

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Kavita Dhakad

DATE: 29/3/24

AGE : 34 y

SEX: Male/ Female

NMU: NMU000 49426

DOCTOR'S NAME:

TEMP :	° f	BP :	<u>113/70</u>	mmHg
PULSE :	<u>84</u>	b/m	HEIGHT :	<u>164</u> cm
RR :	<u>24</u>	b/m	WEIGHT :	<u>49.7</u> kg
SPO2 :	<u>99</u> %	HGT:		—

REMARK:



DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 29/03/24

PATIENT NAME: Mrs. Kavita Dhakad

AGE / SEX: NAVI MUMBAI

UMR NO: NMU 0049428

34/F

	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 HT/DM/Thyroid.

No h/o spectacle use

No h/o ocular Trauma (BE).

OCULAR FINDINGS :

(BE) - Ant seg WNL

(unilateral) Disc \leftarrow 0.3, 0.2, venous tortuosity + superior to disc

ADVICE:

Refresh tears 4x/d 1777 X 1month
- Fundoscopy (BE)

AP
CDR - ANUSHREE VANKAR





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. KAVITA DHAKAD	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : NMBC64177/NMU0049426	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:10 am	Report Date : 29-Mar-24 06:23 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.
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	OCCASIONAL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		3-4	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
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. KAVITA DHAKAD	Age / Gender : 34 Y(s)/Female
Bill No/ UMR No : NMBC64177/NMU0049426	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:10 am	Report Date : 29-Mar-24 06:23 pm

Parameters **Specimen** **Result** **Biological Reference In Method**

*** End Of Report ***





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. KAVITA DHAKAD	Age /Gender : 34Y(s)/Female
Bill No/ UMR No : NMBC64177/NMU0049426	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:10 am	Report Date : 29-Mar-24 01:50 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
<u>RBC</u>				
R B C COUNT	Blood	4.45	3.8 - 4.8 10 ⁶ /μL	
HEMOGLOBIN		13.6	12.0 - 15.0 g/dl	
PCV/HCT		40.7	40 - 50 % 36 - 46 %	
MCV		92	83 - 101 fl 83 - 101 fl	
MCH		30.5	27 - 32 pg	
MCHC		33.3	31.5 - 34.5 g/dL	
RDW(cv)		12.2	11.6 - 14.0 %	
<u>PLATELETS</u>				
PLATELET COUNT	Blood	151	150 - 400 10 ³ /μL	
MPV		10.1	7.5 - 11.5 fl	
<u>WBC</u>				
TC (TOTAL LEUCOCYTE COUNT)	Blood	5.6	4.0 - 11.0 10 ³ /μl	
<u>DIFFERENTIAL COUNT</u>				
NEUTROPHILS	Blood	70	40 - 80 %	
LYMPHOCYTES		23	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		01	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	21	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" AB "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. KAVITA DHAKAD	Age / Gender : 34 Y(s)/Female
Bill No/ UMR No : NMBC64177/NMU0049426	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:10 am	Report Date : 29-Mar-24 05:25 pm

Parameters

Specimen Result

TUBE AGGLUTINATI





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. KAVITA DHAKAD	Age / Gender : 34Y(s)/Female
Bill No/ UMR No : NMBC64177/NMU0049426	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:10 am	Report Date : 29-Mar-24 02:03 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
SERUM ELECTROLYTES				
SERUM SODIUM		141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.7	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		94	Normal Range : 70 - 99 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		68.15	70 - 204 ng/dL	Method : ECLIA
T4		6.40	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.46	0.270 - 4.20 uIU/mL	
SERUM CREATININE				
CREATININE		0.73	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.73	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		13.69	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		1.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.3	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		1.0	<= 1.0 mg/dL	
SGPT (ALT)		14	<= 33 U/L	Method : UV without P5P
SGOT (AST)		16	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		58	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)		16	6 - 42 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. KAVITA DHAKAD	Age /Gender : 34Y(s)/Female
Bill No/ UMR No : NMBC64177/NMU0049426	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:10 am	Report Date : 29-Mar-24 05:50 pm

Specimen

BUN(BLOOD UREA NITROGEN)

