AARTHI SCANS & LABS

Patient	: **RAMANUJAM.T.S-10759668**	SID No.	: **05043048**
Age / Sex	: 40 Y / Male	Reg Date & Time	: 04/10/2022 09:23:42
Referrer	: MEDI ASSIST HEALTH CHECK UP – CREDIT	Coll Date & Time	: 04/10/2022 09:41:26
Branch	: VELACHERY - HUB	Report Date & Time	: 04/10/2022 19:44:00

Final Test Report

INVESTIGATION / METHOD	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
HAEMATOLOGY			
MEDI ASSIST CTS 36-45 YRS MALE PACKAG-2 WITH ECHO			
COMPLETE HAEMOGRAM			
RBC (Red Blood Cell Count) (Method : WB/Automated) (Specimen: EDTA WHOLE BLOOD)	5.21	Million/cmm	4.2-6.1
Haemoglobin (HB) (Method : WB/Automated) (Specimen: EDTA WHOLE BLOOD)	15.7	gm/dL	13-17
PCV -(Haematocrit-Packed Cell Volume) (Method : WB/Automated) (Specimen: EDTA WHOLE BLOOD)	45.7	%	40-50
MCV (Mean Corpuscular Volume) (Method : WB/Automated) (Specimen: EDTA WHOLE BLOOD)	87.6	fl	83-101
MCH (Mean Corpuscular Hemoglobin) (Specimen: EDTA WHOLE BLOOD)	30.0	pg	27-32
MCHC (Mean Corpuscular Hemoglobin Concentration) (Method : WB/Automated) (Specimen: EDTA WHOLE BLOOD)	34.3	%	31.5-34.5
RDW-CV(Red Cell Distribution Width-CV) (Specimen: EDTA WHOLE BLOOD)	13	%	11.6-14.0
Total WBC Count (Method : WB/Automated) (Specimen: EDTA WHOLE BLOOD)	7610	cells/cumm	4000-10000
DIFFERENTIAL COUNT(DC):EDTA WHOLE BLOOD (Optical(light scatter)Microscopy)			
Neutrophils (Specimen: EDTA WHOLE BLOOD)	64	%	40-80
Lymphocytes (Specimen: EDTA WHOLE BLOOD)	24	%	20-40
Monocytes (Specimen: EDTA WHOLE BLOOD)	8	%	2 - 10 %
Eosinophils (Specimen: EDTA WHOLE BLOOD)	4	%	1-6
Basophils (Specimen: EDTA WHOLE BLOOD)	0	%	< 1 - 2 %
Platelet Count (Method : WB/Automated) (Specimen: EDTA WHOLE BLOOD)	2.13	Lakhs/cumm	1.5-4.1

Dr. G. Aarthi, MD., Lab Director | Dr. A. Venu Anand, MD., Pathologist | Dr. M.V.R. Madhavi, MD., Biochemist | Dr. Umesh, MD., Microbiologist
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MPV (Mean Platelet Volume) (Specimen: EDTA WHOLE BLOOD)	12	fl	6.5-12.0
Erythrocyte Sedimentation Rate(ESR) (Westergran Method)			
1 Hour (Specimen: EDTA WHOLE BLOOD)	2	mm/hr	<10
RDW-SD(Red Cell Distribution Width-SD) (Specimen: EDTA WHOLE BLOOD)	41	fl	39-46

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INVESTIGATION / METHOD	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
BIOCHEMISTRY.			
MEDI ASSIST CTS 36-45 YRS MALE PACKAG-2 WITH ECHO			
GLUCOSE FASTING (FBS) (Method : Glucose Oxidase - Peroxidase) (Specimen: FLUORIDE EDTA PLASMA)	**101.0**	mg/d L	74-100
GLUCOSE POST PRANDIAL (PPBS) (Method : Glucose Oxidase - Peroxidase) (Specimen: FLUORIDE EDTA PLASMA)	128.0	mg/d L	80-140

