

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Heekash . Heekal

DATE: 29/3/24

AGE : 38yrs

SEX: Male / Female

NMU: NMU000 49371

DOCTOR'S NAME:
Health-Package

TEMP :	<u>97.6</u>	^o f	BP :	<u>128/83</u>	mmHg
PULSE :	<u>80</u>	b/m	HEIGHT :	<u>165</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>90.7</u>	kg
SPO2 :	<u>98</u> %	RA	HGT:	<u>—</u>	

REMARK:



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. MUKESH CHANDRA MUKUL	Age /Gender : 38 Y(s)/Male
Bill No/ UMR No : NMBC64108/NMU0049371	Referred By : Dr. DMO
Received Dt : 29-Mar-24 08:47 am	Report Date : 29-Mar-24 06:30 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	30ML		
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		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.
BLOOD		NEGATIVE	NEGATIVE	Dipstick/Microscopy
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	3-4	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		OCCASIONAL	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





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

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Received Dt : 29-Mar-24 08:47 am	Report Date : 29-Mar-24 06:30 pm

Parameters
NOTE

Specimen

Result

Biological Reference In Method

Microscopic examination of urine is carried out on centrifuged urinary sediment.

*** End Of Report ***





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. MUKESH CHANDRA MUKUL	Age / Gender : 38 Y(s)/Male
Bill No/ UMR No : NMBC64108/NMU0049371	Referred By : Dr. DMO
Received Dt : 29-Mar-24 08:47 am	Report Date : 29-Mar-24 03:04 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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COMPLETE BLOOD COUNT

RBC

R B C COUNT	Blood	4.84	4.5 - 5.5 $10^6/\mu\text{L}$	
HEMOGLOBIN		14.4	13.0 - 17.0 g/dl	
PCV/HCT		43.5	40 - 50 %	
MCV		90	36 - 46 %	
MCH		29.8	83 - 101 fl	
MCHC		33.1	83 - 101 fl	
RDW(cv)		13.8	27 - 32 pg	
			31.5 - 34.5 g/dL	
			11.6 - 14.0 %	

PLATELETS

PLATELET COUNT	Blood	130	150 - 400 $10^3/\mu\text{L}$	
MPV		12.4	7.5 - 11.5 fl	

WBC

TC (TOTAL LEUCOCYTE COUNT)	Blood	7.7	4.0 - 11.0 $10^3/\mu\text{l}$	
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DIFFERENTIAL COUNT

NEUTROPHILS	Blood	59	40 - 80 %	
LYMPHOCYTES		31	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	

PERIPHERAL SMEAR EXAMINATION

RBC			Predominantly normocytic normochromic.	
WBC			Normal morphology.	
PLATELETS			Mildly reduced in smear. Macroplatelets and giant platelets are also seen.	

ESR	CITRATED BLOOD	08	0 - 10 mm/1st hour	WESTERGREN'S METHOD
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*** End Of Report ***





MEDICOVER
HOSPITALS

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Bill No/ UMR No : NMBC64108/NMU0049371	Referred By : Dr. DMO
Received Dt : 29-Mar-24 08:47 am	Report Date : 29-Mar-24 03:01 pm

Parameters

Specimen

Result

Biological Reference In Method





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. MUKESH CHANDRA MUKUL	Age /Gender : 38 Y(s)/Male
Bill No/ UMR No : NMBC64108/NMU0049371	Referred By : Dr. DMO
Received Dt : 29-Mar-24 08:46 am	Report Date : 29-Mar-24 11:18 am

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		97	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.87	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.87	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		12.6	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		1.2	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.4	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.8	<= 1.0 mg/dL	
SGPT (ALT)		56	<= 41 U/L	Method : UV without P5P
SGOT (AST)		46	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		75	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.7	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.2	2.5 - 3.5 g/dL	
A/G RATIO		1.47	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		36	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		169	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric





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Bill No/ UMR No : NMBC64108/NMU0049371	Referred By : Dr. DMO
Received Dt : 29-Mar-24 08:47 am	Report Date : 29-Mar-24 11:18 am

