DEPARTMENT OF LABORATORY

Patient Name	: Mr. SHARAD DAGADU LAKHIMALE	**Age /Gender**	: 37 Y(s)/Male
Bill No/ UMR No	: NMBC60590/NMU0047007	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 12:45 pm	**Report Date**	: 08-Mar-24 04:59 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	10 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		PRESENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.010	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 sulpher powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
MICROSCOPIC EXAMINATION				
PUS CELLS	Urine	1-2	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		0-1	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		PRESENT		MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SHARAD DAGADU LAKHIMALE	**Age /Gender**	: 37 Y(s)/Male
Bill No/ UMR No	: NMBC60590/NMU0047007	**Referred By**	: Dr. DMO
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Bill No/ UMR No	: NMBC60590/NMU0047007	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:15 am	**Report Date**	: 08-Mar-24 01:53 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM CREATININE				
CREATININE	Serum	0.94	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.94	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		10.63	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		19	<= 41 U/L	Method : UV without P5P
SGOT (AST)		19	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		70	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.3	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.6	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.7	2.5 - 3.5 g/dL	
A/G RATIO		1.7	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		25	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.3	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		223	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		46	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric

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Patient Name	: Mr. SHARAD DAGADU LAKHIMALE	**Age /Gender**	: 37 Y(s)/Male
Bill No/ UMR No	: NMBC60590/NMU0047007	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:15 am	**Report Date**	: 08-Mar-24 01:53 pm

Parameters	Specimen	Result	Biological Reference In	Method
LDL CHOLESTEROL		168	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		83	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.85	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.65		
SERUM URIC ACID		6.5	3.4 - 7.0 mg/dL	uricase
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		91	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		133.7	70 - 204 ng/dL	Method : ECLIA
T4		10.42	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.08	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		70	110 - 180 mg/dL	Hexokinase
URINE SUGAR		SNR		Dipstick
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.3	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		105	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

THIS IS A MODIFIED REPORT

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. SHARAD DAGADU LAKHIMALE	**Age /Gender**	: 37 Y(s)/Male
Bill No/ UMR No	: NMBC60590/NMU0047007	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:15 am	**Report Date**	: 08-Mar-24 01:53 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	10	0 - 10 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.29	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		16.0	13.0 - 17.0 g/dl	
PCV/HCT		46.3	40 - 50 % 36 - 46 %	
MCV		88	83 - 101 fl 83 - 101 fl	
MCH		30.2	27 - 32 pg	
MCHC		34.5	31.5 - 34.5 g/dL	
RDW(cv)		13.1	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	213	150 - 400 10^3/µL	
MPV		9.3	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	8.3	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	57	40 - 80 %	
LYMPHOCYTES		30	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		06	00 - 06 %	
BASOPHILS		00	00 - 01 %	

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. SHARAD DAGADU LAKHIMALE	**Age /Gender**	: 37 Y(s)/Male
Bill No/ UMR No	: NMBC60590/NMU0047007	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:15 am	**Report Date**	: 09-Mar-24 09:10 am

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

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Consultant Hematopathologist
Head- Laboratory Services

Verified By : : 022315

Test results related only to the item tested.

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Sharad Lakhemale DATE: 8/3/24

AGE : 37yrs SEX: Male / Female

NMU: NMU000 47007 DOCTOR'S NAME: Health package

TEMP :	96.4 °f	**BP :**	108/70 mmHg
PULSE :	76 b/m	**HEIGHT :**	155 cm
RR :	20 b/m	**WEIGHT :**	63.5 kg
SPO2 :	97 % RA	**HGT:**	–

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

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DATE: 08/03/24
PATIENT NAME: mr sharad Lakmale AGE / SEX 37/m.
UMR NO : NMN00047007.

	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 :

- H/o Allergic Asthama – 6 yrs.
No h/o HTN/DM/ Thyroid

OCULAR FINDINGS :

(BE) - Ant seg WNL
(undilated) Disc $\lt^{0.2}_{0.2-0.3}$

ADVICE:

Zivifresh e/d qid 1777 x 1month

(DR. ANUSHREE VANKAR)

MEDICOVER
HOSPITALS

Patient ID:	NMU0047007	Patient Name:	SHARAD DAGADU LAKHIMALE
Age:	37 Years	Sex:	M
Accession Number:	NMBC60590	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	08-Mar-2024	Study Time:	09:40:27

USG WHOLE ABDOMEN

LIVER is normal in size (12.0 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 (8.1 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 17 gms.

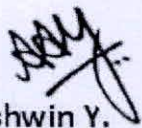
Visualised bowel loops appear normal. There is no free fluid seen.

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 REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



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

MEDICOVER
HOSPITALS

Patient ID:	NMU0047007	Patient Name:	SHARAD DAGADU LAKHIMALE
Age:	37 Years	Sex:	M
Accession Number:	NMBC60590	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	08-Mar-2024	Study Time:	10:01:46

X RAY CHEST PA VIEW

Patient in rotation.

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

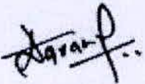
Both hilar shadows are normal in position and density.

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 20:23:57

MEDICOVER HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mr. Sharad Lakhimale**	**Date:- 08/03/2024**
Age / Sex	: **37 Yrs / Male**	**UMR No. 0047007**
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.
- 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 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

M-MODE MEASURMENTS:

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			Trivial
AORTIC	11			Nil
TRICUSPID	N			Nil
PULMONERY	5.3			Nil

NMU0047007 SHARAD LAKHIMALE 3/8/2024 11:48:12 AM
37 Years Male

Rate 65 . Sinus rhythm......................................normal P axis, V-rate 50- 99

PR 138
QRSD 78
QT 389
QTc 405

--AXIS--
P 61
QRS 60
T 38

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

II

Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.15-100 Hz 100B CL P?