

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME: Mr / Mrs Shashank Singh Patel DATE: 8/3/24

AGE: 33y4

SEX: Male / Female

NMU: NMU00047016

DOCTOR'S NAME:
Health package

TEMP :	<u>96.8</u>	° f	BP :	<u>130/90</u>	mmHg
PULSE :	<u>65</u>	b/m	HEIGHT :	<u>165</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>88.5</u>	kg
SPO2 :	<u>98</u>	% RA	HGT:	<u>-</u>	

REMARK:



DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 08/08/25

PATIENT NAME: ~~Mr~~ Shashank Patel.

AGE / SEX : 33 | M NAVI MUMBAI

UMR NO : NMU0047016.

	RE	LE
VA (DISTANCE)	6/6	6/6
VA (NEAR)	N6	N6
COLOUR VISION	Normal	Normal

		SPHERE	CYLINDER	AXIS	VA
MRx	O D	plano	—		6/6 N6
	O S	plano	—		6/6 N6

HISTORY :

• n/o systemic illness (DM, HTN, thyroid). n/o spectacle use
 • n/o ocular trauma, allergies & surgeries.

OCULAR FINDINGS :

(BEI - Ant seg WNL)

(funditd) Disc T 0.4
0.3

ADVICE:

Refresh Tear e/d qid 1777 X (month).

AI
(DR. ANUSHREE VANKAR)





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. SHASHANK SINGH PAL	Age /Gender : 33 Y(s)/Male
Bill No/ UMR No : NMBC60598/NMU0047016	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:46 am	Report Date : 08-Mar-24 05:04 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		5.0	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	0-1	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		
AMORPHOUS DEPOSITS		ABSENT		
MUCUS THREAD		ABSENT		

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. SHASHANK SINGH PAL	Age /Gender : 33 Y(s)/Male
Bill No/ UMR No : NMBC60598/NMU0047016	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:46 am	Report Date : 08-Mar-24 05:04 pm

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





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. SHASHANK SINGH PAL	Age /Gender : 33 Y(s)/Male
Bill No/ UMR No : NMBC60598/NMU0047016	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:46 am	Report Date : 08-Mar-24 01:45 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
ESR	CITRATED BLOOD	11	0 - 10 mm/1st hour	WESTERGREN'S METHOD

COMPLETE BLOOD COUNT

RBC

R B C COUNT	Blood	4.99	4.5 - 5.5 $10^6/\mu\text{L}$
HEMOGLOBIN		14.9	13.0 - 17.0 g/dl
PCV/HCT		44.5	40 - 50 %
MCV		89	36 - 46 %
MCH		29.9	83 - 101 fl
MCHC		33.6	83 - 101 fl
RDW(cv)		14.0	27 - 32 pg
			31.5 - 34.5 g/dL
			11.6 - 14.0 %

PLATELETS

PLATELET COUNT	Blood	90	150 - 400 $10^3/\mu\text{L}$
MPV		14.6	7.5 - 11.5 fl

WBC

TC (TOTAL LEUCOCYTE COUNT)	Blood	7.2	4.0 - 11.0 $10^3/\mu\text{l}$
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DIFFERENTIAL COUNT

NEUTROPHILS	Blood	50	40 - 80 %
LYMPHOCYTES		42	20 - 40 %
MONOCYTES		06	02 - 10 %
EOSINOPHILS		02	00 - 06 %
BASOPHILS		00	00 - 01 %

PERIPHERAL SMEAR EXAMINATION

RBC

Mild anisopoikilocytosis. Predominantly normocytic normochromic with ovalocytes. Normal morphology.

WBC

PLATELETS

Reduced in smear. Macroplatelets and giant platelets are also seen.

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. SHASHANK SINGH PAL	Age /Gender : 33 Y(s)/Male
Bill No/ UMR No : NMBC60598/NMU0047016	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:46 am	Report Date : 09-Mar-24 12:27 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. SHASHANK SINGH PAL	Age /Gender : 33 Y(s)/Male
Bill No/ UMR No : NMBC60598/NMU0047016	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:47 am	Report Date : 08-Mar-24 05:38 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	91	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		101.8	70 - 204 ng/dL	Method : ECLIA
T4		5.38	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.77	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.86	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.86	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		10.46	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)		91	<= 41 U/L	Method : UV without P5P
SGOT (AST)		36	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		101	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.0	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.72	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		52	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. SHASHANK SINGH PAL	Age /Gender : 33 Y(s)/Male
Bill No/ UMR No : NMBC60598/NMU0047016	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:46 am	Report Date : 08-Mar-24 07:20 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		225	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		34	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		144	Optimal : - < 100 mg/dL Near Optimal : 100 - 129 mg/dL Borderline High : 130 - 159 mg/dL High : 160 - 189 mg/dL Very High : - > 190 mg/dL	Direct-Enzymatic colorimetric
VLDL		69		
SERUM TRYGLYCERIDES		343	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		6.62	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		4.24		
SERUM URIC ACID		6.4	3.4 - 7.0 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		72	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.8	< 5.7 Normal Prediabetic 5.7 - 6.4 & >=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		120	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. SHASHANK SINGH PAL	Age / Gender : 33 Y(s)/Male
Bill No/ UMR No : NMBC60598/NMU0047016	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:46 am	Report Date : 09-Mar-24 09:12 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
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Lab Incharge


Dr. VISHAL MEHROTRA, MD Pathology
Head, Laboratory Services

Verified By : : 022315

Test results related only to the item tested.

