

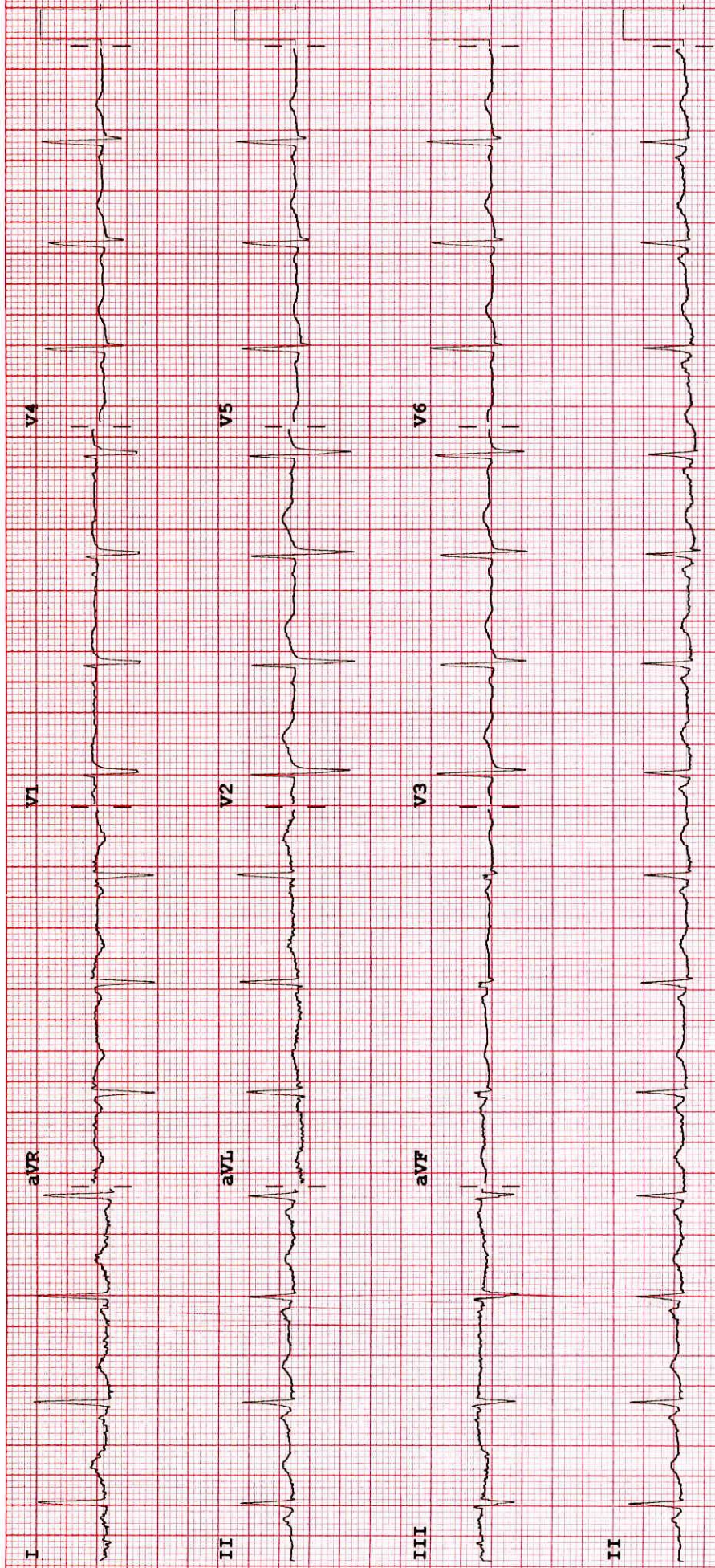
Rate 87 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation  
Sinus rhythm.....normal P axis, V-rate 50- 99

PR 140  
QRSD 81  
QT 370  
QTc 445  
--AXIS--  
P 45  
QRS 6  
T 8

12 Lead; Standard Placement

- NORMAL 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 P2



**MEDICOVER  
HOSPITALS**

# MEDICOVER HOSPITALS

## MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Mrs Aradhita

DATE: 23/3/24

AGE: 40yrs

SEX: Male/ Female



NMU: NMU000 48876

DOCTOR'S NAME:

Health Package

TEMP :	<u>97.4</u>	° f	BP :	<u>110/60</u>	mmHg
PULSE :	<u>85</u>	b/m	HEIGHT :	<u>153</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>80.1</u>	kg
SPO2 :	<u>96</u>	% RA	HGT:	<u>-</u>	

REMARK:



**DEPARTMENT OF LABORATORY**

NAVI MUMBAI

**Patient Name** : Miss. CHATTERJEE ARADHITA      **Age / Gender** : 40 Y(s)/Female  
**Bill No/ UMR No** : NMBC63394/NMU0048876      **Referred By** : Dr. DMO  
**Received Dt** : 23-Mar-24 10:15 am      **Report Date** : 23-Mar-24 12:40 pm

