

ID: 008733

Diagnosis Information:

Female
34 Years
cm / mmHg
kg

Lalitha K.K.

HR	88	bpm
P	95	ms
PR	138	ms
QRS	90	ms
QT/QTc	347/421	ms
PQRST	58/59/19	°
RV5/SV1	0.596/0.591	mV

Report Confirmed by:



V1

V2

V3

V4

WNL

~~Dr. S. Lopez~~

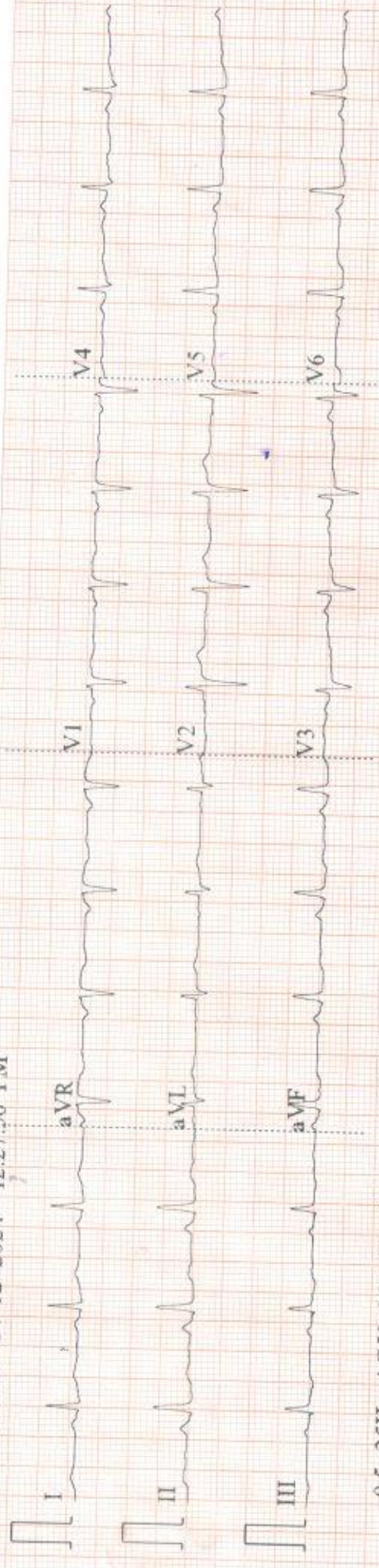
Dr. S. Lopez, MBBS
P.L. No. 7056

1/6 DURG AGILUS PAIN LABS LTD
Aster Square, Medical College, P.O, TVM

Standard

Standard	L I	L II	L III	L III Inspiration
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ID: 008733 24-02-2024 12:27:50 PM



0.5-25Hz AC50 25mm/s 10mm/mV ♡96 V1.0 SEMIP V1.7 DDRC-AGILUS
ARTW CE

RADIOLOGY DIVISION

Acc no:4182XB008875	Name: Mrs. Lekshmi A K	Age: 34 y	Sex: Female	Date:24.02.24
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US SCAN WHOLE ABDOMEN (TAS + TVS)

LIVER is normal in size (12.9 cm). Margins are regular. **Hepatic parenchyma shows increased echogenicity.** No focal lesions seen. No dilatation of intrahepatic biliary radicles. CBD is not dilated. Portal vein is normal in caliber (11.1 mm).

GALL BLADDER is distended and lumen clear. No calculi / polyp noted. Wall thickness is normal. No pericholecystic fluid seen.

SPLEEN is normal in size (8.9 cm) and parenchymal echotexture. No focal lesion seen.

PANCREAS Head and body visualized, appears normal in size and parenchymal echotexture. Pancreatic duct is not dilated.

RIGHT KIDNEY is normal in size (10.3 x 3.8 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

LEFT KIDNEY is normal in size (10.6 x 4.6 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

PARAAORTIC AREA No retroperitoneal lymphadenopathy or mass seen.

URINARY BLADDER is distended, normal in wall thickness, lumen clear.

UTERUS measures 9.7 x 3.6 x 4.9 cm, myometrial echopattern normal. No focal lesions seen. Endometrial thickness is 6.8 mm.

Both ovaries are normal. Right ovary measures 3.1 x 1.8 cm. Left ovary measures 2.5 x 1.2 cm. No adnexal mass seen. No fluid in pouch of Douglas.

No ascites or pleural effusion.