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Patient ID:	NMU0047016	Patient Name:	SHASHANK SINGH PAL
Age:	33 Years	Sex:	M
Accession Number:	NMBC60598	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	08-Mar-2024	Study Time:	10:21:04

USG WHOLE ABDOMEN

LIVER is normal in size (15.3 cm), normal in shape and 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 (12 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 18 gms.

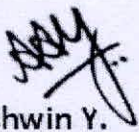
Visualised bowel loops appear normal. There is no free fluid seen.

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

IMPRESSION –

- **No significant abnormality detected.**

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



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

Patient ID:	NMU0047016	Patient Name:	SHASHANK SINGH PAL
Age:	33 Years	Sex:	M
Accession Number:	NMBC60598	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	08-Mar-2024	Study Time:	10:49:25

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

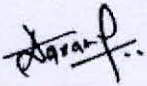
Both hilar shadows are normal in position and density.

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 20:27:32



MEDICOVER
HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: Mr Shashank Pal	Date:- 08/03/2024
Age / Sex	: 33 Yrs / Male	UMR No. 0047016
Referred By	: Health Checkup	

FINDINGS:

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

IMP:

- No RWMA.
- Trivial 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	19	mm
LVID(s)	32	mm
LVID(d)	44	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	11			Nil
TRICUSPID	25			Trivial
PULMONERY	5.3			Nil



NMU0047016

33 Years

SHASHANK PAL

Male

3/8/2024 12:08:26 PM

Rate 58 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Borderline short PR interval.....PR int <120ms
 . Borderline T abnormalities, inferior leads.....T flat/neg, II III aVF

PR 112
 QRS 106
 QT 417
 QTc 410

mm
mm

--AXIS--

P 9

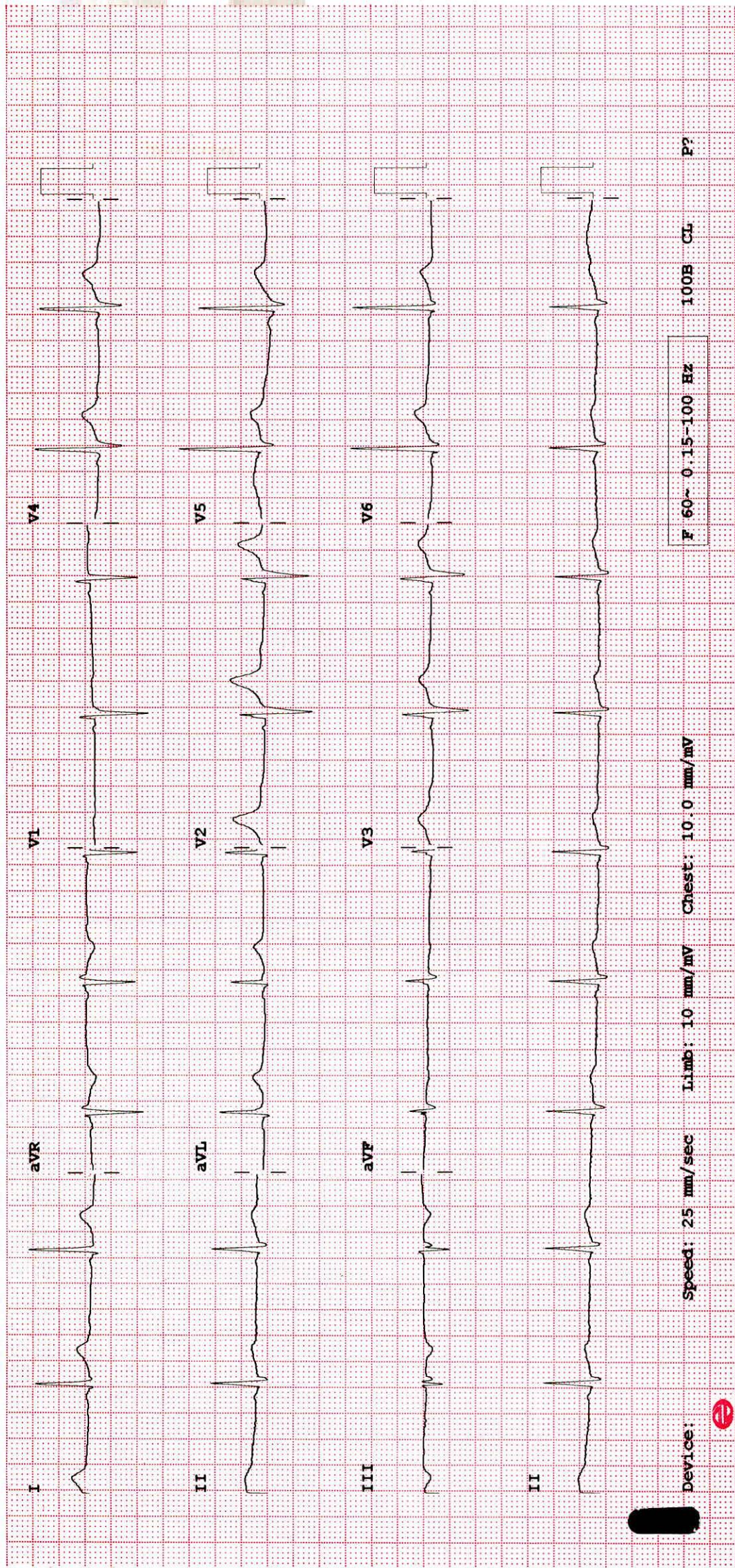
QRS 8

T -4

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis



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

F 60- 0.15-100 HZ

100B CL P?