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BIOCHEMISTRY			
MEDI ASSIST CTS 36-45 YRS MALE PACKAG-2 WITH ECHO			
Blood Urea Nitrogen(BUN) (Method : Urease/GLDH) (Specimen: SERUM)	10.7	mg/dL	6-20
CREATININE (Method : Creatinine amidohydrolase) (Specimen: SERUM)	0.8	mg/dL	0.66-1.25
URIC ACID (Method : Uricase) (Specimen: SERUM)	6.6	mg/dL	3.5-7.2
LIPID PROFILE			
CHOLESTEROL (Method : Cholesterol Oxidase,esterase,Peroxidase) (Specimen: SERUM)	**257.0**	mg/d L	Desirable :<200 Boderline high :200-239 High :>240
HDL CHOLESTEROL (Method : Direct) (Specimen: SERUM)	**33.0**	mg/d L	>40
LDL CHOLESTEROL (Method : Calculated) (Specimen: SERUM)	**156**	mg/dL	Optimal :<100 Near Optimal/above Optimal:100-129 Borderline high :132-159 High :159-189 VeryHigh :>190
TRIGLYCERIDES (Method : Lipase/Glycerol Dehydrogenase) (Specimen: SERUM)	**341.0**	mg/d L	Normal :<150 mg/dl Boderline high:150-199 mg/dl High :200-499 mg/dl very high :>500 mg/dl
VLDL CHOLESTEROL (Method : Calculation) (Specimen: SERUM)	**68.2**	mg/d L	10 - 40
Non-HDL Cholesterol (Method : Calculation) (Specimen: SERUM)	224.0		<160 mg/dl
CHO / HDL RATIO (Method : Calculation) (Specimen: SERUM)	**7.8**	Ratio	Optimal<3.5 Goal <5.0
LDL/HDL RATIO (Specimen: SERUM)	**4.7**	Ratio	1.5-3.5

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TGL/HDL Ratio (Method : Calculated) (Specimen: SERUM)	**10.3**		Ideal :<2.0 High risk :>4.0 Very high risk:6.0
LIVER FUNCTION TEST(LFT)			
BILIRUBIN TOTAL (Method : Diazo) (Specimen: SERUM)	0.70	mg/d L	0.3-1.2
BILIRUBIN DIRECT (Method : Diazo) (Specimen: SERUM)	0.20	mg/d L	<0.2
BILIRUBIN INDIRECT (Method : Diazo) (Specimen: SERUM)	0.50	mg/d L	0.2 - 0.9
Aspartate aminotransferase(AST/SGOT) (Method : UV without P5P, IFCC Traceable) (Specimen: SERUM)	33.0	U/L	<35
Alanine aminotransferase(ALT/SGPT) (Method : UV without P5P, IFCC Traceable) (Specimen: SERUM)	41.0	U/L	<45
ALKALINE PHOSPHATASE (Method : AMP) (Specimen: SERUM)	66.0	U/L	53-128
GAMMA GT (Method : Glutamyltransferase) (Specimen: SERUM)	33.0	U/L	<55
TOTAL PROTEIN (Method : Biuret) (Specimen: SERUM)	7.20	gms/dl	6.4-8.3
ALBUMIN (Specimen: SERUM)	4.40	gms/dl	3.5-5.2
GLOBULIN (Method : Calculation) (Specimen: SERUM)	2.8		2.3 - 3.5
A/G RATIO (Specimen: SERUM)	1.6		0.8-2.0
AST/ALT (Method : Calculated) (Specimen: SERUM)	0.8		

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Branch	: VELACHERY - HUB	Report Date & Time	: 04/10/2022 19:44:00

Final Test Report

INVESTIGATION / METHOD	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
CLINICAL PATHOLOGY			
MEDI ASSIST CTS 36-45 YRS MALE PACKAG-2 WITH ECHO			
URINE COMPLETE ANALYSIS,(CUE) (DIPSTICK)			
METHOD - DIPSTIC & MICROSCOPY			
PHYSICAL EXAMINATION			
COLOUR (Specimen: URINE.)	Pale Yellow		Pale Yellow
CLARITY (Specimen: URINE.)	Clear		
CHEMICAL EXAMINATION			
PH (Specimen: URINE.)	5.0		4.6 - 8.0
SPECIFIC GRAVITY (Specimen: URINE.)	1.030		1.000-1.030
GLUCOSE-URINE(F) (Specimen: URINE.)	Nil		Nil
ALBUMIN (Specimen: URINE.)	Nil		Nil
KETONE (Specimen: URINE.)	Negative		
BILE PIGMENTS&BILESALTS (Specimen: URINE.)	Negative		Absent
UROBILINOGEN (Specimen: URINE.)	Normal		
NITRITE (Specimen: URINE.)	Negative		
BLOOD (Specimen: URINE.)	Negative		
MICROSCOPIC EXAMINATION			
PUS CELLS (Specimen: URINE.)	1-2	/ hpf	0-5
EPITHELIAL CELLS (Specimen: URINE.)	2-4	/ hpf	0-5
RBC'S (Specimen: URINE.)	Nil	/ hpf	0-5
CRYSTAL (Specimen: URINE.)	Nil		

