DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 29/08/24

PATIENT NAME: Mrs Komal Fulekar AGE / SEX: 32/F

UMR NO: NMU0049423

	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 :

– NO H/O spectacle. NO H/O Ocular trauma Allegies & surgeries.
– NO H/O ~~spectacle~~ Systemic Illness. (DM, HTN, thyroid)

OCULAR FINDINGS :

(BE) Lens – Dot Single lenticular opacity ⊕ in central visual axis

(undilated) Disc < 0.3
0.2

ADVICE:

Refresh Tears eld qid 1777 x 1 month.

AS
CDR. ANUSHREE VANKAR

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MEDICOVER
HOSPITALS
NAVI MUMBAI

Komal.

S/B :- Dr. Mandira Kamble

O/E :- Stain + Calculus ++

Advice :- Oral prophylaxis.

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

MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. KOMAL KAILASH FULEKAR	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC64172/NMU0049423	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:57 am	**Report Date**	: 29-Mar-24 06:20 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	1.010	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	3-4	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		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. KOMAL KAILASH FULEKAR	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC64172/NMU0049423	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:57 am	**Report Date**	: 29-Mar-24 06:20 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. KOMAL KAILASH FULEKAR	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC64172/NMU0049423	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:57 am	**Report Date**	: 29-Mar-24 05:08 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	3.60	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		12.1	12.0 - 15.0 g/dl	
PCV/HCT		35.9	40 - 50 % 36 - 46 %	
MCV		100	83 - 101 fl 83 - 101 fl	
MCH		33.6	27 - 32 pg	
MCHC		33.6	31.5 - 34.5 g/dL	
RDW(cv)		12.6	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	127	150 - 400 10^3/µL	
MPV		8.3	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	9.1	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	57	40 - 80 %	
LYMPHOCYTES		35	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		01	00 - 06 %	
BASOPHILS		01	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisocytosis moderate poikilocytosis. Predominantly normocytic normochromic with macrocytes, ovalocytes and elliptocytes.		
WBC		Normal morphology.		
PLATELETS		Mildly reduced in smear.		
ESR	CITRATED BLOOD	40	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" B "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. KOMAL KAILASH FULEKAR	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC64172/NMU0049423	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:57 am	**Report Date**	: 29-Mar-24 05:25 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. KOMAL KAILASH FULEKAR	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC64172/NMU0049423	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:57 am	**Report Date**	: 29-Mar-24 02:05 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		142	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.3	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		89	Normal Range : 70 - 99 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		91.63	70 - 204 ng/dL	Method : ECLIA
T4		6.29	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.09	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.64	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		5	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.64	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		7.8	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.6	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.4	<= 1.0 mg/dL	
SGPT (ALT)		10	<= 33 U/L	Method : UV without P5P
SGOT (AST)		14	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		76	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.6	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.1	2.5 - 3.5 g/dL	
A/G RATIO		1.45	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		11	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. KOMAL KAILASH FULEKAR	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC64172/NMU0049423	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:57 am	**Report Date**	: 29-Mar-24 05:08 pm

Specimen

BUN(BLOOD UREA NITROGEN)

BUN (Blood Urea Nitrogen.)	5	7.0 - 21.0 mg/dL	Calculated

TOTAL PROTEIN

TOTAL PROTEINS	7.6	6.0 - 8.0 g/dL	Method : Biuret method

LIPID PROFILE

TOTAL CHOLESTEROL	138	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL	47	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL	85	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	10		
SERUM TRYGLYCERIDES	51	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO	2.94	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO	1.81		
SERUM URIC ACID	4.7	2.4 - 5.7 mg/dL	uricase

PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)

PLBS (POST LUNCH BLOOD GLUCOSE)	78	110 - 180 mg/dL	Hexokinase

HBA1C (GLYCOSYLATED HAEMOGLOBIN)

HBA1C	5.0	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)	97	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. KOMAL KAILASH FULEKAR	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC64172/NMU0049423	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:57 am	**Report Date**	: 30-Mar-24 09:42 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 026979

Test results related only to the item tested.

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MEDICOVER HOSPITALS

Patient ID:	*NMU0049423*	*Patient Name:*	*KOMAL KAILASH FULEKAR*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC64172*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*29-Mar-2024*	*Study Time:*	*12:41:22*

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. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 29-Mar-2024 15:35:37

MEDICOVER HOSPITALS

Patient ID:	*NMU0049423*	*Patient Name:*	*KOMAL KAILASH FULEKAR*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC64172*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*29-Mar-2024*	*Study Time:*	*11:35:34*

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, normal in shape and 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 – 8.8 mm.

