50025
32 Years

VASU DEVA KUMAR
Male

4/4/2024 12:16:38 PM

Rate 81
PR 139
QRSD 84
QT 333
QTc 387

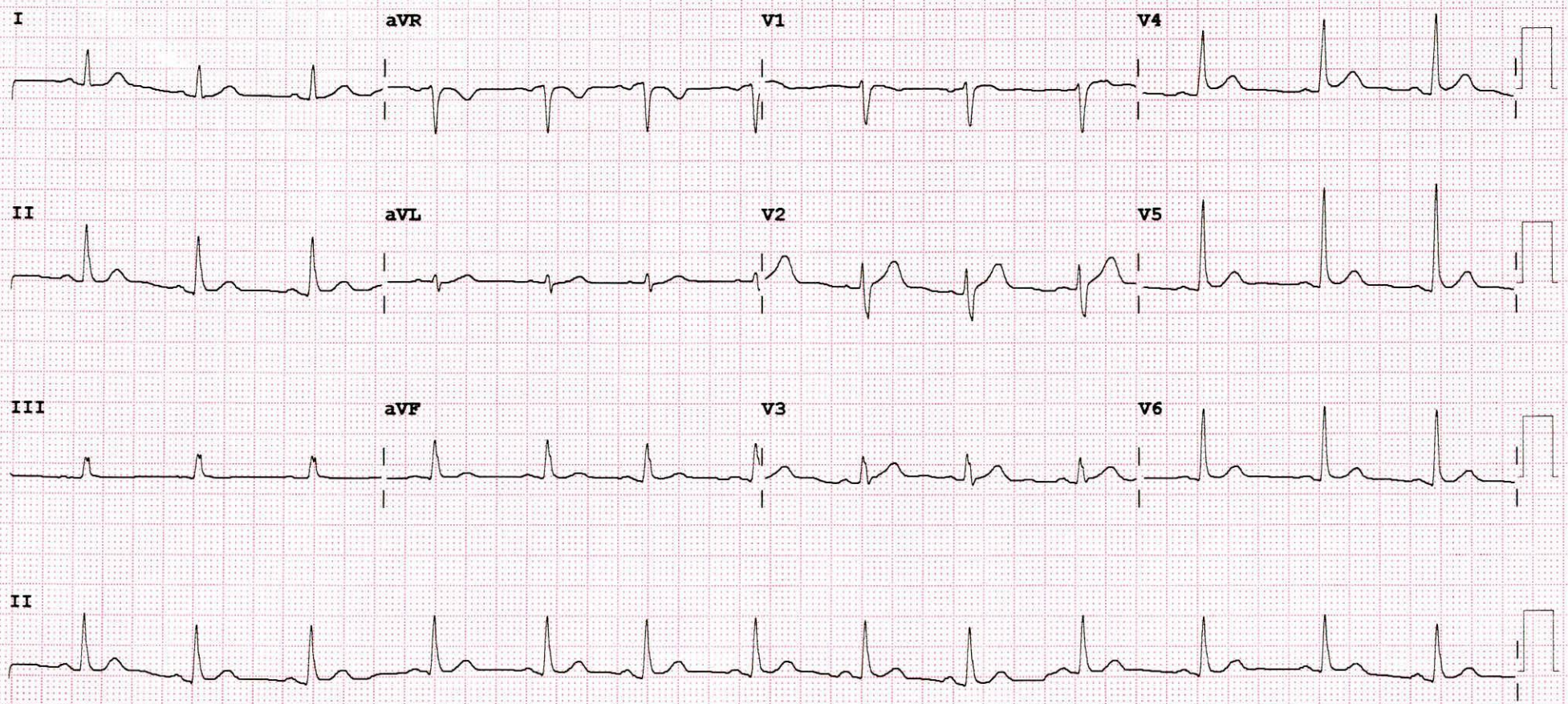
. Sinus rhythm.....normal P axis, V-rate 50- 99
. ST elev, probable normal early repol pattern.....ST elevation, age<55

--AXIS--
P 44
QRS 58
T 28

- NORMAL 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 OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 04/04/24

PATIENT NAME: Mr Vasu Deva Nanda Kumar AGE / SEX: 32/M

UMR NO: NAVI0050025

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-0.50	———	———	6/6, N6
	O (L)	S	-0.75	———	———	6/6, N6

HISTORY :

- H/O using spectacle (Distance)
- NO H/O Ocular trauma Allegies & surgeries.
- NO H/O systemic illness (DM, HTN, thyroid).

OCULAR FINDINGS :

(BE) - Dry Eyes.

(Undilated) Disc < 0.3
0.3

ADVICE:

Refresh Tears eld qid 1 1 1 x 1 month.