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Final Test Report

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HYALINE CAST (Specimen: URINE.)	Nil		0-2 hyaline cast
PATHOLOGICAL CAST (Specimen: URINE.)	Nil		
BACTERIA (Specimen: URINE.)	Nil		
YEAST (Specimen: URINE.)	Nil		
MUCUS (Specimen: URINE.)	Absent		

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Final Test Report

INVESTIGATION / METHOD	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL
IMMUNOLOGY			
MEDI ASSIST CTS 36-45 YRS MALE PACKAG-2 WITH ECHO			
TSH (Thyroid-stimulating hormone) (Method : CLIA) (Specimen: SERUM)	1.62	uIU/ml	0.4-4.5

NOTE:
*Time of the day, stress, intense physical activity, certain medications, sleep deprivation, fasting and illness cause fluctuations in TSH levels.
*Hence it is advised to take the TSH test around the same time of the day and in the same manner (fasting/non-fasting).

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Final Test Report

INVESTIGATION / METHOD	RESULT	UNITS	BIOLOGICAL REFERENCE INTERVAL

CYTOLOGY

MEDI ASSIST CTS 36-45 YRS MALE PACKAG-2 WITH ECHO

COMPLETE HAEMOGRAM

SMEAR STUDY

RBC's (Specimen: EDTA WHOLE BLOOD)	Normocytic Normochromic RBCs are seen
WBC's (Specimen: EDTA WHOLE BLOOD)	Normal in count, distribution and morphology
PLATELETS (Specimen: EDTA WHOLE BLOOD)	Adequate in number
OTHERS (Specimen: EDTA WHOLE BLOOD)	No hemoparasites seen
IMPRESSION (Specimen: EDTA WHOLE BLOOD)	NORMAL SMEAR STUDY

End of the Report

DR.V DIVYA MD.,
Pathologist

Medi Assist

COGNIZANT SUMMARY REPORT

Employee Name	Mr. Ramanujan. T.S.
Employee ID	2205287.
Age	40.
Gender	Male.
Date	04/10/22.
Name of center	Velachery
City	CHENNAI

BASIC PARAMTERS:

Height (in mts)	1.66
Weight (in Kgs)	74
BMI	26.85

Waist circumference (in cms)	85
Hip circumference (in cms)	90
Waist-to-hip ratio	0.94

Systolic BP	120
Diastolic BP	70 mmhg.

Name	**MR.RAMANUJAM.T.S 10759668**	**Patient ID**	**AS_VCY_US_43048**
Accession No	**05_043048_222266**	**Age/Gender**	**40Y / Male**
Referred By	**Dr.MEDI ASSIST HEALTH CHECK UP CREDIT**	**Date**	**4-Oct-2022**

USG REPORT - ABDOMEN AND PELVIS

LIVER:

Is normal in size and diffusely increased echo texture.

No obvious focal lesion seen. No intra hepatic biliary radical dilatation seen.

GALL BLADDER:

Multiple well defined hyperechoic lesions noted attached to anterior and posterior walls, largest measuring 4.5 mm attached to anterior wall.

ANCREAS:

Appears normal in size and shows uniform echo texture. The pancreatic duct is normal. No calcifications are seen.

SPLEEN:

Appears normal in size and it shows uniform echo texture.

RIGHT KIDNEY:

Right kidney appears normal in size.

The shape, size and contour of the right kidney appear normal.

Cortico medullary differentiation is maintained. No evidence of pelvicalyceal dilatation.

No calculi seen.

LEFT KIDNEY:

Left kidney appears normal in size.

The shape, size and contour of the left kidney appear normal.

Cortico medullary differentiation is maintained. No evidence of pelvicalyceal dilatation.

No calculi seen.

URINARY BLADDER:

Is normal in contour. No intraluminal echoes are seen. No calculus or diverticulum is seen.

