



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. NEHA CHAWLA	Age / Gender : 38 Y(s)/Female
Bill No/ UMR No : NMBC62508/NMU0048361	Referred By : Dr. DMO
Received Dt : 18-Mar-24 09:45 am	Report Date : 18-Mar-24 02:14 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	20ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.010	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	OCCASIONAL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		3-4	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
SPERMATOZOA				MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		





MEDICOVER HOSPITALS

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Received Dt : 18-Mar-24 09:45 am	Report Date : 18-Mar-24 02:14 pm

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

*** End Of Report ***





DEPARTMENT OF LABORATORY

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Patient Name : Mrs. NEHA CHAWLA	Age / Gender : 38 Y(s)/Female
Bill No/ UMR No : NMBC62508/NMU0048361	Referred By : Dr. DMO
Received Dt : 18-Mar-24 09:45 am	Report Date : 18-Mar-24 11:09 am

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.59	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		12.7	12.0 - 15.0 g/dl	
PCV/HCT		39.3	40 - 50 % 36 - 46 %	
MCV		86	83 - 101 fl 83 - 101 fl	
MCH		27.6	27 - 32 pg	
MCHC		32.3	31.5 - 34.5 g/dL	
RDW(cv)		14.5	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	185	150 - 400 $10^3/\mu\text{L}$	
MPV		10.5	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	8.0	4.0 - 11.0 $10^3/\mu\text{l}$	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	54	40 - 80 %	
LYMPHOCYTES		37	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	25	0 - 20 mm/1st hour	WESTERGREN'S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***





MEDICOVER HOSPITALS

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Patient Name : Mrs. NEHA CHAWLA	Age / Gender : 38 Y(s)/Female
Bill No/ UMR No : NMBC62508/NMU0048361	Referred By : Dr. DMO
Received Dt : 18-Mar-24 09:45 am	Report Date : 18-Mar-24 03:03 pm

Parameters

Specimen Result

TUBE AGGLUTINATI





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Bill No/ UMR No : NMBC62508/NMU0048361	Referred By : Dr. DMO
Received Dt : 18-Mar-24 09:45 am	Report Date : 18-Mar-24 01:25 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.2	< 5.7 Normal Prediabetic 5.7 - 6.4 & \geq 6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		131	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		97	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM ELECTROLYTES				
SERUM SODIUM		139	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.5	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		104	98 - 107 mmol/L	ISE INDIRECT
SERUM CREATININE				
CREATININE		0.66	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.66	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		13.64	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	
DIRECT BILIRUBIN		0.2	\leq 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	\leq 1.0 mg/dL	
SGPT (ALT)		50	\leq 33 U/L	Method : UV without P5P
SGOT (AST)		28	\leq 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		107	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		8.2	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.9	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.3	2.5 - 3.5 g/dL	
A/G RATIO		1.48	1.2 - 2.5	





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Received Dt : 18-Mar-24 09:45 am	Report Date : 18-Mar-24 03:03 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
GAMMA GLUTAMYL TRANSFERASE(GGT)		13	6 - 42 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				
TOTAL PROTEINS		8.2	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		177	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		50	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		114	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		17		
SERUM TRYGLYCERIDES		86	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.54	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.28		
SERUM URIC ACID		7.2	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		156.8	70 - 204 ng/dL	Method : ECLIA
T4		7.58	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		4.19	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		175	110 - 180 mg/dL	Hexokinase
URINE SUGAR		Nil		Dipstick

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. NEHA CHAWLA	Age / Gender : 38 Y(s)/Female
Bill No/ UMR No : NMBC62508/NMU0048361	Referred By : Dr. DMO
Received Dt : 18-Mar-24 12:53 pm	Report Date : 18-Mar-24 05:03 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head, Laboratory Services

Verified By : : 022443

Test results related only to the item tested.

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Patient ID:	NMU0048361	Patient Name:	NEHA CHAWLA
Age:	38 Years	Sex:	F
Accession Number:	NMBC62508	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	18-Mar-2024	Study Time:	09:57:43

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. Ashwin Y.
1.D. (Radio-Diagnosis)

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

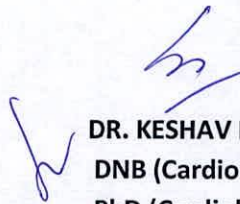
<i>Name</i>	: Mrs. Neha Chawla	Date:- 18/03/2024
<i>Age / Sex</i>	: 38 Yrs / Female	UMR No. 0048361
<i>Referred By</i>	: Health Checkup	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- No left ventricle clot / vegetation/pericardial effusion.
- 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	19	mm
LVID(s)	33	mm
LVID(d)	41	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	7			Nil
TRICUSPID	N			Nil
PULMONERY	4.1			Nil



HC 48361
38 Years

NEHA CHAWLA
Female

3/18/2024 11:22:35 AM

Rate 85 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Low voltage, precordial leads.....precordial leads <1.0mV
PR 140 . Borderline T abnormalities, anterior leads.....T flat or neg, V2-V4
QRSD 93
QT 367
QTc 437