BUN (Blood Urea Nitrogen.) 10 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 208 Desirable : : < 200 mg/dL METHOD : Enzymatic colorimetric
Borderline High : : 200 - 239 mg/dL

HDL CHOLESTEROL 71 High risk : > 240 mg/dL
Low : : < 40 mg/dL Homogeneous enzymatic colorimetric
High : : > 60 mg/dL

LDL CHOLESTEROL 121 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

VLDL 20
SERUM TRYGLYCERIDES 99 < 150 mg/dL METHOD: Enzymatic colorimetric
Borderline High : 150 - 199 mg/dL
High : 200 - 499 mg/dL

CHO/HDL RATIO 2.93 Normal : - < 3.5
High Risk : - > 5.0

LDL/HDL RATIO 1.7
SERUM URIC ACID 3.0 2.4 - 5.7 mg/dL uricase

PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)

PLBS (POST LUNCH BLOOD GLUCOSE) 96 110 - 180 mg/dL Hexokinase

HBA1C (GLYCOSYLATED HAEMOGLOBIN)

HBA1C 5.0 < 5.7 Normal Prediabetic 5.7 TINIA
- 6.4 & >=6.5 Diabetic %

MPG(Mean Plasma Glucose) 97 Excellent Control : 90 - 120 mg/dL
Good Control : 121 - 150 mg/dL

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. KAVITA DHAKAD	Age / Gender : 34Y(s)/Female
Bill No/ UMR No : NMBC64177/NMU0049426	Referred By : Dr. DMO
Received Dt : 29-Mar-24 11:10 am	Report Date : 30-Mar-24 09:43 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
-------------------	-----------------	---------------	---------------------------------------

Lab Incharge


Dr. VISHAL MEHROTRA, MD Pathology
Head, Hematology Services

Verified By : : 026979

Test results related only to the item tested.

No part of the report can be reproduced without written permission of the laboratory.



Patient ID:	NMU0049426	Patient Name:	KAVITA DHAKAD
Age:	34 Years	Sex:	F
Accession Number:	NMBC64177	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	29-Mar-2024	Study Time:	12:08:36

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 15:35:22

Patient ID:	NMU0049426	Patient Name:	KAVITA DHAKAD
Age:	34 Years	Sex:	F
Accession Number:	NMBC64177	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	29-Mar-2024	Study Time:	12:28:42

USG ABDOMEN & PELVIS

The Liver is normal in size (13.3 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 (9.1 cm). No focal lesion is seen.

Horseshoe shaped kidney noted. **Both kidneys** are normal in size and echotexture. They show normal cortical echogenicity with maintained cortico-medullary distinction.

The Right Kidney measures 9.7 x 3.1 cm.

The Left Kidney measures 10.7 x 3.5 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 7.9 x 4.6 x 5.7 cm.

No focal lesion is seen. The Endometrial thickness is 10 mm.

Both ovaries are well visualized and appear normal in size and echotexture.

The Right ovary measures 3.9 x 1.8 cm

The Left ovary measures 3.3 x 1.5 cm

There is no evidence of any ovarian or adnexal mass lesion.

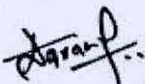
Visualised bowel loops are unremarkable.

There is no evidence of significant lymphadenopathy.

No ascitis is seen.

IMPRESSION:

- Horseshoe shaped kidney.
- No significant abnormality is seen.



2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name : Mrs. Kavita Dhakad

Date:-29/03/2024

Age / Sex : 34 Yrs / Female

UMR No. 0049426

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.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 28 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 MR and 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			Trivial
AORTIC	7			Nil
TRICUSPID	28			Trivial
PULMONERY	4.4			Nil



HC 49426
34 Years

KAVITA DHAKAD
Female

3/29/2024 12:43:59 PM

Rate 101 . Sinus tachycardia.....rate> 99
PR 116 . Borderline left axis deviation.....QRS axis (-15,-29)
QRSD 89 . RSR' in V1 or V2, probably normal variant.....small R' only
QT 335
QTc 435

Sinus tachycardia
[Signature]

--AXIS--

P 54
QRS -17
T 67

- BORDERLINE ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

