

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Rama Krishna

DATE: 8/3/24

AGE : 37

SEX: Male / Female

NMU: NMU000 47011

DOCTOR'S NAME:

Health padmal

| | | | |
|---------|-----------------|----------|--------------------|
| TEMP : | <u>97.3</u> ° f | BP : | <u>130/90</u> mmHg |
| PULSE : | <u>72</u> b/m | HEIGHT : | <u>163.3</u> cm |
| RR : | <u>20</u> b/m | WEIGHT : | <u>76.2</u> kg |
| SPO2 : | <u>96</u> % RA | HGT: | <u>—</u> |

REMARK:



| | |
|---|---|
| Patient Name : Mr. RAMAKRISHNA PATHAKAMUDI | Age /Gender : 37 Y(s)/Male |
| Bill No/ UMR No : NMBC60594/NMU0047011 | Referred By : Dr. DMO |
| Received Dt : 08-Mar-24 09:13 am | Report Date : 08-Mar-24 05:06 pm |

FINAL REPORT

| <u>Parameters</u> | <u>Specimen</u> | <u>Result</u> | <u>Biological Reference Intervals</u> | <u>Method</u> |
|--|-----------------|--|---------------------------------------|--|
| CUE(COMPLETE URINE EXAMINATION) | | | | |
| <u>PHYSICAL EXAMINATION</u> | | | | |
| VOLUME | Urine | 30 ML | | |
| COLOUR | | PALE YELLOW | PALE YELLOW | |
| APPEARANCE | | CLEAR | CLEAR | |
| DEPOSIT | | ABSENT | ABSENT | |
| <u>CHEMICAL EXAMINATION</u> | | | | |
| SPECIFIC GRAVITY | Urine | 1.015 | 1.000 - 1.030 | Dipstick |
| PH | | 6.0 | 5.0 - 8.0 | Dipstick |
| PROTEIN | | NEGATIVE | NEGATIVE | Dipstick/Heat coagulation test |
| GLUCOSE | | ABSENT | ABSENT | Dipstick/Benedict's test |
| UROBILINOGEN | | NORMAL | NORMAL | Dipstick |
| KETONE | | NEGATIVE | NEGATIVE | Dipstick/Rothera's Nitroprusside test. |
| BILIRUBIN | | NEGATIVE | NEGATIVE | Dipstick/Fouchet's test |
| BILE SALT | | NEGATIVE | NEGATIVE | Hay's sulphur powder test |
| BILE PIGMENT | | NEGATIVE | NEGATIVE | Fouchet test |
| NITRITE | | NEGATIVE | NEGATIVE | Dipstick |
| LEUCOCYTE ESTERASE | | NEGATIVE | NEGATIVE | |
| <u>MICROSCOPIC EXAMINATION</u> | | | | |
| PUS CELLS | Urine | 1-2 | 0 - 5 /hpf | MICROSCOPIC EXAMINATION |
| RBC | | NIL | 0 - 5 /hpf | MICROSCOPIC EXAMINATION |
| EPITHELIAL CELLS | | 1-2 | 0 - 5 /hpf | MICROSCOPIC EXAMINATION |
| CRYSTALS | | NIL | NIL | MICROSCOPIC EXAMINATION |
| CASTS | | NIL | NIL | MICROSCOPIC EXAMINATION |
| BACTERIA | | ABSENT | | MICROSCOPIC EXAMINATION |
| YEAST | | ABSENT | | MICROSCOPIC EXAMINATION |
| AMORPHOUS DEPOSITS | | ABSENT | | MICROSCOPIC EXAMINATION |
| MUCUS THREAD | | ABSENT | | MICROSCOPIC EXAMINATION |
| NOTE | | Microscopic examination of urine is carried out on centrifuged urinary sediment. | | |

*** End Of Report ***





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

| | |
|---|---|
| Patient Name : Mr. RAMAKRISHNA PATHAKAMUDI | Age / Gender : 37 Y(s)/Male |
| Bill No/ UMR No : NMBC60594/NMU0047011 | Referred By : Dr. DMO |
| Received Dt : 08-Mar-24 09:13 am | Report Date : 08-Mar-24 05:06 pm |