Parameters	Specimen	Result	Biological Reference In	Method
HDL CHOLESTEROL		35	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		98	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		60		
SERUM TRYGLYCERIDES		301	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.83	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.8		
SERUM URIC ACID		7.3	3.4 - 7.0 mg/dL	uricase
T3,T4 AND TSH				
T3		136.9	70 - 204 ng/dL	Method : ECLIA
T4		7.59	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.40	0.270 - 4.20 uIU/mL	Method : ECLIA
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.7	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		117	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		95	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

*** End Of Report ***





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. MUKESH CHANDRA MUKUL	Age /Gender : 38 Y(s)/Male
Bill No/ UMR No : NMBC64108/NMU0049371	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:45 am	Report Date : 29-Mar-24 04:52 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 of Laboratory Services
Consultant Hematopathologist

Verified By : : 022443

Test results related only to the item tested.

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DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 29/03/24

PATIENT NAME: Mrs. Mukesh Chandra Murali

AGE / SEX: 38 / M NAVI MUMBAI

UMR NO: N000049371

	RE	LE
VA (DISTANCE)	6/6 <u>20/20</u>	6/6 <u>20/20</u>
VA (NEAR)	N6 <u>20/20</u>	N6 <u>20/20</u>
COLOUR VISION	Normal	Normal

		SPHERE	CYLINDER	AXIS	VA
MRx	O Ⓡ D	-1.25	—		6/6, N6
	O Ⓛ S	-1.00	-0.50	120	6/6, N6

HISTORY :

- No H/O systemic illness. (hypertension), - No H/O ocular trauma, Allergies.
 - N/O using spectacles for distance (~10 years)

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc ≤ 0.4
0.4, mild temp. thinning

ADVICE:

Refresh Tear 4x 4x 177 X 1 month.

As
CDR. ANUSHREE VANWAR





MEDICOVER
HOSPITALS

NAVI MUMBAI

Mukesh Mukul .

S/B : Dr. Mandira Kamble

O/E : Cavities \bar{c} $\frac{87}{876} \mid \frac{78}{678}$

Stain⁺ Calculus⁺⁺

Adia : — Restoration \bar{c} $\frac{87}{876} \mid \frac{78}{678}$

Oral prophylaxis

M/Kamble

Dr. Mandira Sushil Kamble

MDS In Conservative Dentistry And Endodontics

Reg. No. A-43282





MEDICOVER
HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name : Mr. Mukesh Mukul

Date:-29/03/2024

Age / Sex : 29 Yrs / Male

UMR No. 0049371

Referred By : Health check up

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I left ventricle diastolic dysfunction.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 30 mm Hg.
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal left atrium and left ventricle dimensions.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- No RWMA.
- Grade I left ventricle diastolic dysfunction.
- Trivial TR. No PH.
- Normal LV and RV systolic function.

DR. SAMEER VANKAR
MD DM CARDIOLOGY





MEDICOVER
HOSPITALS

NAVI MUMBAI

M-MODE MEASUREMENTS:

LA	35	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)	29	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	7			Nil
TRICUSPID	30			Trivial
PULMONERY	4.4			Nil



Patient ID:	NMU0049371	Patient Name:	MUKESH CHANDRA MUKUL
Age:	38 Years	Sex:	M
Accession Number:	NMBC64108	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	29-Mar-2024	Study Time:	09:06:28

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.

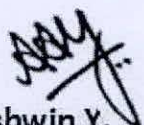
Visualised bowel loops appear normal. There is no free fluid seen.

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 REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



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

Patient ID:	NMU0049371	Patient Name:	MUKESH CHANDRA MUKUL
Age:	38 Years	Sex:	M
Accession Number:	NMBC64108	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	29-Mar-2024	Study Time:	08:59:01

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

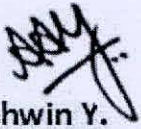
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

No significant abnormality is seen.