Name	**MR.RAMANUJAM.T.S 10759668**	**Patient ID**	**AS_VCY_US_43048**
Accession No	**05_043048_222266**	**Age/Gender**	**40Y / Male**
Referred By	**Dr.MEDI ASSIST HEALTH CHECK UP CREDIT**	**Date**	**4-Oct-2022**

PROSTATE:

Measures 3.5 x 2.9 x 2.6 cm.Vol:14.3 cc. Normal

RIGHT ILIAC FOSSA:

No focal fluid collections seen.

IMPRESSION:

- **Mild Grade I fatty liver.**
- **Gall bladder polyps.**

Dr. Mounika.,MDRD.,
Radiologist

AARTHI SCANS & LABS

This document holds the written Radiology Report for

MR.RAMANUJAM.T.S-10759668

40 Years Male

Visited us on

04 October, 2022

XRAY CHEST

Acc# : 05_043048_222193

Referred By

MEDI ASSIST HEALTH CHECK UP – CREDIT

Name	**MR.RAMANUJAM.T.S 10759668**	**Patient ID**	**AS_VCY_CR_43048**
Accession No	**05_043048_222193**	**Age/Gender**	**40Y / Male**
Referred By	**Dr.MEDI ASSIST HEALTH CHECK UP CREDIT**	**Date**	**4-Oct-2022**

X-RAY - CHEST PA VIEW

OBSERVATION:

The trachea is central.

The mediastinal and cardiac silhoutte are normal.

Cardiothoracic ratio is normal.

Cardiophrenic and costophrenic angles are normal.

Both hila are normal.

Lung zones are clear.

Bones of the thoracic cage are normal.

Soft tissues of the chest wall are normal.

IMPRESSION:

- **No radiographically significant abnormality detected in chest.**

Please note that this report is a radiological professional opinion. It has to be correlated clinically and interpreted along with other investigations.
For referring doctors – Kindly contact 7824-860997 from 9am – 8pm, for any report clarifications

DR.M.Venkatesan., MDRD.,
Radiologist

Name	MR.RAMANUJAM.T.S 10759668	Patient ID	AS_VCY_ECHO_43048
Accession No	05_043048_223371	Age/Gender	40Y / Male
Referred By	Dr.MEDI ASSIST HEALTH CHECK UP CREDIT	Date	4-Oct-2022

Echocardiograpic Evaluation

Measurements:

M Mode Echo:

IVSD - 0.6 cm **LVIDD – 5.0 cm** **LVPWD – 0.9 cm**

IVSS - 1.2 cm **LVIDS - 3.3 cm** **LVPWS - 1.4 cm**

LVEF - 61.3 % **FS - 33.0%**

MV

E vel– 85.2.

A vel– 56.9.

MM & 2D Echo:

All four chambers (RA, RV, LA & LV) dimensions normal.

Valves appear normal.

Interatrial and interventricular septae intact.

No regional wall motion abnormalities of left ventricle.

Left ventricular size, systolic contraction and function normal.

Pericardial effusion – nil.

Intracardiac thrombus, vegetations or mass – nil.

Name	**MR.RAMANUJAM.T.S 10759668**	**Patient ID**	**AS_VCY_ECHO_43048**
Accession No	**05_043048_223371**	**Age/Gender**	**40Y / Male**
Referred By	**Dr.MEDI ASSIST HEALTH CHECK UP CREDIT**	**Date**	**4-Oct-2022**

Spectral and Color Doppler:

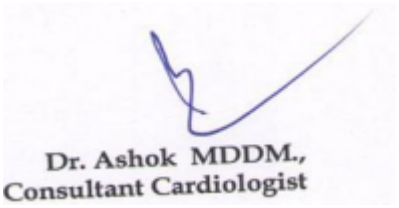
Aortic regurgitation Mild.

Interatrial or interventricular shunt – nil.

Patent ductus arteriosus flow – nil.

