MEDICOVER HOSPITALS

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs ✓ shital Rohan suryagandh DATE:

AGE : 38yrs SEX: Male/Female (circled)

NMU: NMU00049408 DOCTOR'S NAME: Health-Package

TEMP :	97 °f	BP :	105/76 mmHg
PULSE :	94 b/m	HEIGHT :	152 cm
RR :	18 b/m	WEIGHT :	53.5 kg
SPO2 :	98 % RA	HGT:	—

REMARK:

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL ROHAN SURYAGANDH		
Bill No/ UMR No	: NMBC64151/NMU0049408	**Age /Gender**	: 38 Y(s)/Female
Received Dt	: 29-Mar-24 10:39 am	**Referred By**	: Dr. DMO
		Report Date	: 29-Mar-24 05:51 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	30ML		
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	2-3	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		3-4	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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Bill No/ UMR No	: NMBC64151/NMU0049408	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:39 am	**Report Date**	: 29-Mar-24 05:51 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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Patient Name	: Mrs. SHITAL ROHAN SURYAGANDH		
Bill No/ UMR No	: NMBC64151/NMU0049408	**Age /Gender**	: 38 Y(s)/Female
Received Dt	: 29-Mar-24 10:49 am	**Referred By**	: Dr. DMO
		Report Date	: 29-Mar-24 12:51 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.13	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		12.0	12.0 - 15.0 g/dl	
PCV/HCT		36.3	40 - 50 % 36 - 46 %	
MCV		88	83 - 101 fl 83 - 101 fl	
MCH		29.0	27 - 32 pg	
MCHC		33.0	31.5 - 34.5 g/dL	
RDW(cv)		12.2	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	253	150 - 400 10^3/µL	
MPV		8.8	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.9	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	59	40 - 80 %	
LYMPHOCYTES		36	20 - 40 %	
MONOCYTES		04	02 - 10 %	
EOSINOPHILS		01	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	60	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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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL ROHAN SURYAGANDH	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC64151/NMU0049408	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:49 am	**Report Date**	: 29-Mar-24 05:23 pm

Parameters	**Specimen**	**Result**	**TUBE AGGLUTINATI**

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL ROHAN SURYAGANDH		
Bill No/ UMR No	: NMBC64151/NMU0049408	**Age /Gender**	: 38 Y(s)/Female
Received Dt	: 29-Mar-24 10:49 am	**Referred By**	: Dr. DMO
		Report Date	: 29-Mar-24 02:12 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.6	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		104	98 - 107 mmol/L	ISE INDIRECT
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		108	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.55	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		0.55	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		10.9	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)		19	<= 33 U/L	Method : UV without P5P
SGOT (AST)		21	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		103	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		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.5	2.5 - 3.5 g/dL	
A/G RATIO		1.29	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		20	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		8.0	6.0 - 8.0 g/dL	Method : Biuret method

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL ROHAN SURYAGANDH	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC64151/NMU0049408	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:49 am	**Report Date**	: 29-Mar-24 05:03 pm

Parameters	Specimen	Result	Biological Reference In	Method
LIPID PROFILE				
TOTAL CHOLESTEROL		169	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		43	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		113	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		22		
SERUM TRYGLYCERIDES		110	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.93	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.63		
SERUM URIC ACID		4.9	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		107.8	70 - 204 ng/dL	Method : ECLIA
T4		7.69	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.58	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		152	110 - 180 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.4	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		137	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL ROHAN SURYAGANDH	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC64151/NMU0049408	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:50 am	**Report Date**	: 30-Mar-24 09:41 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 026979

Test results related only to the item tested.

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2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: Mrs. Shital Suryagandh	Date:-29/03/2024
Age / Sex	: 38 Yrs / Female	UMR No. 0049408
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.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
  PASP = 22 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 and 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	22			Trivial
PULMONERY	4.4			Nil

HC 49408
38 Years

SHITAL SURYAGANDH
Female

Rate 79 . Sinus rhythm....................................normal P axis, V-rate 50- 99