--AXIS--

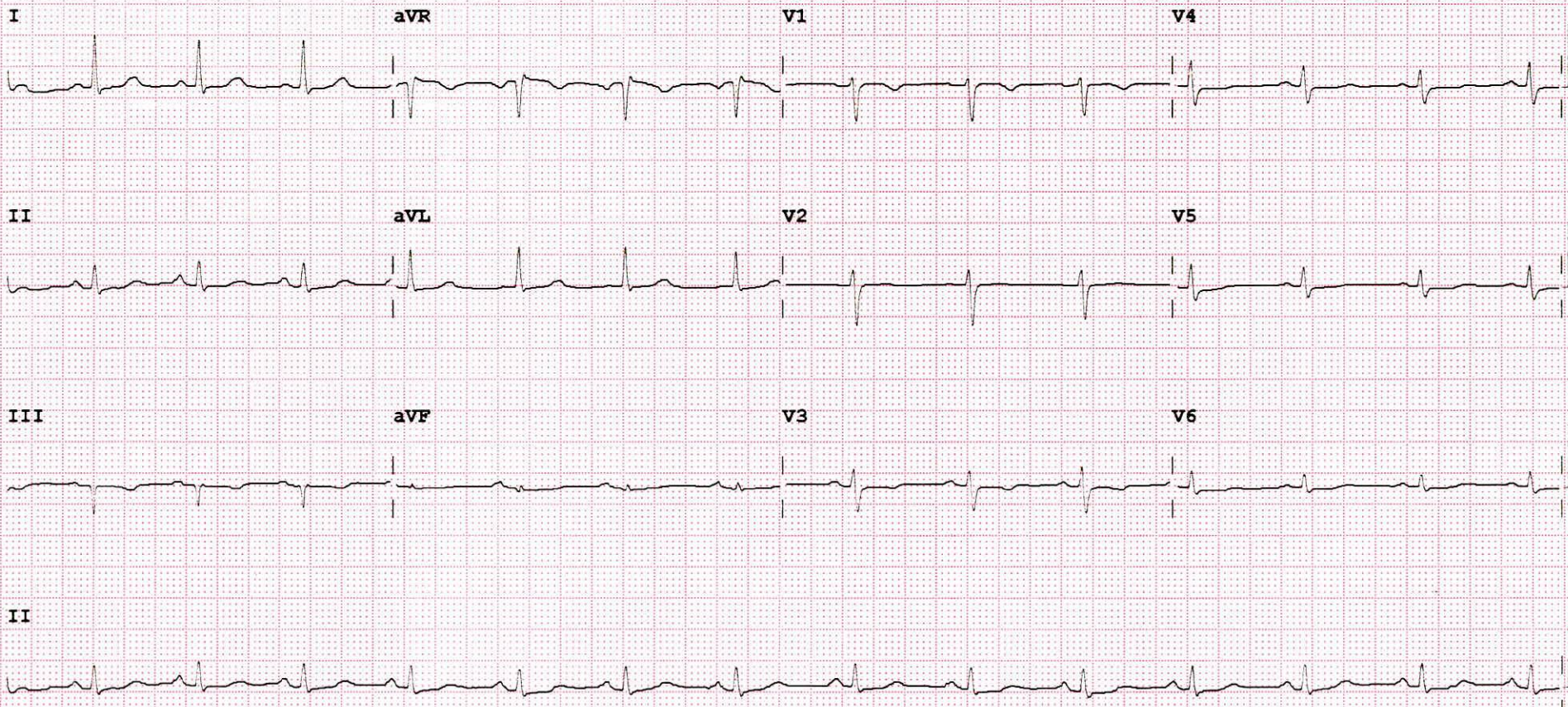
P 51
QRS -1
T 5

- BORDERLINE ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

AM
L



MEDICAL HEALTH CHECK-UP ASSESMENT FORM

NAME: Mr / Mrs Neha Chawal

DATE: 18/3/24

AGE: 38 yrs

SEX: Male / Female

NMU: NMU000 48361

DOCTOR'S NAME:

Health Package

TEMP :	98.8	° f	BP :	150/100	mmHg
PULSE :	74	b/m	HEIGHT :	154	cm
RR :	20	b/m	WEIGHT :	72.3	kg
SPO2 :	99	% RA	HGT:	—	

REMARK:

Patient ID:	NMU0048361	Patient Name:	NEHA CHAWLA
Age:	38 Years	Sex:	F
Accession Number:	NMBC62508	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	18-Mar-2024		

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, normal in shape and shows bright echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal 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. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal.

SPLEEN is normal in size and echotexture. No focal lesion seen. Splenic vein 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.

UTERUS is anteverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures – 8.6 mm.

Both ovaries are normal in size, shape and position.

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

Neha Chawla.

8/B :- Dr. Mandira Kumbale

o/e :- Deep caries $\bar{\frac{8}{8}}$
Buially impacted $\bar{\frac{8}{8}}$

Advice :- Surgical extraction $\bar{\frac{8}{8}}$

Dr. Mandira Kumbale
M. Kumbale





DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 18/03/24
 PATIENT NAME: Miss Neha Chawla
 UMR NO: NM00048361

AGE / SEX: 38 / F
 NAVI MUMBAI

	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 NC
	O S	plano	_____		6/6 NC

HISTORY :

- H/O HTN & DM. No H/O spectacle use.
 - No H/O ocular trauma, Allergis. & surgeries.

OCULAR FINDINGS :

(BE) - Ant seg w Nc
 (undilated) Disc 0.2
 0.2

ADVICE:

Refresh Tears 4d qid 1777 X 1 month
 Dilated Fundus Examination (BE).

AS
 CDR. ANUSHREE VANWANE