Parameters **Specimen** **Result** **Biological Reference In Method**





DEPARTMENT OF LABORATORY

NAVI MUMBAI

| | |
|---|---|
| Patient Name : Mr. RAMAKRISHNA PATHAKAMUDI | Age /Gender : 37 Y(s)/Male |
| Bill No/ UMR No : NMBC60594/NMU0047011 | Referred By : Dr. DMO |
| Received Dt : 08-Mar-24 09:13 am | Report Date : 08-Mar-24 01:43 pm |

FINAL REPORT

| <u>Parameters</u> | <u>Specimen</u> | <u>Result</u> | <u>Biological Reference Intervals</u> | <u>Method</u> |
|-----------------------------|-----------------|---------------|---------------------------------------|---------------------|
| ESR | CITRATED BLOOD | 10 | 0 - 10 mm/1st hour | WESTERGREN'S METHOD |
| COMPLETE BLOOD COUNT | | | | |
| RBC | | | | |
| R B C COUNT | Blood | 5.46 | 4.5 - 5.5 $10^6/\mu\text{L}$ | |
| HEMOGLOBIN | | 15.2 | 13.0 - 17.0 g/dl | |
| PCV/HCT | | 45.0 | 40 - 50 % 36 - 46 % | |
| MCV | | 83 | 83 - 101 fl 83 - 101 fl | |
| MCH | | 27.8 | 27 - 32 pg | |
| MCHC | | 33.7 | 31.5 - 34.5 g/dL | |
| RDW(cv) | | 14.0 | 11.6 - 14.0 % | |
| PLATELETS | | | | |
| PLATELET COUNT | Blood | 296 | 150 - 400 $10^3/\mu\text{L}$ | |
| MPV | | 8.4 | 7.5 - 11.5 fl | |
| WBC | | | | |
| TC (TOTAL LEUCOCYTE COUNT) | Blood | 6.1 | 4.0 - 11.0 $10^3/\mu\text{l}$ | |
| DIFFERENTIAL COUNT | | | | |
| NEUTROPHILS | Blood | 42 | 40 - 80 % | |
| LYMPHOCYTES | | 50 | 20 - 40 % | |
| MONOCYTES | | 06 | 02 - 10 % | |
| EOSINOPHILS | | 02 | 00 - 06 % | |
| BASOPHILS | | 00 | 00 - 01 % | |

*** End Of Report ***





DEPARTMENT OF LABORATORY

NAVI MUMBAI

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|---|---|
| Patient Name : Mr. RAMAKRISHNA PATHAKAMUDI | Age /Gender : 37 Y(s)/Male |
| Bill No/ UMR No : NMBC60594/NMU0047011 | Referred By : Dr. DMO |
| Received Dt : 08-Mar-24 09:13 am | Report Date : 08-Mar-24 07:20 pm |

FINAL REPORT

| <u>Parameter</u> | <u>Specimen</u> | <u>Result Values</u> | <u>Biological Reference</u> | <u>Method</u> |
|---|------------------|----------------------|------------------------------|---|
| FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE) | | | | |
| FASTING BLOOD GLUCOSE | PLASMA AND URINE | 100 | Normal Range : 70 - 99 mg/dL | Hexokinase |
| FASTING URINE SUGAR | | NIL | | |
| T3,T4 AND TSH | | | | |
| T3 | | 103.1 | 70 - 204 ng/dL | Method : ECLIA |
| T4 | | 7.40 | 5.1 - 14.1 ug/dL | Method : ECLIA |
| TSH(THYROID STIMULATING HORMONE) | | 1.31 | 0.270 - 4.20 uIU/mL | Method : ECLIA |
| PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR) | | | | |
| PLBS (POST LUNCH BLOOD GLUCOSE) | | 89 | 110 - 180 mg/dL | Hexokinase |
| URINE SUGAR | | NIL | | Dipstick |
| SERUM CREATININE | | | | |
| CREATININE | | 0.96 | 0.8 - 1.3 mg/dl | Method : jaffe |
| BUN / CREATININE RATIO | | | | |
| BUN (Blood Urea Nitrogen.) | | 7 | 7.0 - 21.0 mg/dL | Calculated |
| SERUM CREATININE | | 0.96 | 0.8 - 1.3 mg/dL | |
| BUN / CREATININE RATIO | | 7.29 | 10 - 20 | |
| LFT(LIVER FUNCTION TEST) | | | | |
| TOTAL BILIRUBIN | | 0.5 | < 1.2 mg/dL | Method : Diazo Method |
| DIRECT BILIRUBIN | | 0.2 | <= 0.20 mg/dL | Method: Diazo Method |
| INDIRECT BILIRUBIN | | 0.3 | <= 1.0 mg/dL | |
| SGPT (ALT) | | 36 | <= 41 U/L | Method : UV without P5P |
| SGOT (AST) | | 22 | <= 40 U/L | Method : UV without P5P |
| ALKALINE PHOSPHATASE (ALP) | | 74 | 40 - 129 U/L 35 - 105 U/L | Method : PNPP, AMP Buffer - IFCC Ref. |
| TOTAL PROTEINS | | 7.5 | 6.0 - 8.0 g/dL | Method : Biuret method |
| SERUM ALBUMIN | | 5.0 | 3.5 - 5.2 g/dL | Method : Bromcresol Green (BCG) |
| GLOBULINS | | 2.5 | 2.5 - 3.5 g/dL | |
| A/G RATIO | | 2.0 | 1.2 - 2.5 | |
| GAMMA GLUTAMYL TRANSFERASE(GGT) | | 35 | 10 - 71 U/L | Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref. |





