MEDICOVER HOSPITALS

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : ~~Mr~~ / Mrs CH kusi Annapurna · DATE: 31/3/24

AGE : 35 yr

SEX: Male/ Female ✓

NMU: NMU000 49609.

DOCTOR'S NAME: Health package.

TEMP :	96.4 °f	BP :	116/70. mmHg
PULSE :	80 b/m	HEIGHT :	156. cm
RR :	20 b/m	WEIGHT :	82.1 kg
SPO2 :	99 % RA	HGT:	—

REMARK:

MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. CH KASI ANNAPURNA	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC64446/NMU0049609	**Referred By**	: Dr. DMO
Received Dt	: 31-Mar-24 09:12 am	**Report Date**	: 01-Apr-24 09:42 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	20 ml		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.025	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	1-2	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		Occasional	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. CH KASI ANNAPURNA	Age /Gender	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC64446/NMU0049609	Referred By	: Dr. DMO
Received Dt	: 31-Mar-24 09:12 am	Report Date	: 01-Apr-24 09:42 am

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. CH KASI ANNAPURNA	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC64446/NMU0049609	**Referred By**	: Dr. DMO
Received Dt	: 31-Mar-24 09:12 am	**Report Date**	: 01-Apr-24 10:23 am

FINAL REPORT

Parameters	**Specimen**	**Result**		**TUBE AGGLUTINATI**
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		30	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	EDTA Blood	3.96	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		9.9	12.0 - 15.0 g/dl	
PCV/HCT		32.2	40 - 50 %	
MCV		81.2	83 - 101 fl	
MCH		25.0	27 - 32 pg	
MCHC		30.8	31.5 - 34.5 g/dL	
RDW(cv)		16.9	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	EDTA Blood	390	150 - 400 10^3/µL	
MPV		10.0	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	6.60	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	50	40 - 80 %	
LYMPHOCYTES		41	20 - 40 %	
MONOCYTES		03	02 - 10 %	
EOSINOPHILS		06	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisopoikilocytosis. Predominantly normocytic normochromic with microcytes ,ovalocytes and some polychromatic macrocytes.		
WBC		Normal morphology.		
PLATELETS		Adequate in smear.		

*** End Of Report ***

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Patient Name	: Mrs. CH KASI ANNAPURNA	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC64446/NMU0049609	**Referred By**	: Dr. DMO
Received Dt	: 31-Mar-24 09:12 am	**Report Date**	: 01-Apr-24 01:11 pm

Parameter	**Specimen**	**Result Values**	**Biological Reference**	**Method**

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. CH KASI ANNAPURNA	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC64446/NMU0049609	**Referred By**	: Dr. DMO
Received Dt	: 31-Mar-24 09:13 am	**Report Date**	: 01-Apr-24 08:35 am

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE	PLASMA AND URINE	84	Normal Range : 70 - 99 mg/dL	Hexokinase
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	
SERUM ELECTROLYTES				
SERUM SODIUM		143	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.8	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		105	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		67.66	70 - 204 ng/dL	Method : ECLIA
T4		6.57	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		5.12	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.62	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		6	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.62	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		9.6	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		14	<= 33 U/L	Method : UV without P5P
SGOT (AST)		19	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		77	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.3	6.0 - 8.0 g/dL	Method : Biuret method

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. CH KASI ANNAPURNA	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC64446/NMU0049609	**Referred By**	: Dr. DMO
Received Dt	: 31-Mar-24 09:12 am	**Report Date**	: 01-Apr-24 08:35 am

Parameters	Specimen	Result	Biological Reference In	Method
SERUM ALBUMIN		4.3	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.0	2.5 - 3.5 g/dL	
A/G RATIO		1.43	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		19	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		6	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.3	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		173	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		38	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		118	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		20		
SERUM TRYGLYCERIDES		99	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.55	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.11		
SERUM URIC ACID		3.9	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		104	110 - 180 mg/dL	Hexokinase
URINE SUGAR		Nil		Dipstick

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. CH KASI ANNAPURNA	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC64446/NMU0049609	**Referred By**	: Dr. DMO
Received Dt	: 31-Mar-24 01:18 pm	**Report Date**	: 01-Apr-24 08:35 am

Parameter	Specimen	Result Values	Biological Reference	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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2 D Transthoracic Echocardiography and Color Doppler

NAME	UMR No	REF. BY
MRS. CH KASI ANNAPURNA	49609	HEALTH CHECK UP

DATE	AGE	SEX
31/03/2024	35 YRS.	FEMALE

ECHO FINDINGS :

No RWMA.

LVEF is 60%.

No LV Diastolic Dysfunction.

Trivial mitral regurgitation.

No aortic regurgitation. No aortic stenosis.

Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 22 mm Hg

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

M-MODE MEASUREMENTS (in Cm)

LA	3.4
AORTA	2.9
LVID (d)	4.3
LVID (s)	3.1
IVS (d)	1.0
PW (d)	1.0
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

49609 CH KASI ANNAPURNA 3/31/2024 11:06:35 AM
35 Years Female

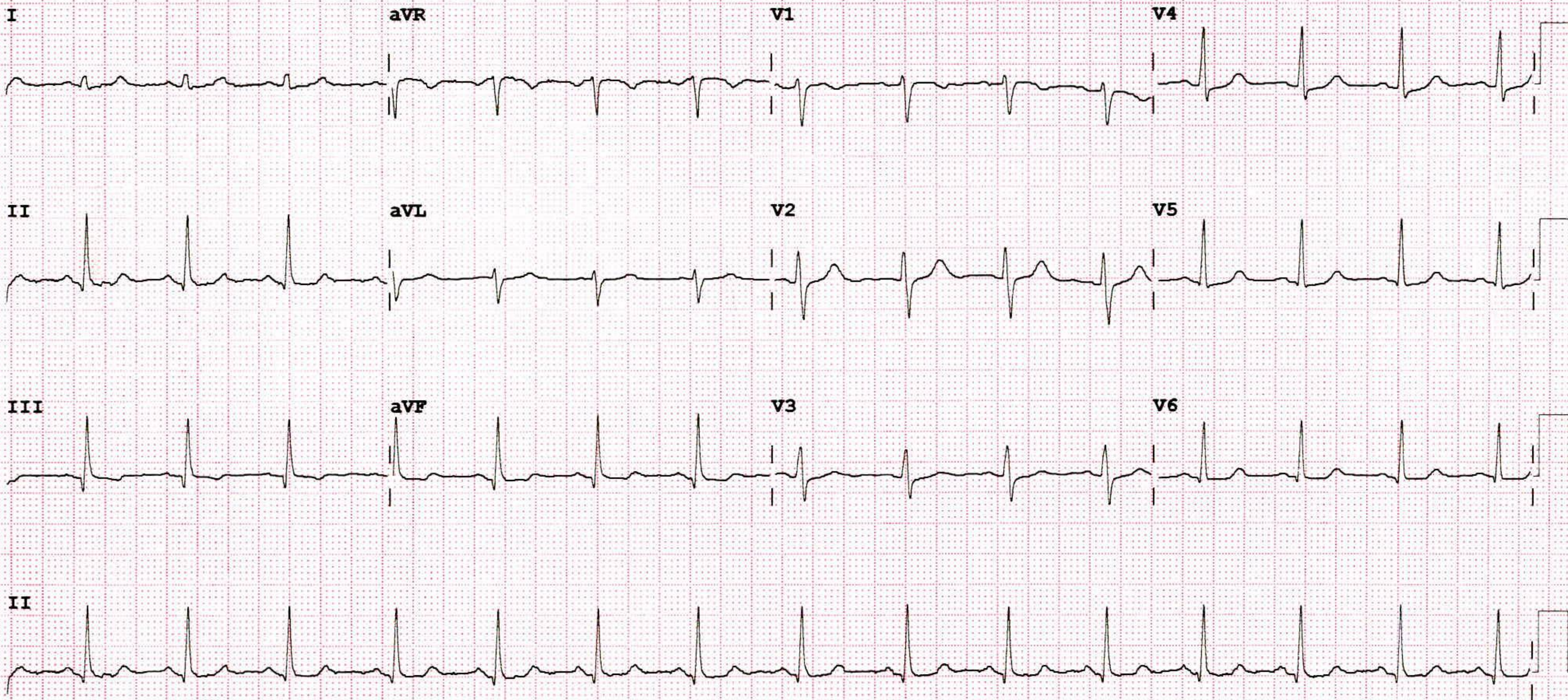
Rate 91 . Sinus rhythm....................................normal P axis, V-rate 50- 99
. Borderline short PR interval...........................PR int <120mS
PR 118 . Abnormal inferior Q waves..........................Qs add to 80 mS in II III aVF
QRSD 110 . Baseline wander in lead(s) V1
QT 371
QTc 457

--AXIS--
P 54
QRS 75
T 15

- 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?

MEDICOVER
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Patient ID:	NMU0049609	Patient Name:	CH KASI ANNAPURNA
Age:	35 Years	Sex:	F
Accession Number:	NMBC64446	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	31-Mar-2024		

USG ABDOMEN & PELVIS

The Liver is normal in size (14.3 cm) and shows normal echotexture. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

The gall bladder is physiologically distended with normal wall thickness. There is no evidence of gallstones. C.B.D. is of normal caliber.

The Pancreas is normal in size and echotexture.

The spleen is normal size (7.4 cm). No focal lesion is seen.

Both kidneys are normal in size, shape and echotexture. They shows normal cortical echogenicity with maintained cortico-medullary distinction.
The Right Kidney measures 9.5 x 3.5 cm.
The Left Kidney measures 10.4 x 4.4 cm.
There is no evidence of a calculus, hydronephrosis, or hydroureter.

The Urinary bladder is adequately distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

The uterus is normal in size and echotexture. It measures 8.1 x 5.1 x 3.8 cm.
No focal lesion is seen. The Endometrial thickness is 4.0 mm.

Both ovaries are well visualized and appear normal in size and echotexture.
The Right ovary measures 2.8 x 2.0 cm
The Left ovary measures 2.4 x 1.2 cm
There is no evidence of any ovarian or adnexal mass lesion.

Visualised bowel loops are unremarkable.
There is no evidence of significant lymphadenopathy.
No ascitis is seen.

IMPRESSION:

- **No significant abnormality is seen.**

DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 31-Mar-2024 10:37:14

MEDICOVER
HOSPITALS

Patient ID:	NMU0049609	Patient Name:	CH KASI ANNAPURNA
Age:	35 Years	Sex:	F
Accession Number:	NMBC64446	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	31-Mar-2024	Study Time:	09:33:04

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: 31-Mar-2024 11:29:56