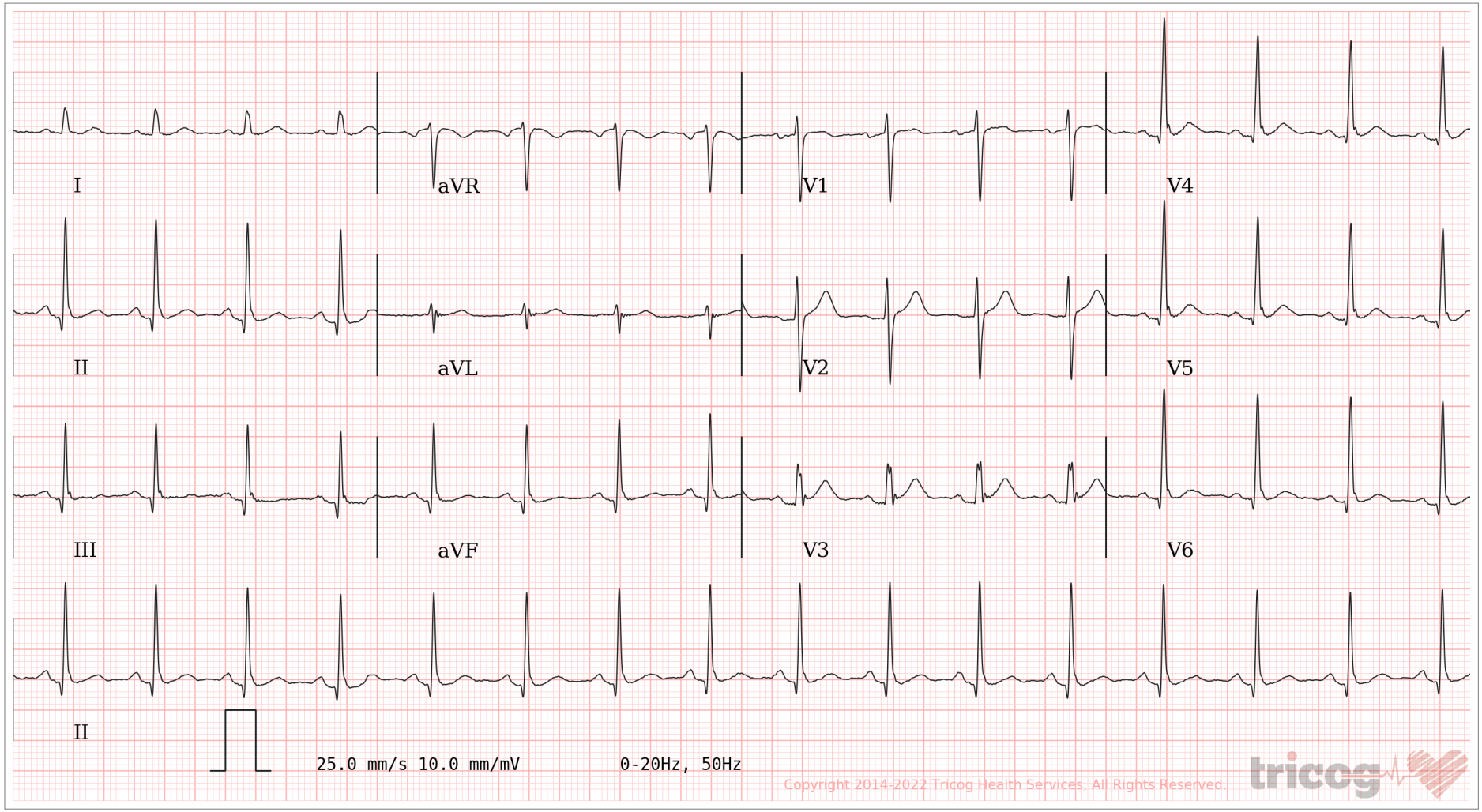
Impression:

- **Normal valves & chamber dimensions.**
- **Normal mitral, tricuspid and pulmonary valves.**
- **Intact IAS & IVS.**
- **Aortic regurgitation Mild.**
- **No regional wall motion abnormality.**
- **Normal LV systolic function.**
- **LVEF – 61.3%.**
- **No LV clot or aneurysm.**
- **No pericardial effusion.**
- **Normal diastolic function.**



Aarthi scans and lab Private Ltd-Velachery 1

Age / Gender:	40/Male	Date and Time:	4th Oct 22 2:12 PM
Patient ID:	0005043048		
Patient Name:	MR.RAMANUJAM.T.S		



AR: 99bpm VR: 99bpm QRSD: 82ms QT: 322ms QTc: 413ms PRI: 148ms P-R-T: 67° 74° 48°

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

AUTHORIZED BY

Dr. Charit
MD, DM: Cardiology

63382

REPORTED BY

Dr Prashant Solshe

34384