DEPARTMENT OF LABORATORY

NAVI MUMBAI

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| Bill No/ UMR No : NMBC60594/NMU0047011 | Referred By : Dr. DMO |
| Received Dt : 08-Mar-24 09:13 am | Report Date : 08-Mar-24 07:40 pm |

Specimen

BUN(BLOOD UREA NITROGEN)

BUN (Blood Urea Nitrogen.) 7 7.0 - 21.0 mg/dL Calculated

TOTAL PROTEIN

TOTAL PROTEINS 7.5 6.0 - 8.0 g/dL Method : Biuret method

LIPID PROFILE

TOTAL CHOLESTEROL 181
 Desirable : : < 200 mg/dL METHOD : Enzymatic colorimetric
 Borderline High : : 200 - 239 mg/dL
 High risk : > 240 mg/dL
 HDL CHOLESTEROL 35 Low : : < 40 mg/dL Homogeneous enzymatic colorimetric
 High : : > 60 mg/dL
 LDL CHOLESTEROL 114 Optimal : - < 100 mg/dL Direct-Enzymatic colorimetric
 Near Optimal : 100 - 129 mg/dL
 Borderline High : 130 - 159 mg/dL
 High : 160 - 189 mg/dL
 Very High : - > 190 mg/dL

VLDL 42
 SERUM TRYGLYCERIDES 212 < 150 mg/dL METHOD: Enzymatic colorimetric
 Borderline High : 150 - 199 mg/dL
 High : 200 - 499 mg/dL
 CHO/HDL RATIO 5.17 Normal : - < 3.5
 High Risk : - > 5.0

LDL/HDL RATIO 3.26
 SERUM URIC ACID 6.4 3.4 - 7.0 mg/dL uricase

HBA1C (GLYCOSYLATED HAEMOGLOBIN)

HBA1C 6.4 < 5.7 Normal Prediabetic 5.7 TINIA
 - 6.4 & >/=6.5 Diabetic %
 MPG(Mean Plasma Glucose) 137 Excellent Control : 90 - 120 mg/dL
 Good Control : 121 - 150 mg/dL

*** End Of Report ***

THIS IS A MODIFIED REPORT





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

| | |
|---|---|
| Patient Name : Mr. RAMAKRISHNA PATHAKAMUDI | Age /Gender : 37 Y(s)/Male |
| Bill No/ UMR No : NMBC60594/NMU0047011 | Referred By : Dr. DMO |
| Received Dt : 08-Mar-24 09:13 am | Report Date : 09-Mar-24 09:10 am |

Parameters **Specimen** **Result** **Biological Reference In Method**

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head, Laboratory Services

Verified By : : 022315

Test results related only to the item tested.

