

Patient ID:	NMU0048852	Patient Name:	PEDAVI SWAPNIL KASHINATH
Age:	34 Years	Sex:	M
Accession Number:	NMBC63388	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	23-Mar-2024	Study Time:	11:40:01

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

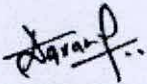
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

- **No significant abnormality is seen.**



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 23-Mar-2024 12:09:52



MEDICOVER
HOSPITALS

NAVI MUMBAI

Swapnil .

S/B: Dr. Mandira Kamble .

O/E: Grossly decayed \bar{c} $\frac{8}{8}$

Caries \bar{c} $\frac{8}{678}$

Stain⁺ Calculus⁺ .

Advice :- Surgical extraction \bar{c} $\frac{8}{8}$

Restoration \bar{c} $\frac{8}{678}$

Oral prophylaxis .

mkamble

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





DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 23/03/24

PATIENT NAME: Mr. Swapnil Pedavi AGE / SEX: NAVI MUMBAI

UMR NO: NMu 00 48852 34/M

	RE	LE
VA (DISTANCE)	6/6 (CB) $\overline{24}$	6/6 $\overline{24}$
VA (NEAR)	N6	N6
COLOUR VISION	Normal	Normal

		SPHERE	CYLINDER	AXIS	VA
MRx	O D Ⓟ	$\overline{0.50}$	$\overline{1.00}$	120°	6/6 INC
	O S Ⓛ	$\overline{0.50}$	$\overline{1.00}$	120 60°	6/6 INC

HISTORY :

No h/o HT / DM / Thyroid .

No h/o ocular Trauma (BE) .

OCULAR FINDINGS :

(BE) - Ant seg wNL

(undilated) Disc (BE) - 0.4

ADVICE:

Refresh Tears e/d q/d 1-1-1 X / month .

AP
CDR. ANUSHREE VANKAR





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. PEDAVI SWAPNIL KASHINATH	Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : NMBC63388/NMU0048852	Referred By : Dr. DMO
Received Dt : 23-Mar-24 10:00 am	Report Date : 23-Mar-24 05:40 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	10 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	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	8-10	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		1-2	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





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. PEDAVI SWAPNIL KASHINATH	Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : NMBC63388/NMU0048852	Referred By : Dr. DMO
Received Dt : 23-Mar-24 10:00 am	Report Date : 23-Mar-24 05:40 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. PEDAVI SWAPNIL KASHINATH	Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : NMBC63388/NMU0048852	Referred By : Dr. DMO
Received Dt : 23-Mar-24 10:00 am	Report Date : 23-Mar-24 01:06 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	5.27	4.5 - 5.5 $10^6/\mu\text{L}$	
HEMOGLOBIN		15.6	13.0 - 17.0 g/dl	
PCV/HCT		45.8	40 - 50 % 36 - 46 %	
MCV		87	83 - 101 fl 83 - 101 fl	
MCH		29.5	27 - 32 pg	
MCHC		34.0	31.5 - 34.5 g/dL	
RDW(cv)		12.4	11.6 - 14.0 %	

PLATELETS

PLATELET COUNT	Blood	374	150 - 400 $10^3/\mu\text{L}$	
MPV		7.7	7.5 - 11.5 fl	

WBC

TC (TOTAL LEUCOCYTE COUNT)	Blood	10.5	4.0 - 11.0 $10^3/\mu\text{l}$	
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DIFFERENTIAL COUNT

NEUTROPHILS	Blood	48	40 - 80 %	
LYMPHOCYTES		28	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		18	00 - 06 %	
BASOPHILS		00	00 - 01 %	

PERIPHERAL SMEAR EXAMINATION

RBC		Predominantly normocytic normochromic .		
WBC		Mild eosinophilia is present.		
PLATELETS		Adequate in smear.		

ESR	CITRATED BLOOD	05	0 - 10 mm/1st hour	WESTERGREN'S METHOD
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*** End Of Report ***





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. PEDAVI SWAPNIL KASHINATH	Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : NMBC63388/NMU0048852	Referred By : Dr. DMO
Received Dt : 23-Mar-24 10:00 am	Report Date : 23-Mar-24 04:10 pm

Parameters

Specimen

Result

Biological Reference In Method





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. PEDAVI SWAPNIL KASHINATH	Age / Gender : 34 Y(s)/Male
Bill No/ UMR No : NMBC63388/NMU0048852	Referred By : Dr. DMO
Received Dt : 23-Mar-24 09:59 am	Report Date : 23-Mar-24 01:54 pm

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		88	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		133.1	70 - 204 ng/dL	Method : ECLIA
T4		5.83	5.1 - 14.1 ug/dL	
TSH(THYROID STIMULATING HORMONE)		1.98	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		72	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
SERUM CREATININE				
CREATININE		1.08	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		13	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		1.08	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		12.0	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.5	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		23	<= 41 U/L	Method : UV without P5P
SGOT (AST)		15	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		69	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		8.0	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.0	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.0	2.5 - 3.5 g/dL	
A/G RATIO		1.67	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		25	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.