Gaseous distension of bowel loops noted. No obvious bowel wall thickening seen sonologically.

CONCLUSION:-

- **Grade II fatty liver - Correlate with LFT.**

Dr. Nisha Unni MD, DNB (RD)
Consultant radiologist.

Thanks for referral. Your feedback will be appreciated.

(Please bring relevant investigation reports during all visits)

Because of technical and technological limitations complete accuracy cannot be assured on imaging.

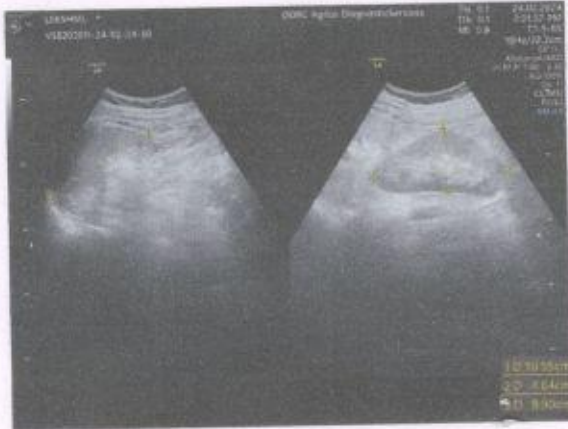
Suggested correlation with clinical findings and other relevant investigations consultations, and if required repeat imaging recommended in the event of controversies. AR

(For appointments / any clarification of report please contact 9496005190 between 9 am – 5.30 pm).

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Corp. Office : Express House, Second Floor, Opp. Pothys Silks, Banerjee Road, Kaloor -682017

Contact :- 93334 93334, Web :- www.ddrcagilus.com Email :- info.ddrc@agilus.in



MEDICAL EXAMINATION REPORT (MER)

If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee	:	Mr./Mrs./Ms. <u>Lekshmi</u>
2. Mark of Identification	:	(Mole/Scar/any other (specify location)):
3. Age/Date of Birth	:	<u>34</u> Gender: <u>F/M</u>
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height <u>147</u> (cms)	b. Weight <u>56</u> (Kgs)	c. Girth of Abdomen (cms)
d. Pulse Rate <u>72</u> (/Min)	e. Blood Pressure:	Systolic Diastolic
	1 st Reading	<u>120</u> <u>80</u>
	2 nd Reading	

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father			
Mother			
Brother(s)			
Sister(s)			

HABITS & ADDICTIONS: Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol
<u>Nil</u>	<u>Nil</u>	<u>Nil</u>

PERSONAL HISTORY

- | | |
|---|---|
| a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. <u>Y/N</u> ✓ | c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? <u>Y/N</u> ✓ |
| b. Have you undergone/been advised any surgical procedure? <u>LSCS → HYD</u> <u>Y/N</u> ✓ | d. Have you lost or gained weight in past 12 months? <u>Y/N</u> ✓ |

Have you ever suffered from any of the following?

- | | |
|--|---|
| • Psychological Disorders or any kind of disorders of the Nervous System? <u>Y/N</u> ✓ | • Any disorder of Gastrointestinal System? <u>Y/N</u> ✓ |
| • Any disorders of Respiratory system? <u>Y/N</u> ✓ | • Unexplained recurrent or persistent fever, and/or weight loss <u>Y/N</u> ✓ |
| • Any Cardiac or Circulatory Disorders? <u>Y/N</u> ✓ | • Have you been tested for HIV/HBsAg / HCV before? If yes attach reports <u>Y/N</u> ✓ |
| • Enlarged glands or any form of Cancer/Tumour? <u>Y/N</u> ✓ | • Are you presently taking medication of any kind? <u>Y/N</u> ✓ |
| • Any Musculoskeletal disorder? <u>Y/N</u> ✓ | |

• Any disorders of Urinary System? Y/N

• Any disorder of the Eyes, Ears, Nose, Throat or Mouth & Skin Y/N

FOR FEMALE CANDIDATES ONLY

a. Is there any history of diseases of breast/genital organs? Y/N

d. Do you have any history of miscarriage/ abortion or MTP Y/N

b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports) Y/N

e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc Y/N *↳ fasting*

c. Do you suspect any disease of Uterus, Cervix or Ovaries? Y/N

f. Are you now pregnant? If yes, how many months? Y/N

CONFIDENTIAL COMMENTS FROM MEDICAL EXAMINER

- Was the examinee co-operative? Y/N
- Is there anything about the examinee's health, lifestyle that might affect him/her in the near future with regard to his/her job? Y/N
- Are there any points on which you suggest further information be obtained? Y/N
- Based on your clinical impression, please provide your suggestions and recommendations below;

Patient is clinically well,

➤ Do you think he/she is MEDICALLY FIT or UNFIT for employment.

