Desirable >= 40 mg/dl
(>= 60 mg/dl) >= 40 mg/dl

LDL CHOLESTEROL

Optimal < 100 mg/dl
Near Optimal 100-129 mg/dl
Borderline High 130-159 mg/dl
High 160-189 mg/dl
Very High >= 189 mg/dl



(Signature)

Dr. Arvind Sagarwal

M.D. Pathology



Patient: MR KUNDAN KUMAR

M/8 Y

10-Aug-24

Ref By : Dr ARCOFEMI HEALTHCARE LT

No : 12

RENAL FUNCTION TEST

Test	Value	Normal Range	Units
BUN	13.5	5.0-21.0	mg/dl
Urea	29.5	13.0-43.0	mg/dl
Creatinine	1.0	0.5-1.3	mg/dl
Total Protein	7.0	6.0-8.5	gm/dl
Albumin	4.5	3.2-5.3	gm/dl
Globulin	2.5	2.3-3.3	gm/dl
A/G Ratio	1.8	1.0-2.0	
Calcium	9.5	8.0-10.0	mg/dl
Phosphorus	4.4	2.5-4.5	mg/dl
Uric Acid	5.2	3.3-7.2	mg/dl
Sodium	141.2	133.0-148.0	mEq/L
Potassium	4.5	3.5-5.3	mEq/L
Chloride	103.8	96.0-107.0	mEq/L


Dr. Arcofemi
M.D. Pathology



Patient : MR KUNDAN KUMAR

M/38 Y

10-Aug-24

Ref By : Dr ARCOFEMI HEALTHCARE LT

No : 12

LIVER FUNCTION TEST

<u>Test</u>	<u>Value</u>	<u>Normal Range</u>	<u>Units</u>
SGOT	24.2	0.0-40.0	I.U.L.
SGPT	26.1	0.0-40.0	I.U.L.
Bilirubin (Total)	0.59	0.0-1.20	mg/dl
Bilirubin (Direct)	0.17	0.0-0.40	mg/dl
Bilirubin (Indirect)	0.4	0.1-1.0	mg/dl
Total Protein	7.0	6.0-8.5	gm/dl
Albumin	4.5	3.2-5.0	gm/dl
Globulin	2.5	2.3-3.8	gm/dl
AG Ratio	1.8	1.0-2.0	
Alkaline Phosphatase	188	30-100	I.U.L.
GAMMA GT	33	4-55	I.U.L.



Dr. Arcofemi

M.D. Pathology



Patient : MR KUNDAN KUMAR

M/38 Y

10-Aug-24

Ref By : Dr ARCOFEMI HEALTHCARE LT

No : 12

BLOOD GROUP

Test

Value

BLOOD GROUP

"A" Positive

Method: Slide & Tube Agglutination

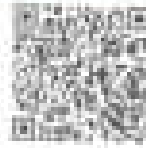


Dr. Arcofemi

MD Pathology



Patient Name : MR. SURDAN KUMAR
Age / Gender : 38 Years / Male
Patient ID : 000015007
Referrer : Radwave Diagnostics LLP



Collection Time : Aug 10, 2024, 10:25 PM
Receiving Time : Aug 10, 2024, 05:00 PM
Reporting Time : Aug 10, 2024, 07:14 PM

Sample ID



00015007

THYROID PROFILE

Sample Type : Serum

TEST

T3 (TRIIODOTHYRONINE)

Method : CLIA

RESULT

66.05

UNITS

ng/dL

REFERENCE RANGES

75 - 130

T4 (THYROXINE)

Method : CLIA

10.0

ug/dL

4.87 - 11.72

TSH - (ULTRA SENSITIVE)

Method : CLIA

1.93

uIU/mL

0.35 - 4.94

Interpretation:

T3 : Triiodothyronine T3 constitutes significantly a lesser percentage of the collected state and the total T3 concentration has a role in assessing the thyroid status in conjunction with other tests. T3 alone cannot diagnose hyperthyroidism, but it may be more sensitive than thyroxine (T4) for hyperthyroidism. A fall in T3 concentration of up to 30% is known to occur in a variety of clinical conditions, including acute and chronic disease.

T4 : Thyroxine accounts for at least 90% of circulating protein-bound iodine. 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 level is a good indicator of thyroid status, however it can sometimes be ambiguous and diagnostic efficiency may be improved by use of a total T4 test in conjunction with other tests.