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>COMPLETE BLOOD COUNT</b>				
<b>RBC</b>				
R B C COUNT	Blood	4.51	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		13.1	12.0 - 15.0 g/dl	
PCV/HCT		39.4	40 - 50 % 36 - 46 %	
MCV		87	83 - 101 fl 83 - 101 fl	
MCH		29.1	27 - 32 pg	
MCHC		33.4	31.5 - 34.5 g/dL	
RDW(cv)		12.6	11.6 - 14.0 %	
<b>PLATELETS</b>				
PLATELET COUNT	Blood	306	150 - 400 $10^3/\mu\text{L}$	
MPV		8.8	7.5 - 11.5 fl	
<b>WBC</b>				
TC (TOTAL LEUCOCYTE COUNT)	Blood	8.3	4.0 - 11.0 $10^3/\mu\text{l}$	
<b>DIFFERENTIAL COUNT</b>				
NEUTROPHILS	Blood	58	40 - 80 %	
LYMPHOCYTES		33	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	45	0 - 20 mm/1st hour	WESTERGREN'S METHOD

\*\*\* End Of Report \*\*\*





**DEPARTMENT OF LABORATORY**

NAVI MUMBAI

<b>Patient Name</b> : Miss. CHATTERJEE ARADHITA	<b>Age / Gender</b> : 40 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC63394/NMU0048876	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 23-Mar-24 10:14 am	<b>Report Date</b> : 23-Mar-24 01:57 pm

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)</b>				
FASTING BLOOD GLUCOSE		103	Normal Range : 70 - 99 mg/dL	Hexokinase
<b>SERUM ELECTROLYTES</b>				
SERUM SODIUM		142	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.5	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		107	98 - 107 mmol/L	ISE INDIRECT
<b>T3, T4 AND TSH</b>				
T3		139.9	70 - 204 ng/dL	Method : ECLIA
T4		7.63	5.1 - 14.1 ug/dL	Method : ECLIA
TSH (THYROID STIMULATING HORMONE)		1.43	0.270 - 4.20 uIU/mL	Method : ECLIA
<b>PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)</b>				
PLBS (POST LUNCH BLOOD GLUCOSE)		95	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
<b>SERUM CREATININE</b>				
CREATININE		0.71	0.6 - 1.2 mg/dl	Method : jaffe
<b>BUN / CREATININE RATIO</b>				
BUN (Blood Urea Nitrogen.)		14	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.71	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		19.7	10 - 20	
<b>LFT (LIVER FUNCTION TEST)</b>				
TOTAL BILIRUBIN		0.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		42	<= 33 U/L	Method : UV without P5P
SGOT (AST)		20	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		90	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		8.1	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.6	2.5 - 3.5 g/dL	





**DEPARTMENT OF LABORATORY**

NAVI MUMBAI

<b>Patient Name</b> : Miss. CHATTERJEE ARADHITA	<b>Age / Gender</b> : 40 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC63394/NMU0048876	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 23-Mar-24 10:15 am	<b>Report Date</b> : 25-Mar-24 10:19 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
A/G RATIO		1.25	1.2 - 2.5
GAMMA GLUTAMYL TRANSFERASE(GGT)		26	6 - 42 U/L Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
<b>BUN(BLOOD UREA NITROGEN)</b>			
BUN (Blood Urea Nitrogen.)		14	7.0 - 21.0 mg/dL Calculated
<b>TOTAL PROTEIN</b>			
TOTAL PROTEINS		8.1	6.0 - 8.0 g/dL Method : Biuret method
<b>LIPID PROFILE</b>			
TOTAL CHOLESTEROL		214	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		37	Low : : < 40 mg/dL High : : > 60 mg/dL Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		155	Optimal : - < 100 mg/dL Near Optimal : 100 - 129 mg/dL Direct-Enzymatic colorimetric Borderline High : 130 - 159 mg/dL High : 160 - 189 mg/dL Very High : - > 190 mg/dL
VLDL		25	
SERUM TRYGLYCERIDES		124	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL METHOD: Enzymatic colorimetric
CHO/HDL RATIO		5.78	Normal : - < 3.5 High Risk : - > 5.0
LDL/HDL RATIO		4.19	
SERUM URIC ACID		5.7	2.4 - 5.7 mg/dL uricase
<b>HBA1C (GLYCOSYLATED HAEMOGLOBIN)</b>			
HBA1C		5.9	< 5.7 Normal Prediabetic 5.7 - 6.4 % Diabetic >=6.5 % TINIA
MPG(Mean Plasma Glucose)		122	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL

\*\*\* End Of Report \*\*\*





**MEDICOVER**  
HOSPITALS

**DEPARTMENT OF LABORATORY**

NAVI MUMBAI

**Patient Name** : Miss. CHATTERJEE ARADHITA      **Age / Gender** : 40 Y(s)/Female  
**Bill No/ UMR No** : NMBC63394/NMU0048876      **Referred By** : Dr. DMO  
**Received Dt** : 23-Mar-24 10:15 am      **Report Date** : 25-Mar-24 10:19 am

Parameters                      Specimen      Result                      Biological Reference In Method

**Lab Incharge**

**Dr. VISHAL MEHROTRA, MD Pathology**  
Head, Laboratory Services

Verified By : : 026560

Test results related only to the item tested.