Dr ANUSHREE VANKAR

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. VASU DEVA NANDA KUMAR THATICHERLA	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC65058/NMU0050025	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:42 am	**Report Date**	: 04-Apr-24 03:24 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	20ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.020	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 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		NIL	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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Parameters	Specimen	Result	Biological Reference In	Method

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Bill No/ UMR No	: NMBC65058/NMU0050025	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:42 am	**Report Date**	: 04-Apr-24 03:53 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	EDTA Blood	5.47	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		13.4	13.0 - 17.0 g/dl	
PCV/HCT		41.0	40 - 50 %	
MCV		74.9	83 - 101 fl	
MCH		24.5	27 - 32 pg	
MCHC		32.8	31.5 - 34.5 g/dL	
RDW(cv)		14.0	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	EDTA Blood	234	150 - 400 10^3/µL	
MPV		9.3	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	5.34	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	60	40 - 80 %	
LYMPHOCYTES		35	20 - 40 %	
MONOCYTES		04	02 - 10 %	
EOSINOPHILS		01	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisocytosis moderate poikilocytosis. Microcytic hypochromic with ovalocytes and elliptocytes.		
WBC		Normal morphology.		
PLATELETS		Adequate in smear.		
ADVISED		Haemoglobin electrophoresis/ HPLC assay.		
ESR	CITRATED BLOOD	09	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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Bill No/ UMR No	: NMBC65058/NMU0050025	**Referred By**	: Dr. DMO
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Parameters	Specimen	Result	Biological Reference In	Method

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Patient Name	: Mr. VASU DEVA NANDA KUMAR THATICHERLA	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC65058/NMU0050025	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:42 am	**Report Date**	: 04-Apr-24 12:52 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		87	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.85	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.85	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		8.2	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		35	<= 41 U/L	Method : UV without P5P
SGOT (AST)		25	<= 40 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		6.9	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.3	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.6	2.5 - 3.5 g/dL	
A/G RATIO		1.65	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		18	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		6.9	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		142	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric

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Patient Name	: Mr. VASU DEVA NANDA KUMAR THATICHERLA	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC65058/NMU0050025	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:42 am	**Report Date**	: 04-Apr-24 12:52 pm

Parameters	Specimen	Result	Biological Reference In	Method
HDL CHOLESTEROL		42	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		87	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		13		
SERUM TRYGLYCERIDES		66	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.38	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.07		
SERUM URIC ACID		6.1	3.4 - 7.0 mg/dL	uricase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.0	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		125	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
T3,T4 AND TSH				
T3		99.78	70 - 204 ng/dL	Method : ECLIA
T4		8.66	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.92	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		132	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. VASU DEVA NANDA KUMAR THATICHERLA	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC65058/NMU0050025	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 01:23 pm	**Report Date**	: 04-Apr-24 03:16 pm

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

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

Verified By : : 022633

Test results related only to the item tested.

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2 D Transthoracic Echocardiography and Color Doppler

NAME	UMR No	REF. BY
MR. VASU DEVA KUMAR	50025	HEALTH CHECK UP

DATE	AGE	SEX
04/04/2024	32 YRS.	MALE

ECHO FINDINGS :

No RWMA.

LVEF is 60%.

No Diastolic Dysfunction.

Trivial mitral regurgitation.

No aortic regurgitation. No aortic stenosis.

Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 20 mm Hg.

Thinned IAS.

IAS & IVS Are Intact.

No Thrombus/ Vegetation/ Pericardial Effusion.

Normal RV systolic function. No hepatic congestion.

DR ANUP V MAHAJANI
MBBS, MD (MED), DNB (CARDIOLOGY)
INTERVENTIONAL CARDIOLOGIST
REG NO 2013/05/1759

MEDICOVER HOSPITALS
NAVI MUMBAI

M-MODE MEASUREMENTS (in Cm)

LA	3.3
AORTA	2.9
LVID (d)	4.2
LVID (s)	3.1
IVS (d)	1.0
PW (d)	0.9
LVEF %	60

COLOUR DOPPLER

Mitral Velocity	AJV	PJV	MS	MR	AS	AR	TR
E < A	1.5	0.4	Nil	Trivial	Nil	Nil	Trivial

----------END OF THE REPORT----------

DR ANUP V MAHAJANI

MBBS, MD (MED), DNB (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

REG NO 2013/05/1759

MEDICOVER HOSPITALS

Patient ID:	*NMU0050025*	*Patient Name:*	*VASU DEVA NANDA KUMAR THATICHERLA*
Age:	*32 Years*	*Sex:*	*M*
Accession Number:	*NMBC65058*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*04-Apr-2024*	*Study Time:*	*10:59:16*

USG WHOLE ABDOMEN

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 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 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.

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 REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

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

MEDICOVER HOSPITALS

Patient ID:	*NMU0050025*	*Patient Name:*	*VASU DEVA NANDA KUMAR THATICHERLA*
Age:	*32 Years*	*Sex:*	*M*
Accession Number:	*NMBC65058*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*04-Apr-2024*		

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 JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 04-Apr-2024 12:36:07