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Received Dt : 23-Mar-24 10:00 am	Report Date : 25-Mar-24 10:32 am

Specimen

BUN(BLOOD UREA NITROGEN)

BUN (Blood Urea Nitrogen.) 13 7.0 - 21.0 mg/dL Calculated

TOTAL PROTEIN

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

LIPID PROFILE

TOTAL CHOLESTEROL 199 Desirable : : < 200 mg/dL METHOD : Enzymatic colorimetric
Borderline High : : 200 - 239 mg/dL
High risk : > 240 mg/dL

HDL CHOLESTEROL 43 Low : : < 40 mg/dL Homogeneous enzymatic colorimetric
High : : > 60 mg/dL

LDL CHOLESTEROL 144 Optimal : - < 100 mg/dL Direct-Enzymatic colorimetric
Near Optimal : 100 - 129 mg/dL
Borderline High : 130 - 159 mg/dL
High : 160 - 189 mg/dL
Very High : - > 190 mg/dL

VLDL 14
SERUM TRYGLYCERIDES 68 < 150 mg/dL METHOD: Enzymatic colorimetric
Borderline High : 150 - 199 mg/dL
High : 200 - 499 mg/dL

CHO/HDL RATIO 4.63 Normal : - < 3.5
High Risk : - > 5.0

LDL/HDL RATIO 3.35
SERUM URIC ACID 5.3 3.4 - 7.0 mg/dL uricase

HBA1C (GLYCOSYLATED HAEMOGLOBIN)

HBA1C 5.6 < 5.7 Normal Prediabetic 5.7 TINIA
- 6.4 & >/=6.5 Diabetic %

MPG(Mean Plasma Glucose) 114 Excellent Control : 90 - 120 mg/dL
Good Control : 121 - 150 mg/dL

*** End Of Report ***





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

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Bill No/ UMR No : NMBC63388/NMU0048852	Referred By : Dr. DMO
Received Dt : 23-Mar-24 10:00 am	Report Date : 25-Mar-24 10:32 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
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Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head of Laboratory Services

Verified By : : 026560

Test results related only to the item tested.

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48852

pedavi swapnil
Male

Age: 34

1/7/2008 12:56:28 AM

Rate 80 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation
 . Sinus rhythm.....normal P axis, V-rate 50-99
 PR 148 . Abnormal R-wave progression, early transition.....QRS area>0 in V2
 QRS 110 . Probable left ventricular hypertrophy.....multiple LVH criteria
 QT 342 . Borderline T abnormalities, inferior leads.....T flat/neg, II III aVF
 QTc 395 . Anterior ST elevation, probably due to LVH.....ST >0.20 mV in V1-V4 & LVH

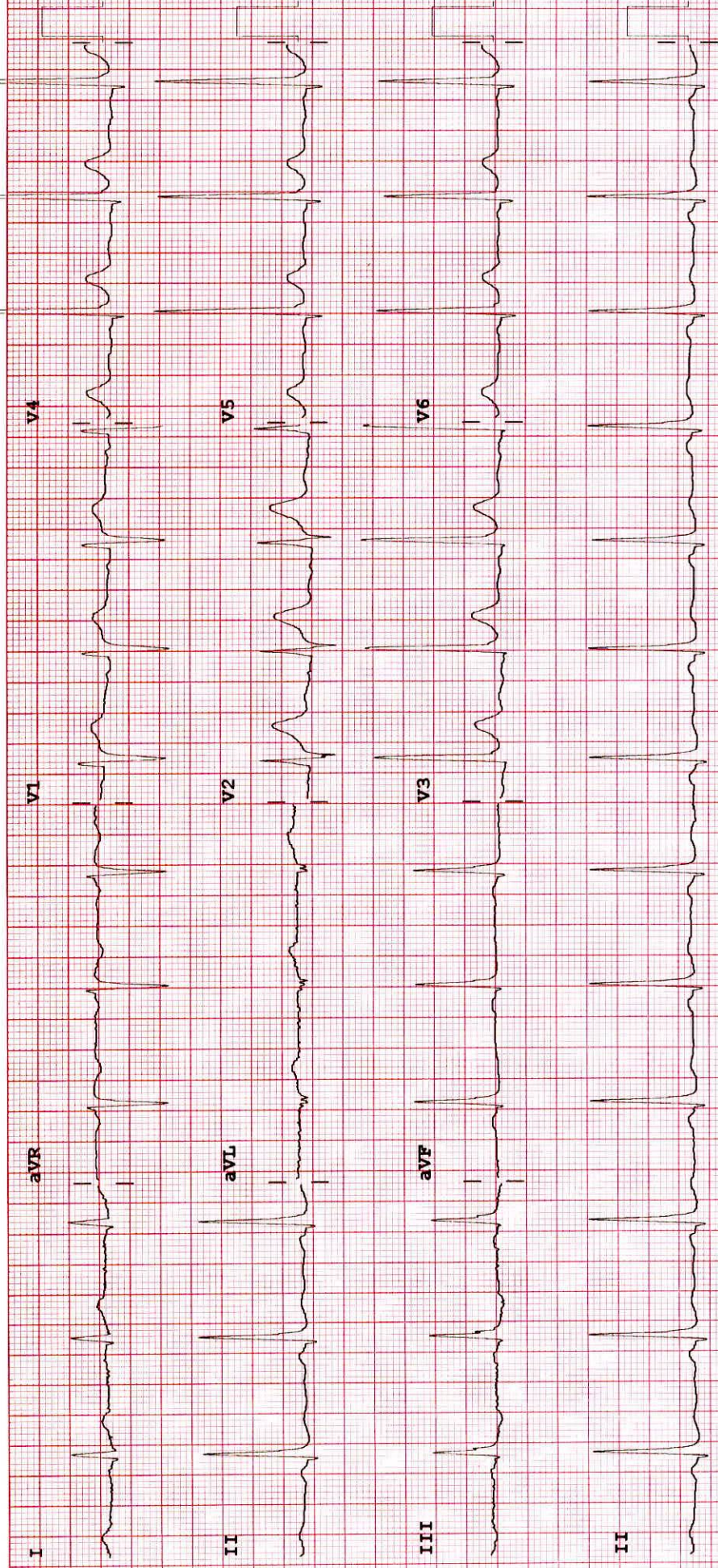
--AXIS--

P 68
 QRS 71
 T -5

12 Lead; Standard Placement

- ABNORMAL ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

100B CI

P?

PHILIPS

REORDER # M2483A