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# DEPARTMENT OF OPHTHALMOLOGY

# MEDICOVER HOSPITALS

DATE: 29/03/24

PATIENT NAME: Ms Aradhita Chatterjee AGE / SEX: 40 / F NAVI MUMBAI

UMR NO: UMR004887e

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

		SPHERE	CYLINDER	AXIS	VA
MRx	O D	Plano	_____		6/6, NG
	O S	Plano	_____		6/6, NG

### HISTORY :

- NO H/O DM, HTN, thyroid.

- NO H/O spectacle NO H/O ocular trauma Allergies.

### OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc < 0.3  
0.3

### ADVICE:

Refresh Teax e/d q/d 1777 X 1 month

Dr. ANUSHREE VANJAR



## 2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

<i>Name</i>	: Mrs. Arudhita Chatterjee	Date:- 23/03/2024
<i>Age / Sex</i>	: 40 Yrs / Female	UMR No. 0048976
<i>Referred By</i>	: 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.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- No left ventricle clot / vegetation.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

### IMP:

- No RWMA.
- Trivial MR.
- 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	29	mm
AO CUSP SEP	18	mm
LVID( s)	31	mm
LVID(d)	43	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	5			Nil
TRICUSPID	N			Nil
PULMONERY	4.4			Nil



<b>Patient ID:</b>	NMU0048876	<b>Patient Name:</b>	ARADHITA CHATTERJEE 40YRS/F
<b>Age:</b>		<b>Sex:</b>	O
<b>Accession Number:</b>		<b>Modality:</b>	CR
<b>Referring Physician:</b>		<b>Study:</b>	BREAST
<b>Study Date:</b>	23-Mar-2024		

### X-RAY MAMMOGRAPHY

**INDICATION:** Routine screening.

#### MAMMOGRAPHY

Bilateral mammograms were obtained in the oblique mediolateral and craniocaudad projections.

The film markers are placed on the axillary / lateral part of the breast.

Both breasts display almost entirely fatty parenchyma (ACR category a).

Regional area of coarse rounded and rod like calcification seen in upper and outer quadrant of left breast.

There is no focal spiculated mass lesion seen.

There are no clusters of microcalcification, distortion of the lobular architecture or nipple retraction.

Skin and subcutaneous tissues are normal.

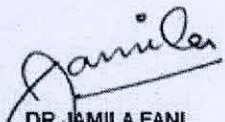
#### IMPRESSION :-

- Regional area of coarse rounded and rod like calcification seen in upper and outer quadrant of left breast.
- No other significant abnormality is seen.

**BIRADS Category III ( Probably benign findings )**

**Suggest a routine screening mammography after one year.**

*(BIRADS CATEGORY : BIRADS O - Requires additional evaluation, I - Negative, II - Benign findings, III - Probably benign findings, IV - Suspicious abnormality, V - Highly suggestive of malignancy, VI - Known biopsy proven malignancy.)*



DR. JAMILA FANI  
Consultant Radiologist  
MBBS, MD

Date: 23-Mar-2024 16:11:48

<b>Patient ID:</b>	NMU0048876	<b>Patient Name:</b>	CHATTERJEE ARADHITA
<b>Age:</b>	40 Years	<b>Sex:</b>	F
<b>Accession Number:</b>	NMBC63394	<b>Modality:</b>	US
<b>Referring Physician:</b>	DR.DMO	<b>Study:</b>	USG ABDOMEN WHOLE
<b>Study Date:</b>	23-Mar-2024	<b>Study Time:</b>	14:38:17

**USG ABDOMEN & PELVIS**

**The Liver** is enlarged in size (16.8 cm) and shows grade I fatty liver. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

**The gall bladder** is not visualised – Post cholecystectomy status. C.B.D. is of normal caliber.

**The Pancreas** is normal in size and echotexture.

**The spleen** is normal size (7 cm). No focal lesion is seen.

**Both kidneys** are normal in size, shape and echotexture. They shows normal cortical echogenicity with maintained cortico-medullary distinction.

The Right Kidney measures 10.2 x 3.5 cm.

The Left Kidney measures 9.7 x 4.3 cm.

There is no evidence of a calculus, hydronephrosis, or hydroureter.

**The Urinary bladder** is partially distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

**The uterus** is normal in size and echotexture. It measures 6 x 3 x 3.5 cm.

No focal lesion is seen. The Endometrial thickness is 7 mm.

**Both ovaries** are well visualized and appear normal in size and echotexture.

The Right ovary measures 2.2 x 1.5 cm

The Left ovary measures 2.2 x 1.4 cm

There is no evidence of any ovarian or adnexal mass lesion.

Visualised bowel loops are unremarkable.

There is no evidence of significant lymphadenopathy.

No ascitis is seen.

**IMPRESSION:**

**Hepatomegaly with grade I fatty liver.**

**No other significant abnormality is seen.**



DR. ANUPKUMAR AGRAWAL  
Consultant & HOD Radiology  
MBBS, MD

Date: 23-Mar-2024 14:50:22