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner : Dr. Praveen S.L *[Signature]*

Seal of Medical Examiner : Dr. PRAVEEN S.L
MBBS

Reg. No: 74089

Name & Seal of DDRC SRL Branch :



Date & Time :

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ECHO REPORT

RADIOLOGY DIVISION

SRD No :XB008875	Name:LAKSHMI.A.K	Age:34Y	Sex:F	Date: 24/02/24
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Left Ventricle:-

	Diastole	Systole
IVS	1.16cm	1.24cm
LV	4.24cm	3.02cm
LVPW	1.15cm	1.24cm

EF -66% FS- 33%

AO	LA
2.76cm	3.59cm

PV - 1.03m/s
AV - 1.18m/s
MVE - 0.96m/s
MVA - 0.60m/s
E/A - 1.60

IMPRESSION:-

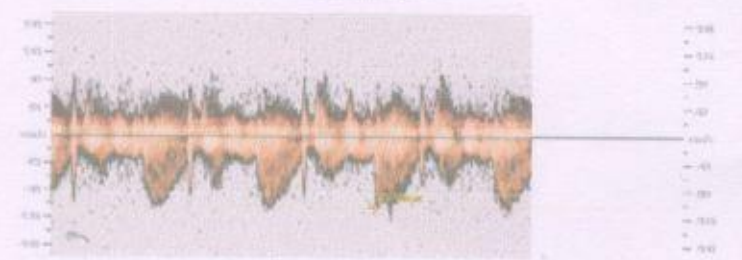
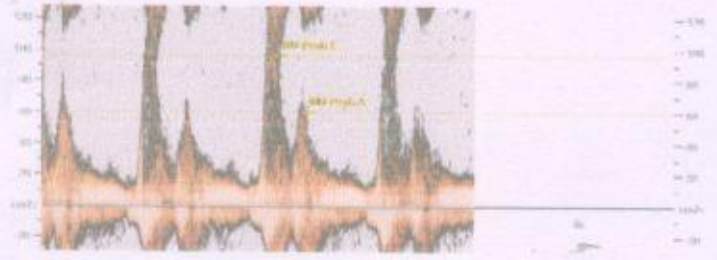
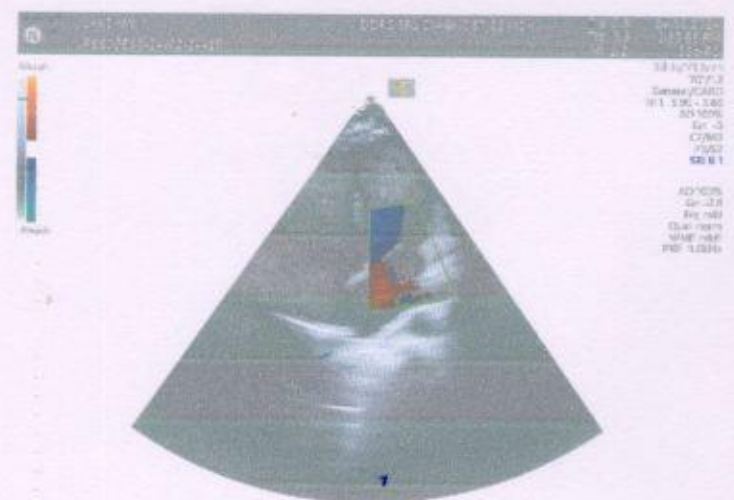
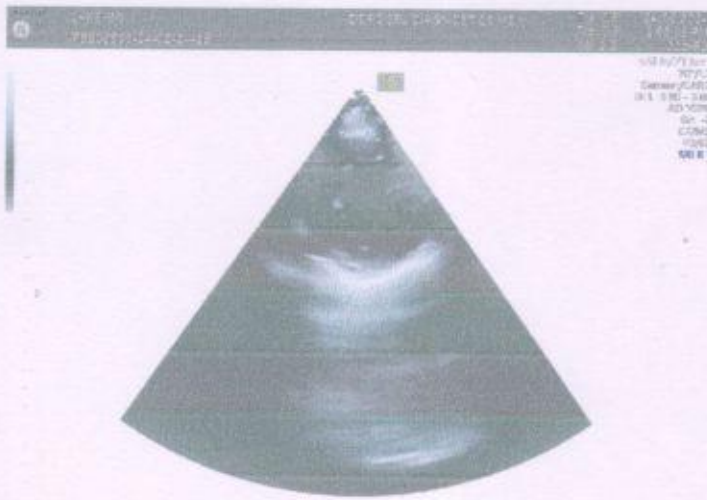
- Normal chambers dimension
- No RWMA
- Good LV systolic function
- No diastolic dysfunction
- No AS,AR,MR,MS,TR,PAH
- IAS/IVS intact.No clots/effusion/coarctation