TSH : A high TSH result often means an under active thyroid gland that is not responding adequately to the stimulation of TSH due to some type of acute or chronic thyroid dysfunction. A high TSH value can also occur when someone with a known thyroid disorder, or who has had their thyroid gland removed is missing too little thyroid hormone medication. A low TSH result can indicate an over active thyroid gland (hyperthyroidism) or excessive amounts of thyroid hormone medication in those who are being treated for an under active (or removed) thyroid gland. Whether high or low, an abnormal TSH indicates an excess or deficiency in the amount of thyroid hormone available to the body, but it does not indicate the reason why. An abnormal TSH test result is usually followed by additional testing to investigate the cause of the increase or decrease.

**** END OF REPORT ****

Bhunkra

DR. BHUNKRA C. BORANA
M.B.B.S., M.D., DNB. (PATH)
Consultant Pathologist



Patient : MR KUNDAN KUMAR

M/38 Y

10-Aug-24

Ref By : Dr ARCOFEMI HEALTHCARE LT

No : 12

Urine Routine

<u>Test</u>	<u>Value</u>
<u>Physical Examination:</u>	
Quantity	25 ml
Colour	Pale Yellow
Appearance	Slightly Turb
Reaction (pH)	Acidic(6.0)
Specific Gravity	1.015
<u>Chemical Examination:</u>	
Proteins	Absent
Glucose	Absent
Ketone Bodies	Absent
Occult Blood	Absent
Bile Salts	Absent
Bile Pigments	Absent
Urobilinogen	Normal
<u>Microscopic Examination:</u>	
WBCs	4 - 5 / hpf
RBCs	Absent
Epithelial Cells	2 - 3 / hpf
Casts	Absent
Crystals	Absent
Bacteria	Absent
Yeast Cells	Absent
Amorphous Deposits	Absent
Mucus	Absent
Other	—




Dr. Tarun Kumar
M.D. Pathology



NAME:	MR KUNDAN KUMAR	DATE:	11/08/2024
E-NO:	E-01	AGE:	38 YRS
REF BY DR:	APOLLO - ARCOPUM HEALTHCARE LTD	SEX:	MALE

2D-ECHOCARDIOGRAPHY REPORT

No diastolic dysfunction by PWD at present.

No concentric left ventricular hypertrophy seen.

All cardiac valves show normal structure and physiological function.

No significant stenosis nor regurgitation seen.

No regional wall motion abnormality seen at rest at present.

All cardiac chambers are normal in size.

IAS / IVS : No defect visualized.

Visual LVEF = 65 perCent.

No α thrombus/ pericardial effusion.


Mild TR jet. PASP by TR jet measured to 28 mm Hg.

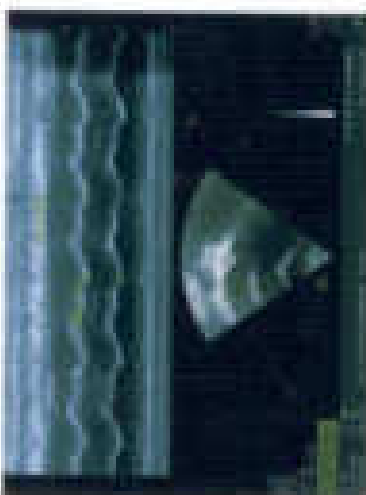
MR KUNDAN KUMAR

M-MODE STUDY			COLOUR DOPPLER STUDY		
Value	Unit		Value	Unit	
IVSd	09	mm	Mitral Valve E velocity	0.7	m/s
IVSs	13	mm	Mitral Valve A velocity	0.5	m/s
LVIDd	44	mm	E/A Ratio		
LVIDs	30	mm	Mitral Regurgitation	Absent	
LVPWd	07	mm			
LVPWs	13	mm			
2D STUDY					
		mm	AORTIC VALVE		
Ao	31	mm	AVmax	1.13	m/s
		mm	Aortic Regurgitation	absent	
LA	35	mm			
RV		mm			
RA		mm	PULMONARY VALVE		
PS	33	%	PVmax	0.8	m/s
EF	65	%	Regurgitation	Absent	
Mitral annulus	normal	mm			
			TR jet ve		m/s
			PASP	20	

Note: 2 D Echo has a poor sensitivity in cases of angina pectoris. Negative echo findings does not rule out coronary artery disease

Adv: Please correlate clinically. CAG/Further cardiac evaluation as indicated. PBM for diastolic dysfunction


Dr. Priyam Bhatnagar
M.D. Cert. in 2 D Echo &
Doppler Studies





Patient Name: Mr. Kundan Kumar

M / 35yrs

Ref. by: Apollo-Arculenti Healthcare Ltd.