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

3/29/2024 9:26:51 AM

MUKESH MUKUL

29 Years

Male

Rate 82 . Sinus rhythm. normal P axis, V-rate 50-99
ST elev, probable normal early repol pattern. ST elevation, age<55

PR 145
QRS 86
QT 351
QTc 410

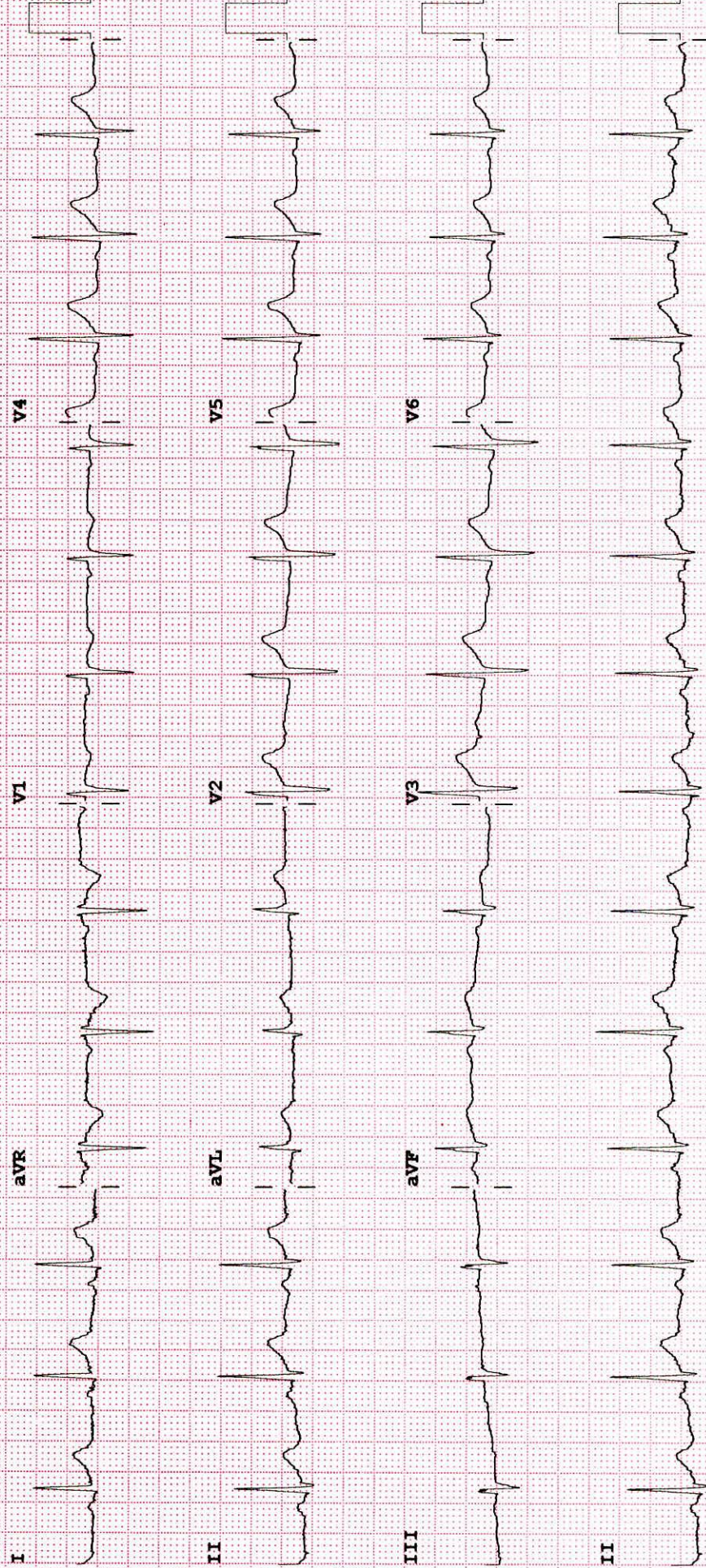
WIR
S

--AXIS--
P 48
QRS 30
T 27

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

100B CL

P?