No part of the report can be reproduced without written permission of the laboratory.



| | | | |
|-----------------------------|--------------------|----------------------|--------------------------------|
| Patient ID: | NMU0047011 | Patient Name: | RAMAKRISHNA PATHAKAMUDI |
| Age: | 37 Years | Sex: | M |
| Accession Number: | NMBC60594 | Modality: | DX |
| Referring Physician: | DR.DMO | Study: | CHEST |
| Study Date: | 08-Mar-2024 | Study Time: | 10:28:59 |

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

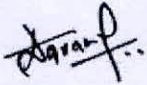
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

- **No significant abnormality is seen.**



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 08-Mar-2024 20:26:00

| | | | |
|-----------------------------|--------------------|----------------------|--------------------------------|
| Patient ID: | NMU0047011 | Patient Name: | RAMAKRISHNA PATHAKAMUDI |
| Age: | 37 Years | Sex: | M |
| Accession Number: | NMBC60594 | Modality: | US |
| Referring Physician: | DR.DMO | Study: | USG ABDOMEN WHOLE |
| Study Date: | 08-Mar-2024 | Study Time: | 10:01:54 |

USG WHOLE ABDOMEN

LIVER is normal in size (14.5 cm), normal in shape with bright echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears partially distended with normal wall thickness. There is no obvious calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

SPLEEN is normal in size (9.1 cm) and echotexture. No focal lesion seen. SV is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

Urinary Bladder is adequately distended; no e/o wall thickening or mass or calculi seen. Post-void residue is not significant.

PROSTATE is normal in size, shape & echotexture. It ms 22 gms.

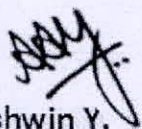
Visualised bowel loops appear normal. There is no free fluid seen.

NB:- This scan does not rule out all pathologies related to bowel and appendix.

IMPRESSION –

- **Grade I fatty liver.**
- **No other significant abnormality detected**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



Dr. Ashwin Y.
M.D. (Radio-Diagnosis)



MEDICOVER
HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : Mr. Ramakrishna

Date:-08/03/2024

Age / Sex : 37 Yrs / Male

UMR No. 0047011

Referred By : Health Check Up

FINDINGS:

- Mild concentric left ventricle hypertrophy.
- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 25 mm Hg
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- Mild LVH.
- No RWMA.
- Grade I LV diastolic dysfunction.
- Trivial MR and TR. No PH.
- Normal LV and RV systolic function.

DR. KESHAV KALE

DNB (Cardiology), MD (Medicine), MBBS
PhD (Cardiology), MNAMS, LL.B (Law)
FSCAI (USA), AFACC (USA), FESC (EU)
Consultant & Interventional Cardiologist





MEDICOVER
HOSPITALS

NAVI MUMBAI

M-MODE MEASUREMENTS:

| | | |
|-------------|----|-----|
| LA | 34 | mm. |
| AO root | 28 | mm |
| AO CUSP SEP | 18 | mm |
| LVID(s) | 32 | mm |
| LVID(d) | 43 | mm |
| IVS(d) | 14 | mm |
| LVPW(d) | 13 | mm |
| RVID(d) | 29 | mm |
| RA | 32 | mm |
| LVEF | 60 | % |

| | PEAK | MEAN | Vmax | Gradient of Regurgitation |
|-----------|------|------|------|---------------------------|
| MITRAL | N | | | Trivial |
| AORTIC | 10 | | | Nil |
| TRICUSPID | 25 | | | Trivial |
| PULMONERY | 5.3 | | | Nil |





DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 08/08/24

PATIENT NAME: Mrs Ramesh Krishna P.

AGE / SEX 37 / F NAVI MUMBAI

UMR NO: N500047011

| | RE | LE |
|---------------|--------|--------|
| VA (DISTANCE) | 6/6p | 6/6 |
| VA (NEAR) | Ng | Ng |
| COLOUR VISION | Normal | Normal |

| | | SPHERE | CYLINDER | AXIS | VA |
|-----|-----|--------|----------|------|-------|
| MRx | O D | + — | -0.50 | 100° | 6/6pc |
| | O S | Plano | — | | 6/6nc |

HISTORY :

- NHI systemic illness (DM, HTN, Thyroid) NHI spectacle use.
- NHI ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

(BE) - Ant seg WNL
 (indicated) Disc ≤ 0.4
 0.4

ADVICE:

Refresh cld qd 1777X 1 month

AP
 CDR. ANUSHREE VANIKAR



NMU0047011

37 Years

RAMAKRISHNA PATHAKAMUDI

Male

3/8/2024 12:15:33 PM

Rate 67 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . RSR' in V1 or V2, right VCD or RVH.....QRS area positive & R' V1/V2
 . Borderline T abnormalities, inferior leads.....T flat/neg, II III aVF

QRSD 106
 QT 397
 QTc 419

--AXIS--

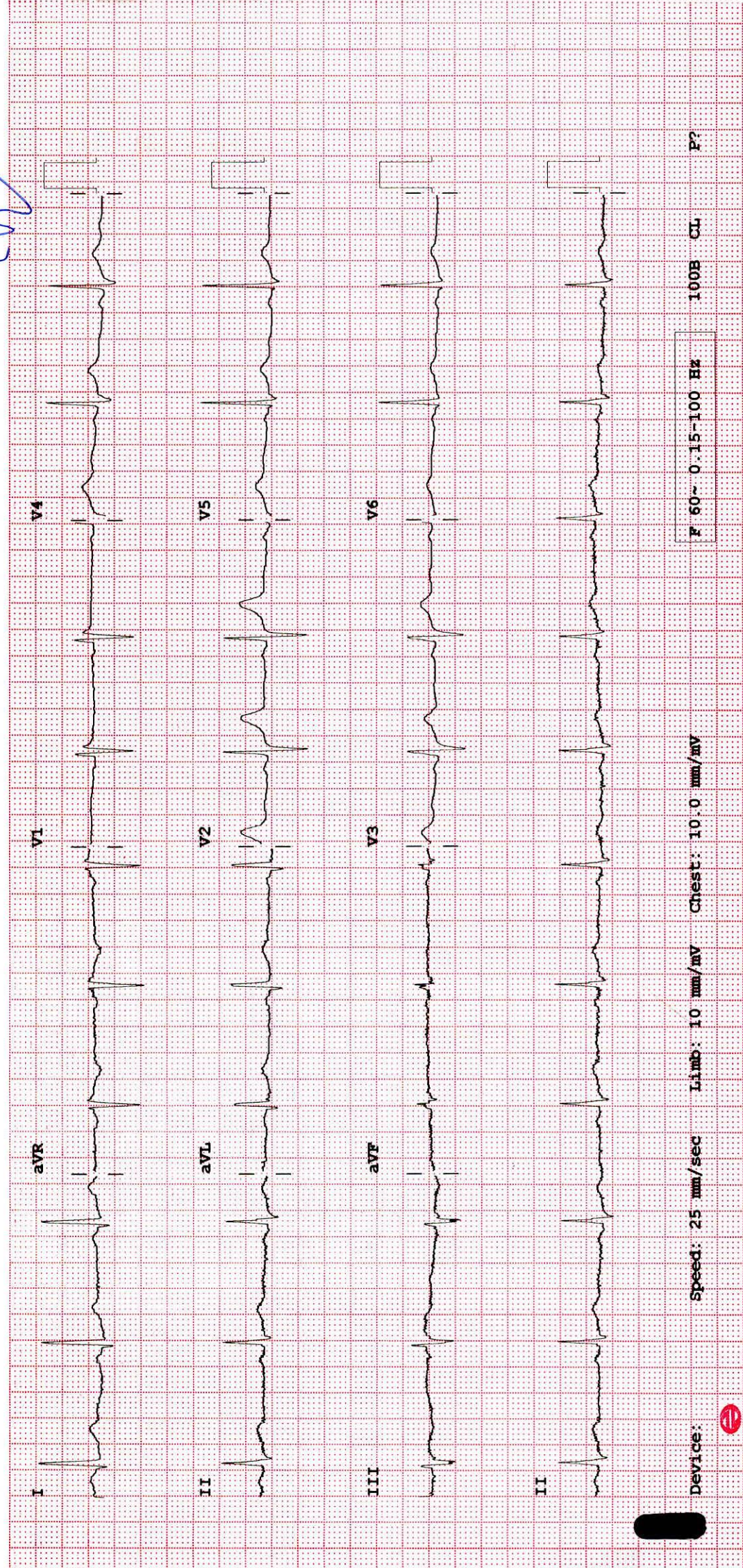
P 21
 QRS 8
 T 3

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

WNR
[Signature]



Device:

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

100B CL

P2