Dr. SAJITH. K
MD,DNB
CONSULTANT CARDIOLOGIST
Reg:No: 19436


Consultant Cardiologis



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PATIENT NAME : MRS. LAKSHMI A K

REF. DOCTOR : SELF

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DELHI,
SOUTH DELHI 110030
8800465156ACCESSION NO : **4182XB008875**
PATIENT ID : LAKSF1211904182
CLIENT PATIENT ID:
ABHA NO :AGE/SEX : 34 Years Female
DRAWN :
RECEIVED : 24/02/2024 15:05:38
REPORTED : 26/02/2024 10:07:24Test Report Status **Final**

Results

Biological Reference Interval Units

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO**PHYSICAL EXAMINATION**

PHYSICAL EXAMINATION

REPORT GIVEN

**DR NISHA UNNI, MBBS,MD**
(RD),DNB (Reg.No:50162)
Consultant Radiologist

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Patient Ref. No. 66600007983037

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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO**ECG WITH REPORT**

REPORT

REPORT GIVEN

USG ABDOMEN AND PELVIS

REPORT

REPORT GIVEN

CHEST X-RAY WITH REPORT

REPORT

REPORT GIVEN

2D - ECHO WITH COLOR DOPPLER

REPORT

REPORT GIVEN

HAEMATOLOGY**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO****GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C	5.9 High	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
MEAN PLASMA GLUCOSE	122.6 High	< 116.0	mg/dL



DR NISHA UNNI, MBBS,MD
(RD),DNB (Reg.No:50162)
Consultant Radiologist



DR.HARI SHANKAR, MBBS MD
(Reg No - TCMC:62092)
HEAD - Biochemistry &
Immunology



DR.VAISHALI RAJAN, MBBS DCP
(Pathology)
(Reg No - TCC 27150)
HOD - HAEMATOLOGY

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BLOOD COUNTS,EDTA WHOLE BLOOD

HEMOGLOBIN	12.7	12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	4.64	3.80 - 4.80	mil/ μ L
WHITE BLOOD CELL COUNT	9.60	4.0 - 10.0	thou/ μ L
PLATELET COUNT	314	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT	38.8	36.0 - 46.0	%
MEAN CORPUSCULAR VOL	83.6	83.0 - 101	fL
MEAN CORPUSCULAR HGB.	27.4	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	32.7	31.50 - 34.50	g/dL
RED CELL DISTRIBUTION WIDTH	12.8	11.60 - 14.0	%
MENTZER INDEX	18.0		
MEAN PLATELET VOLUME	8.8	6.80 - 10.90	fL

WBC DIFFERENTIAL COUNT

SEGMENTED NEUTROPHILS	48	40.0 - 80.0	%
LYMPHOCYTES	38	20.0 - 40.0	%
MONOCYTES	4	2.0 - 10.0	%
EOSINOPHILS	10 High	1.0 - 6.0	%
BASOPHILS	0	0.0 - 1.0	%
ABSOLUTE NEUTROPHIL COUNT	4.61	2.0 - 7.0	thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT	3.60 High	1.0 - 3.0	thou/ μ L
ABSOLUTE MONOCYTE COUNT	0.41	0.20 - 1.0	thou/ μ L
ABSOLUTE EOSINOPHIL COUNT	0.92 High	0.02 - 0.50	thou/ μ L
ABSOLUTE BASOPHIL COUNT	0.00		thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3		

DR.HARI SHANKAR, MBBS MD
(Reg No - TCMC:62092)
HEAD - Biochemistry & Immunology

DR.VAISHALI RAJAN, MBBS DCP
(Pathology)
(Reg No - TCC 27150)
HOD - HAEMATOLOGY



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ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

SEDIMENTATION RATE (ESR)	31 High	0 - 20	mm at 1 hr
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SUGAR URINE - POST PRANDIAL

SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED
-----------------------------	--------------	--------------

SUGAR URINE - FASTING

SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED
-----------------------	--------------	--------------

IMMUNOHAEMATOLOGY**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO****ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP	TYPE O
RH TYPE	POSITIVE

METHOD : COLUMN AGGLUTINATION TECHNOLOGY

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.



