



DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 01/04/24

PATIENT NAME: Mrs Jagannath Panda AGE / SEX : 46 / M NAVI MUMBAI
UMR NO: NMMU00049643

| | RE | LE |
|---------------|---------------|---------------|
| VA (DISTANCE) | 6/6 <u>cm</u> | 6/6 <u>cm</u> |
| VA (NEAR) | N13 | N13 |
| COLOUR VISION | Normal | Normal |

| | | SPHERE | CYLINDER | AXIS | VA | Teas |
|-----|------------|--------|----------|------|-----|----------------------|
| MRx | O D (R) | + - | -0.50 | 10° | 6/6 | + 1.75 <u>inc</u> |
| | O S (L) | + - | -0.50 | 170° | 6/6 | + 1.75 <u>inc</u> |

HISTORY :

- NO H/O ocular trauma Allergies & surgeries.
- H/O using spectacles (Distances).
- NO H/O systemic illness (DM, HTN, thyroid).

OCULAR FINDINGS :

(RE) - ~~Asst~~
Pupil - oval RTL, lens - clear
(LE) Pupil - slightly irregular RTL, lens - clear

ADVICE:

(undilated) Disc < 0.3
0.3

Refresh Teas as old qid 1777 + 1 month

AS
CDR. ANUSHREE VANUWANE



MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / ~~Mrs~~ Jagannath panda DATE: 01/04/24.

AGE : 46 yrs

SEX: Male / Female

NMU: NMU000 49643.

DOCTOR'S NAME:

Health package

| | | | |
|---------|-----------------|----------|--------------------|
| TEMP : | <u>98.7</u> ° f | BP : | <u>119/77</u> mmHg |
| PULSE : | <u>88</u> b/m | HEIGHT : | <u>163</u> cm |
| RR : | <u>21</u> b/m | WEIGHT : | <u>61.9</u> kg |
| SPO2 : | <u>99</u> % | HGT: | <u>—</u> |

REMARK:

IC 49643
46 Years

JAGANNATH PANDA
Male

4/1/2024 10:49:44 AM

Rate 78 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Probable left atrial enlargement.....P >50mS, <-0.10mV V1
 PR 176 . Baseline wander in lead(s) V3
 QRSD 83
 QT 367
 QTc 419