PR 151
QRSD 83
QT 361
QTc 414

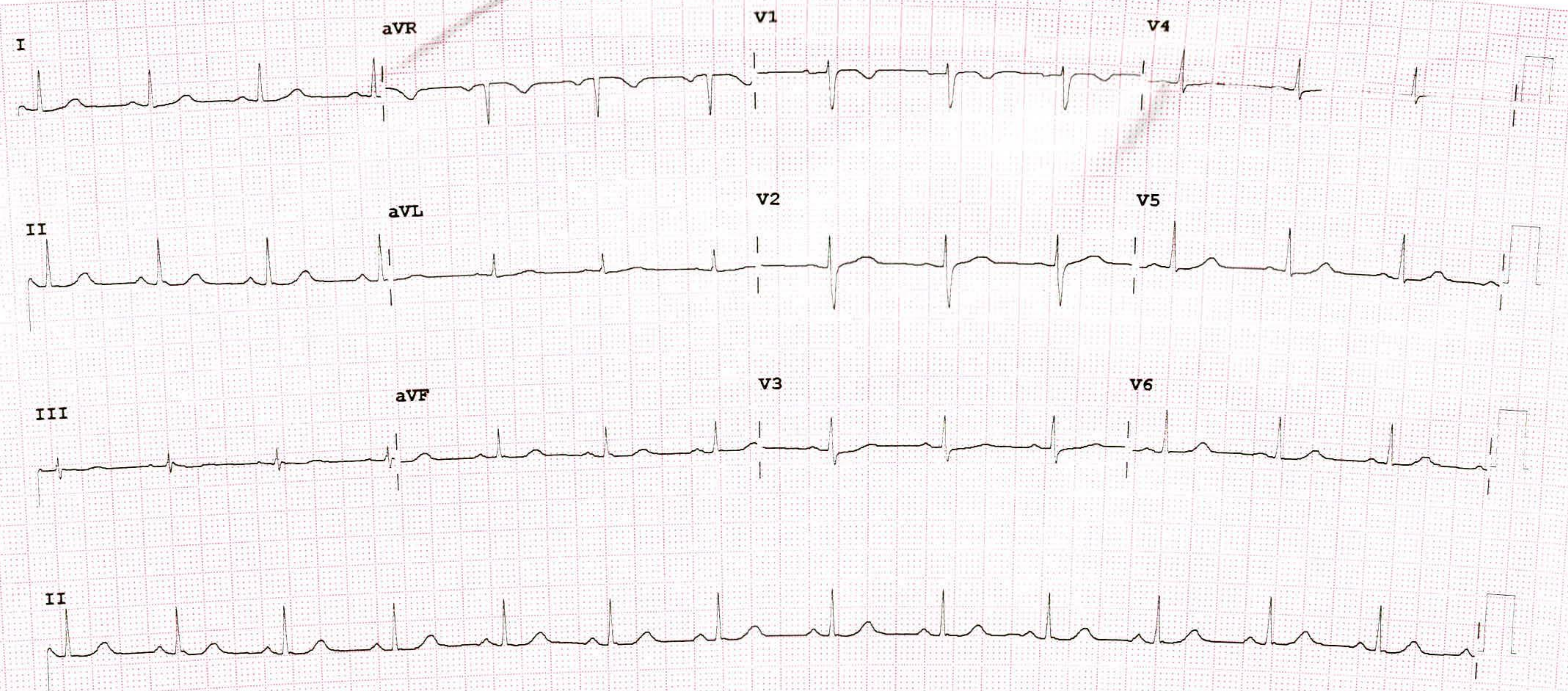
--AXIS--
P 41
QRS 38
T 36

- NORMAL ECG -

Unconfirmed Diagnosis

N/R

12 Lead; Standard Placement



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.15-100 Hz 100B CL P?

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HOSPITALS

Patient ID:	NMU0049408	Patient Name:	SHITAL ROHAN SURYAGANDH
Age:	38 Years	Sex:	F
Accession Number:	NMBC64151	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	29-Mar-2024	Study Time:	11:25:43

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)

MEDICOVER
HOSPITALS

Patient ID:	NMU0049408	Patient Name:	SHITAL SURYAGANDH
Age:	38 YRS	Sex:	F
Accession Number:		Modality:	US
Referring Physician:	DR. DMO	Study:	
Study Date:	29-Mar-2024	Study Time:	11:49:00

USG ABDOMEN & PELVIS

The Liver is normal in size (11.1 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 (8.3 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 9.3 x 3.8 cm.
The Left Kidney measures 9.7 x 5.2 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 8.0 x 4.8 x 4.0 cm.
No focal lesion is seen. The Endometrial thickness is 6.2 mm.

Both ovaries are well visualized and appear normal in size and echotexture.
The Right ovary measures 2.2 x 1.3 cm
The Left ovary measures 2.6 x 2.2 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: 29-Mar-2024 12:58:05