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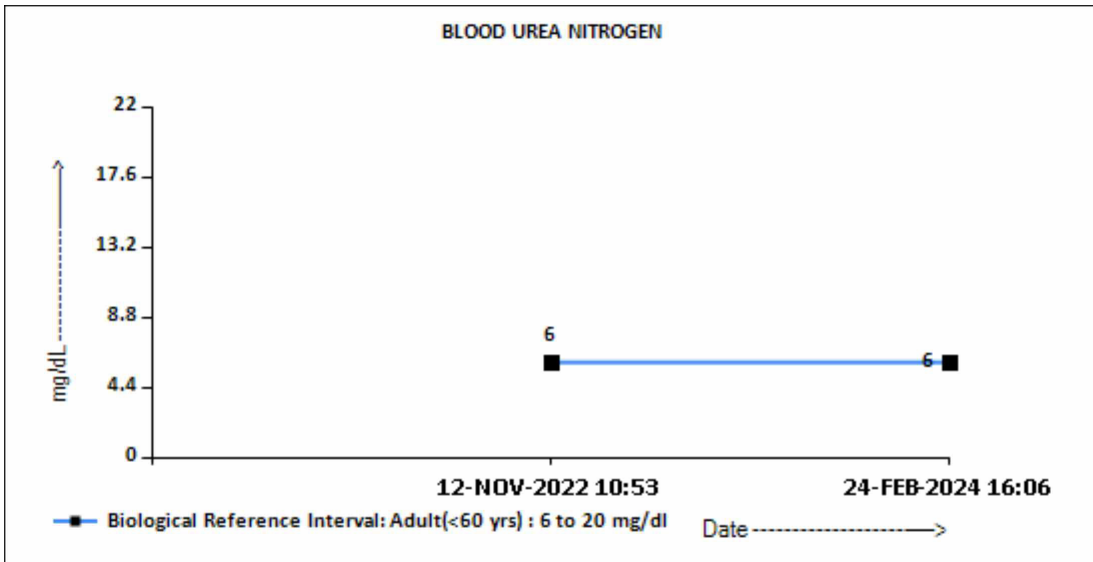
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BIO CHEMISTRY

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 6 Adult(<60 yrs) : 6 to 20 mg/dL