WNL
A

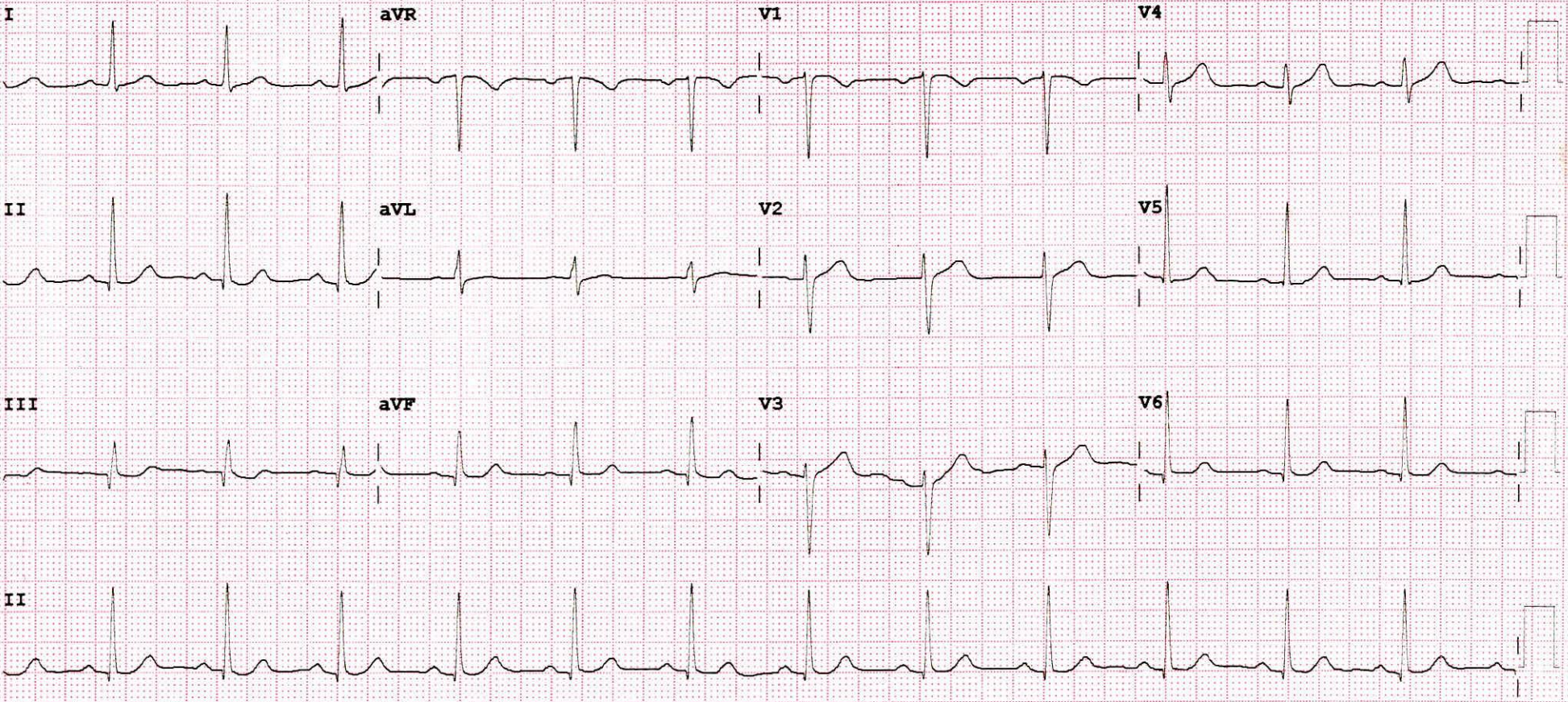
--AXIS--

P 42
QRS 46
T 41

- BORDERLINE ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 60~ 0.50- 40 Hz W

100B CL

P?



DEPARTMENT OF LABORATORY

NAVI MUMBAI

| | |
|---|---|
| Patient Name : Mr. JAGANNATH PANDA | Age / Gender : 46 Y(s)/Male |
| Bill No/ UMR No : NMBC64494/NMU0049643 | Referred By : Dr. DMO |
| Received Dt : 01-Apr-24 09:54 am | Report Date : 01-Apr-24 12:10 pm |

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 | EDTA Blood | 5.28 | 4.5 - 5.5 $10^6/\mu\text{L}$ | |
| HEMOGLOBIN | | 15.2 | 13.0 - 17.0 g/dl | |
| PCV/HCT | | 48.5 | 40 - 50 % | |
| MCV | | 91.9 | 83 - 101 fl | |
| MCH | | 28.8 | 27 - 32 pg | |
| MCHC | | 31.3 | 31.5 - 34.5 g/dL | |
| RDW(cv) | | 14.5 | 11.6 - 14.0 % | |
| PLATELETS | | | | |
| PLATELET COUNT | EDTA Blood | 161 | 150 - 400 $10^3/\mu\text{L}$ | |
| MPV | | 12.9 | 7.5 - 11.5 fl | |
| WBC | | | | |
| TC (TOTAL LEUCOCYTE COUNT) | EDTA Blood | 5.99 | 4.0 - 11.0 $10^3/\mu\text{l}$ | |
| DIFFERENTIAL COUNT | | | | |
| NEUTROPHILS | EDTA Blood | 54 | 40 - 80 % | |
| LYMPHOCYTES | | 38 | 20 - 40 % | |
| MONOCYTES | | 04 | 02 - 10 % | |
| EOSINOPHILS | | 04 | 00 - 06 % | |
| BASOPHILS | | 00 | 00 - 01 % | |
| ESR | CITRATED BLOOD | 04 | 0 - 10 mm/1st hour | WESTERGREN'S METHOD |

*** End Of Report ***





DEPARTMENT OF LABORATORY

NAVI MUMBAI

| | |
|---|---|
| Patient Name : Mr. JAGANNATH PANDA | Age /Gender : 46 Y(s)/Male |
| Bill No/ UMR No : NMBC64494/NMU0049643 | Referred By : Dr. DMO |
| Received Dt : 01-Apr-24 09:54 am | Report Date : 01-Apr-24 11:38 am |