Date: - 18/08/2024

SONOGRAPHY OF ABDOMEN AND PELVIS

TECHNIQUE: Real time, B mode, gray scale sonography of the abdominal and pelvic organs was performed with convex transducer.

LIVER: The liver is normal in size (14.7 cm), shape and has smooth margins. The hepatic parenchyma shows homogeneous echotexture without solid or cystic mass lesion or calcification. No evidence of intrahepatic biliary radical dilatation.

PORTAL VEIN: It measures 11.7 mm in transverse diameter.

GALL BLADDER: The gall bladder is well distended. There is no evidence of calculus, wall thickening or pericholecystic collection.

COMMON BILE DUCT: The visualized common bile duct is normal in caliber. No evidence of calculus is seen in the common bile duct. Terminal common bile duct is obscured due to bowel gas artifacts.

PANCREAS: The head and body of pancreas is normal in size, shape, contours and echo texture. Rest of the pancreas is obscured due to bowel gas artifacts.

SPLEEN: The spleen measures 10.1 cm and is normal in size and shape. Its echotexture is homogeneous.

KIDNEYS:

Right kidney	Left kidney
9.4 x 3.8 cm	10.1 x 4.9 cm

The kidneys are normal in size and have smooth renal margins. Cortical echotexture is normal. The central echo complex does not show evidence of hydronephrosis. No evidence of hydronephrosis or calculi bilaterally.

URINARY BLADDER: The urinary bladder is well distended. It shows uniformly thin walls and sharp mucosa. No evidence of calculus is seen. No evidence of mass or diverticulum is noted.

Patient Name: Mr. Kundan Kumar

M / 35yrs

Ref. by: Apollo-Arcolomi Healthcare Ltd

Date: 10/08/2024

PROSTATE: It measures about 3.5 x 2.9 x 3.0 cm; volume is 16.3 gm. The prostate gland shows well defined and smooth margins. The prostatic echotexture is normal and homogenous.

There is no ascites. There is no obvious evidence of significant lymphadenopathy.

IMPRESSION:

- No significant abnormality is seen.

Thanks for the reference.
With regards,

Dr. Tilak Deshpande
Consultant Radiologist







PATIENT NAME : MR KUNDAN KUMAR
AGE/ SEX : 38 YRS / MALE
REF. CLINICIAN : APOLLO-ARCOFEMI HEALTHCARE LTD.
DATE : 10/06/2024

X-RAY CHEST (P A VIEW)

- Both lung fields are clear.
- Both CP angle are normal.
- Cardiac and aortic shadows are normal.
- No obvious hilar or mediastinal lesion is seen.
- Bony thorax appears normal. No evidence of fracture seen.

CONCLUSION, X-Ray findings show....

- No significant abnormality of note.

Please correlate clinically.
Thanks for the referral.


Dr. Tushar Manoj Deshpande
M.B.B.S., M.D., D.F.B. (Radio-diagnosis)
Consultant Radiologist

DC



Illustration of the human chest and upper abdomen, showing the ribcage, lungs, and diaphragm. The drawing is detailed, showing the structure of the ribs, the heart, and the branching of the bronchial tree. The diaphragm is shown at the bottom, separating the thoracic and abdominal cavities.