BUN/CREAT RATIO

BUN/CREAT RATIO 10.5

CREATININE, SERUM

CREATININE 0.59 18 - 60 yrs : 0.6 - 1.1 mg/dL

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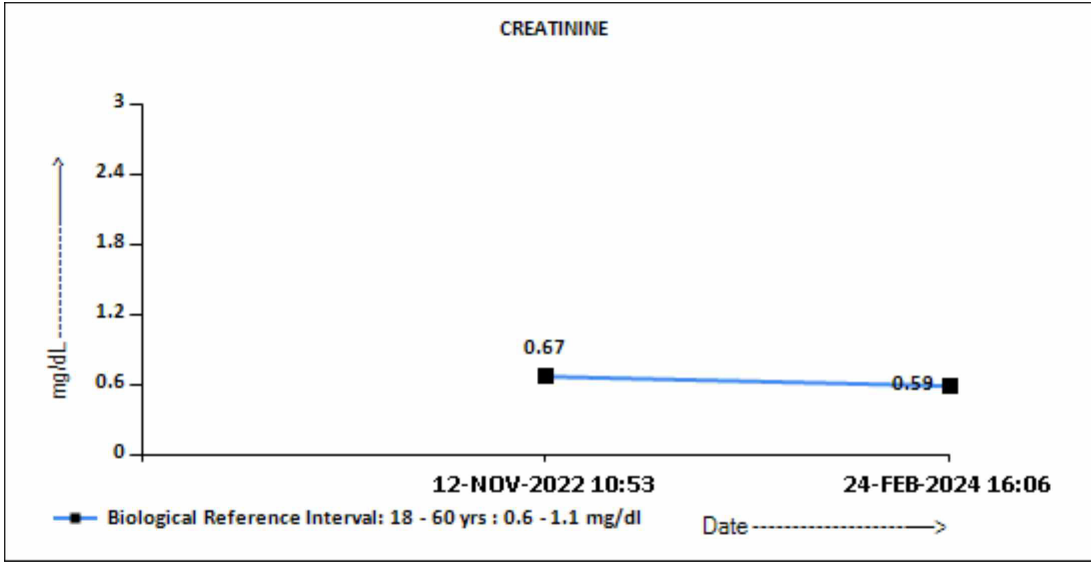
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GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	128	Diabetes Mellitus : > or = 200. mg/dL Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.
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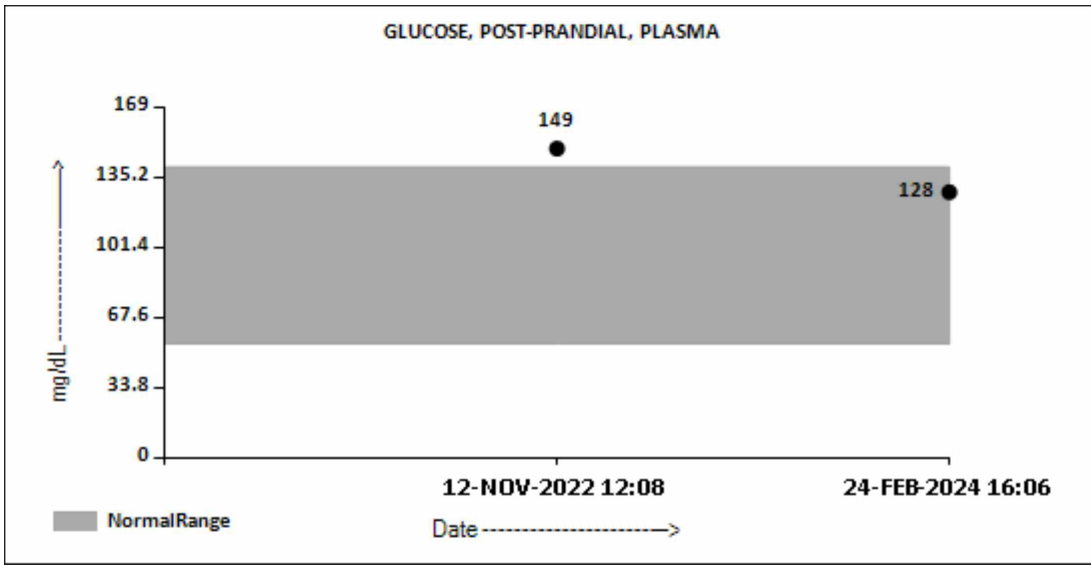
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GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) 86 mg/dL
 Diabetes Mellitus : > or = 126. mg/dL
 Impaired fasting Glucose/
 Prediabetes : 101 - 125.
 Hypoglycemia : < 55.

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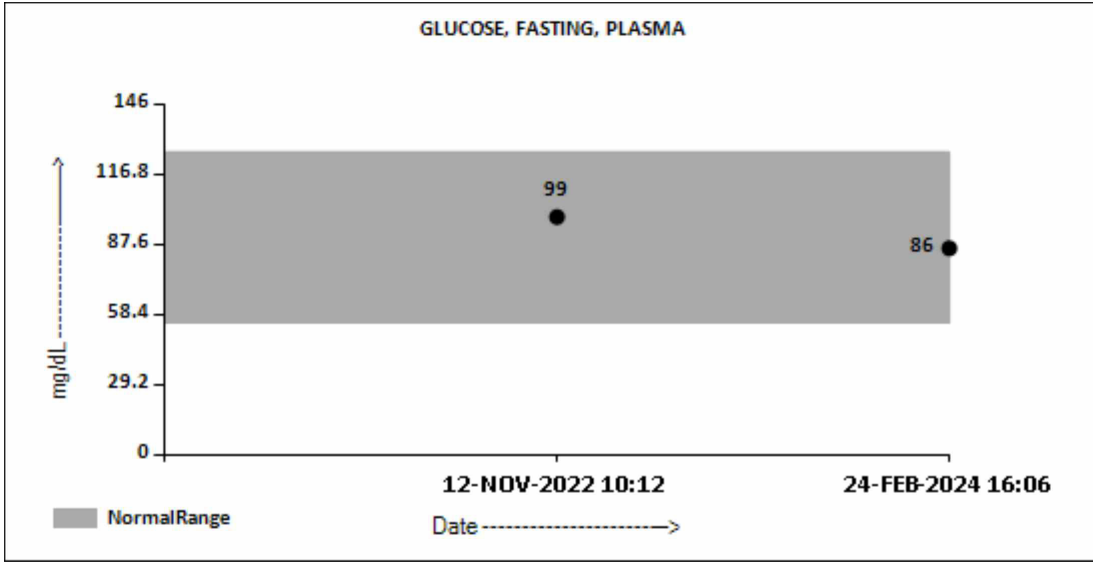
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LIVER FUNCTION TEST WITH GGT