FINAL REPORT

| <u>Parameters</u> | <u>Specimen</u> | <u>Result</u> | <u>Biological Reference Intervals</u> | <u>Method</u> |
|---|-----------------|---------------|--|-------------------------|
| SERUM ELECTROLYTES | | | | |
| SERUM SODIUM | | 142 | 136 - 145 mmol/L | ISE INDIRECT |
| SERUM POTASSIUM | | 4.1 | 3.5 - 5.1 mmol/L | ISE INDIRECT |
| SERUM CHLORIDES | | 105 | 98 - 107 mmol/L | ISE INDIRECT |
| FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE) | | | | |
| FASTING BLOOD GLUCOSE | | 98 | Normal Range : 70 - 99 mg/dL | Hexokinase |
| FASTING URINE SUGAR | | NIL | | |
| HBA1C (GLYCOSYLATED HAEMOGLOBIN) | | | | |
| HBA1C | | 6.0 | < 5.7 Normal Prediabetic 5.7 - 6.4 & \geq 6.5 Diabetic % | TINIA |
| MPG(Mean Plasma Glucose) | | 125 | Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL | |
| PSA (PROSTATE SPECIFIC ANTIGEN). | | | | |
| PROSTATE SPECIFIC ANTIGEN (PSA) | | 0.662 | 0 - 4.0 ng/mL | Method : ECLIA |
| T3,T4 AND TSH | | | | |
| T3 | | 97.67 | 70 - 204 ng/dL | Method : ECLIA |
| T4 | | 6.84 | 5.1 - 14.1 ug/dL | Method : ECLIA |
| TSH(THYROID STIMULATING HORMONE) | | 2.54 | 0.270 - 4.20 uIU/mL | Method : ECLIA |
| BUN / CREATININE RATIO | | | | |
| BUN (Blood Urea Nitrogen.) | | 11 | 7.0 - 21.0 mg/dL | Calculated |
| SERUM CREATININE | | 1.00 | 0.8 - 1.3 mg/dL | |
| BUN / CREATININE RATIO | | 11.0 | 10 - 20 | |
| LFT(LIVER FUNCTION TEST) | | | | |
| TOTAL BILIRUBIN | | 1.0 | < 1.2 mg/dL | Method : Diazo Method |
| DIRECT BILIRUBIN | | 0.3 | \leq 0.20 mg/dL | Method: Diazo Method |
| INDIRECT BILIRUBIN | | 0.7 | \leq 1.0 mg/dL | |
| SGPT (ALT) | | 53 | \leq 41 U/L | Method : UV without P5P |
| SGOT (AST) | | 32 | \leq 40 U/L | Method : UV without P5P |





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NAVI MUMBAI

| | |
|---|---|
| Patient Name : Mr. JAGANNATH PANDA | Age / Gender : 46 Y(s)/Male |
| Bill No/ UMR No : NMBC64494/NMU0049643 | Referred By : Dr. DMO |
| Received Dt : 01-Apr-24 09:54 am | Report Date : 01-Apr-24 01:17 pm |

| <u>Parameters</u> | <u>Specimen</u> | <u>Result</u> | <u>Biological Reference In</u> | <u>Method</u> |
|---|-----------------|---------------|---|---|
| ALKALINE PHOSPHATASE (ALP) | | 81 | 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 | | 5.6 | 3.5 - 5.2 g/dL | Method : Bromcresol Green (BCG) |
| GLOBULINS | | 2.5 | 2.5 - 3.5 g/dL | |
| A/G RATIO | | 2.24 | 1.2 - 2.5 | |
| GAMMA GLUTAMYL TRANSFERASE(GGT) | | 30 | 10 - 71 U/L | Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref. |
| NOTE | | | Rechecked for Total Proteins and Albumin - serum. | |
| BUN(BLOOD UREA NITROGEN) | | | | |
| BUN (Blood Urea Nitrogen.) | | 11 | 7.0 - 21.0 mg/dL | Calculated |
| TOTAL PROTEIN | | | | |
| TOTAL PROTEINS | | 8.1 | 6.0 - 8.0 g/dL | Method : Biuret method |
| LIPID PROFILE | | | | |
| TOTAL CHOLESTEROL | | 157 | Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL | METHOD : Enzymatic colorimetric |
| HDL CHOLESTEROL | | 43 | Low : : < 40 mg/dL High : : > 60 mg/dL | Homogeneous enzymatic colorimetric |
| LDL CHOLESTEROL | | 84 | 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 | | 40 | | |
| SERUM TRYGLYCERIDES | | 201 | < 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL | METHOD: Enzymatic colorimetric |
| CHO/HDL RATIO | | 3.65 | Normal : - < 3.5 High Risk : - > 5.0 | |
| LDL/HDL RATIO | | 1.95 | | |
| SERUM URIC ACID | | 6.6 | 3.4 - 7.0 mg/dL | uricase |
| PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR) | | | | |
| PLBS (POST LUNCH BLOOD GLUCOSE) | | 162 | 110 - 180 mg/dL | Hexokinase |