X

12 LEAD ECG REPORT



PULSE RADWAVE
DIAGNOSTIC
UNIT OF RADWAVE DIAGNOSTIC LLP



10/08/2024

Name: MR. KONDAN KOMAR 38/male Apollo- Arceloni Healthcare Ltd

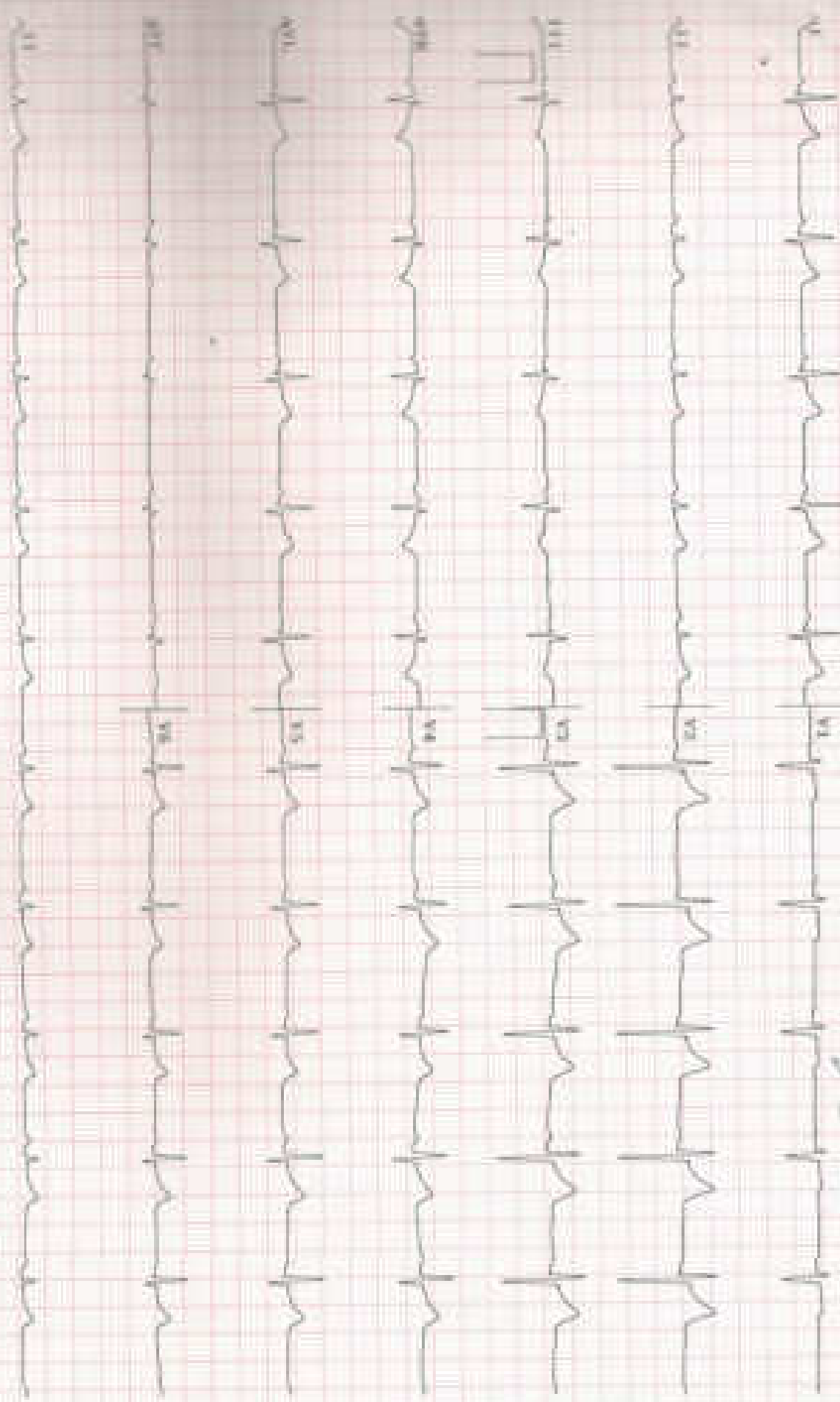
- ▶ Pathology ▶ Digital X - ray ▶ Sonography ▶ 3D - 4D Sonography ▶ Color Doppler ▶ ECG
- ▶ 2D Echo ▶ EEG ▶ EMG ▶ NCV ▶ PFT ▶ Mammography ▶ FNAC ▶ USG Guided Procedures
- ▶ X-Ray Special Investigations ▶ Holter Monitor ▶ Sleep Study & Others.

10
Name: [unclear]
Age: 18 years
Sex: Male
Date: 10/10/10

ECG No: 10000000000000000000
Date: 10/10/10
Time: 10:10 AM
ECG Type: 12 Lead ECG
ECG Machine: GE Healthcare

ECG Interpretation:
Normal Sinus Rhythm
Normal Axis
Normal QRS
Normal T

[Handwritten Signature]



ECG Machine: GE Healthcare

ECG Operator: [unclear]

ECG Station: [unclear]

ELECTROCARDIOGRAM

Please Photocopy ECG As Tracings Fades After Some Time

Name:

Mr. Kundan Kumar

Date:

10/01/2024

Time:

Age / Sex:

38 / M

Heart Rate:

Rhythm:

Axis:

Voltage:

P Wave:

PR Interval:

QRS Interval & Complex:

ST Segment:

T Wave:

QT Interval:

QTc:

Impression:

Signature of Physician:

Conc

RKD

DR. PRAVESH KUMAR JAIN, M.D.
MED. (M) (GEN)