BILIRUBIN, TOTAL	0.40	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.16	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.24	General Range : <0.85	mg/dL
TOTAL PROTEIN	7.8	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.6	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	3.2	General Range : 2 - 3.5 Premature Neonates : 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.4	General Range : 1.1 - 2.5	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	19	Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	18	Adults : < 34	U/L
ALKALINE PHOSPHATASE	53	Adult (<60yrs) : 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	27	Adult (female) : < 40	U/L

TOTAL PROTEIN, SERUM

DR.HARI SHANKAR, MBBS MD
(Reg No - TCMC:62092)
HEAD - Biochemistry & Immunology



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TRIVANDRUM, 695011
KERALA, INDIA
Tel : 93334 93334, Fax : CIN - U85190MH2006PTC161480
Email : customercare.ddrc@agilus.in



Patient Ref. No. 666000007983037

PATIENT NAME : MRS. LAKSHMI A K

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : CA00010147 -
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI, SOUTH DELHI,
DELHI,
SOUTH DELHI 110030
8800465156

ACCESSION NO : **4182XB008875**
PATIENT ID : LAKSF1211904182
CLIENT PATIENT ID:
ABHA NO :

AGE/SEX : 34 Years Female
DRAWN :
RECEIVED : 24/02/2024 15:05:38
REPORTED : 26/02/2024 10:07:24

Test Report Status	Final	Results	Units
TOTAL PROTEIN		7.8	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8 g/dL
URIC ACID, SERUM			
URIC ACID		4.4	Adults : 2.4-5.7 mg/dL

BIOCHEMISTRY - LIPID

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO

LIPID PROFILE, SERUM

CHOLESTEROL	207	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	163 High	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	44	General range : 40-60	mg/dL
LDL CHOLESTEROL, DIRECT	150	Optimum : < 100 Above Optimum : 100-129 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	163	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO	32.6 4.7	</= 30.0 Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	mg/dL
LDL/HDL RATIO	3.4	Desirable/Low Risk - 0.5-3	

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Test Report Status	Final	Results	Units
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Borderline/Moderate Risk- 3.1-6
High Risk- >6.0

SPECIALISED CHEMISTRY - HORMONE

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO

THYROID PANEL, SERUM

T3	101.00	Non-Pregnant : 80-200	ng/dL
		Pregnant Trimester-wise	
		1st : 81-190	
		2nd : 100-260	
		3rd : 100-260	
T4	10.40	Adults : 4.5-12.1	µg/dl
TSH 3RD GENERATION	1.280	Non-Pregnant : 0.4-4.2	µIU/mL
		Pregnant Trimester-wise :	
		1st : 0.1 - 2.5	
		2nd : 0.2 - 3	
		3rd : 0.3 - 3	

CLINICAL PATH - URINALYSIS

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)2DECHO

PHYSICAL EXAMINATION, URINE

COLOR	YELLOWISH
APPEARANCE	CLEAR

CHEMICAL EXAMINATION, URINE

Page 10 Of 11



DR. HARI SHANKAR, MBBS MD
(Reg No - TCMC:62092)
HEAD - Biochemistry &
Immunology



DR. VAISHALI RAJAN, MBBS DCP
(Pathology)
(Reg No - TCC 27150)
HOD - HAEMATOLOGY



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Test Report Status	Final	Results	Units
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PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.008	1.003 - 1.035	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NEGATIVE		
CRYSTALS	NEGATIVE		
REMARKS	NIL		

METHOD : AUTOMATED ANALYSER, MICROSCOPY

DR.VAISHALI RAJAN, MBBS DCP
(Pathology)
(Reg No - TCC 27150)
HOD - HAEMATOLOGY



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