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. JAGANNATH PANDA
Age / Gender : 46 Y(s)/Male
Bill No/ UMR No : NMBC64494/NMU0049643
Referred By : Dr. DMO
Received Dt : 01-Apr-24 12:27 pm
Report Date : 01-Apr-24 02:09 pm

| <u>Parameter</u> | <u>Specimen</u> | <u>Result Values</u> | <u>Biological Reference</u> | <u>Method</u> |
|------------------|-----------------|----------------------|-----------------------------|---------------|
| URINE SUGAR | | Trace | | Dipstick |

*** End Of Report ***

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head, Laboratory Services

Verified By : : 025493

Test results related only to the item tested.

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MEDICOVER
HOSPITALS
NAVI MUMBAI

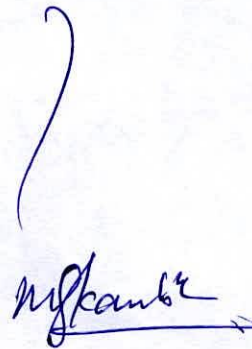
Jaganath.

S/B: Dr. mandira kamble

O/E: Faulty restoration. $\bar{c} \leftarrow / 6$
Stain^d Calculus \rightarrow

Advice: oral prophylaxis

Re restoration $\bar{c} \leftarrow / 6$



Dr Mandira Sushil Kamble
MDS In Conservative Dentistry And Endodontics
Reg. No. A-43282



| | | | |
|-----------------------------|-------------|----------------------|-------------------|
| Patient ID: | NMU0049643 | Patient Name: | JAGANNATH PANDA |
| Age: | 46 Years | Sex: | M |
| Accession Number: | NMBC64494 | Modality: | US |
| Referring Physician: | DR.DMO | Study: | USG ABDOMEN WHOLE |
| Study Date: | 01-Apr-2024 | Study Time: | 10:30:02 |

USG WHOLE ABDOMEN

LIVER is normal in size, 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 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 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.


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

VB:- *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 CO-RELATION BEFORE ANY APPLICATION.



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

| | | | |
|-----------------------------|-------------|----------------------|-----------------|
| Patient ID: | NMU0049643 | Patient Name: | JAGANNATH PANDA |
| Age: | 46 Years | Sex: | M |
| Accession Number: | NMBC64494 | Modality: | DX |
| Referring Physician: | DR.DMO | Study: | CHEST |
| Study Date: | 01-Apr-2024 | | |

X RAY CHEST PA VIEW

Few calcific foci are seen in bilateral para-hilar regions.

Fibrotic changes in right lower zone.

Rest of the 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:

- Findings are suggestive of old infection.
- No other significant abnormality is seen.



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

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : Mr. Jagannath Panda

Date:-01/04/2024

Age / Sex : 46 Yrs / Male

UMR No. 0049643

Referred By : Health Checkup

FINDINGS:

- Mild concentric left ventricular 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.
- Mild mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Mild tricuspid regurgitation. No pulmonary hypertension.
PASP = 30 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 left ventricle diastolic dysfunction.
- Mild MR and TR. No PH.
- Normal LV and RV systolic function.



DR. RISHI BHARGAVA
MD DM CARDIOLOGY



MEDICOVER
HOSPITALS

NAVI MUMBAI

M-MODE MEASUREMENTS:

| | | |
|-------------|----|----|
| LA | 35 | mm |
| AO root | 28 | mm |
| AO CUSP SEP | 17 | mm |
| LVID(s) | 32 | mm |
| LVID(d) | 44 | mm |
| IVS(d) | 13 | mm |
| LVPW(d) | 12 | mm |
| RVID(d) | 28 | mm |
| RA | 32 | mm |
| LVEF | 60 | % |

| | PEAK | MEAN | Vmax | Gradient of Regurgitation |
|-----------|------|------|------|---------------------------|
| MITRAL | N | | | Mild |
| AORTIC | 09 | | | Nil |
| TRICUSPID | 30 | | | Mild |
| PULMONERY | 4.4 | | | Nil |