Both ovaries are normal in size, shape and position.
A 5.1 x 4.0 cm sized simple cyst is seen in right ovary.

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 –

- **Right ovarian simple cyst.**
- **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
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: Mrs. Komal Fulekar	Date:-29/03/2024
Age / Sex	: 32 Yrs / Female	UMR No. 0049423
Referred By	: Health check up	

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.
- Mild 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.**
- **Trivial MR. Mild TR. No PH.**
- **Normal LV and RV systolic function.**

DR. SAMEER VANKAR
MD DM CARDIOLOGY

M-MODE MEASURMENTS:

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			Trivial
AORTIC	7			Nil
TRICUSPID	30			Mild
PULMONERY	4.4			Nil

HC 49423 KOMAL FULEKAR 3/29/2024 12:58:59 PM
32 Years Female

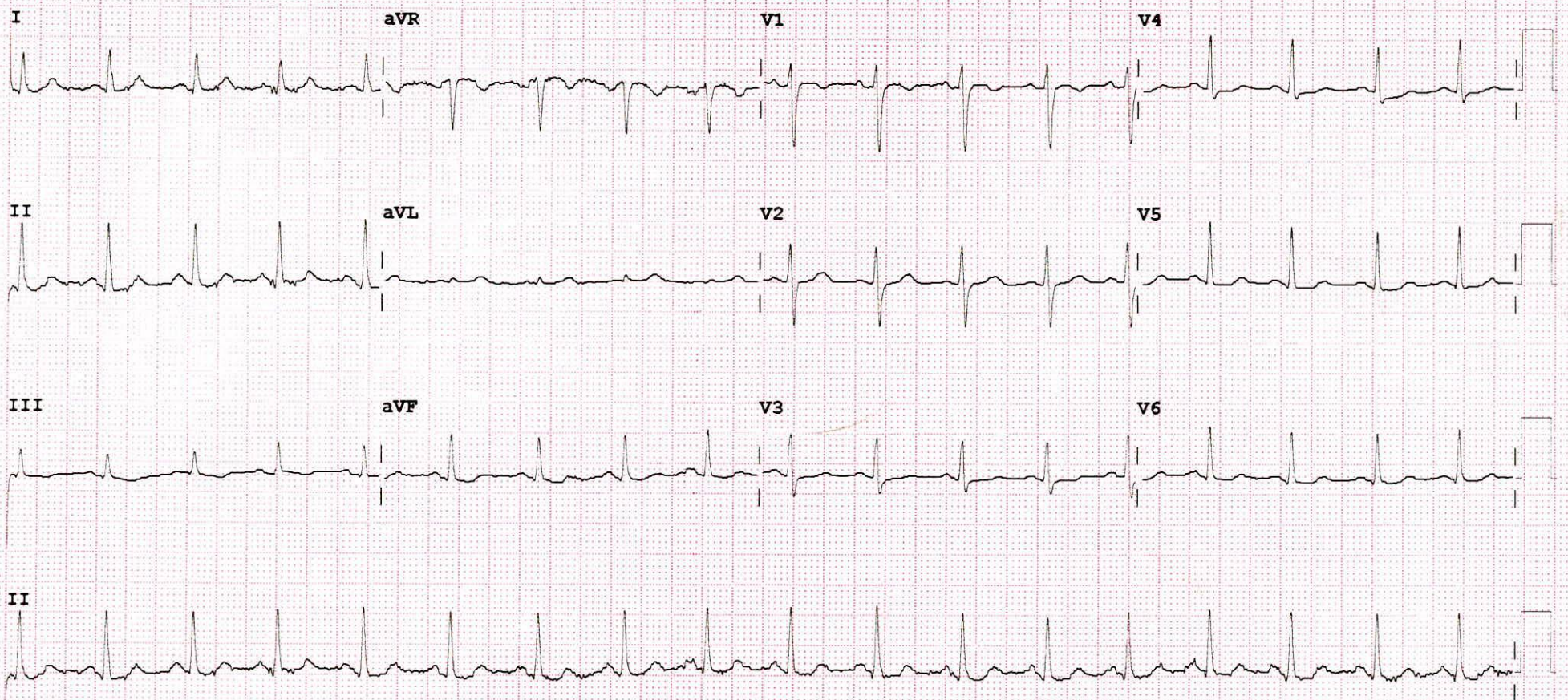
Rate 107 . Sinus tachycardia.....rate> 99
. Borderline repolarization abnormality.....ST dep & abnormal T
PR 118
QRSD 85
QT 302
QTc 403

--AXIS--
P 60
QRS 53
T -1
12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

NIR
prepcall ST ↓ in V3—V6



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.50~ 40 Hz W 100B CL P?