HC 50026 NILAM CHORMALE 4/4/2024 12:05:35 PM
34 Years Female

Rate	80	. Sinus rhythm....................normal P axis, V-rate 50- 99
		. Short PR interval....................PR <110mS
PR	91	. Left bundle branch block....................QRSd>120, broad/notched R
QRSD	126	
QT	397	
QTc	458	

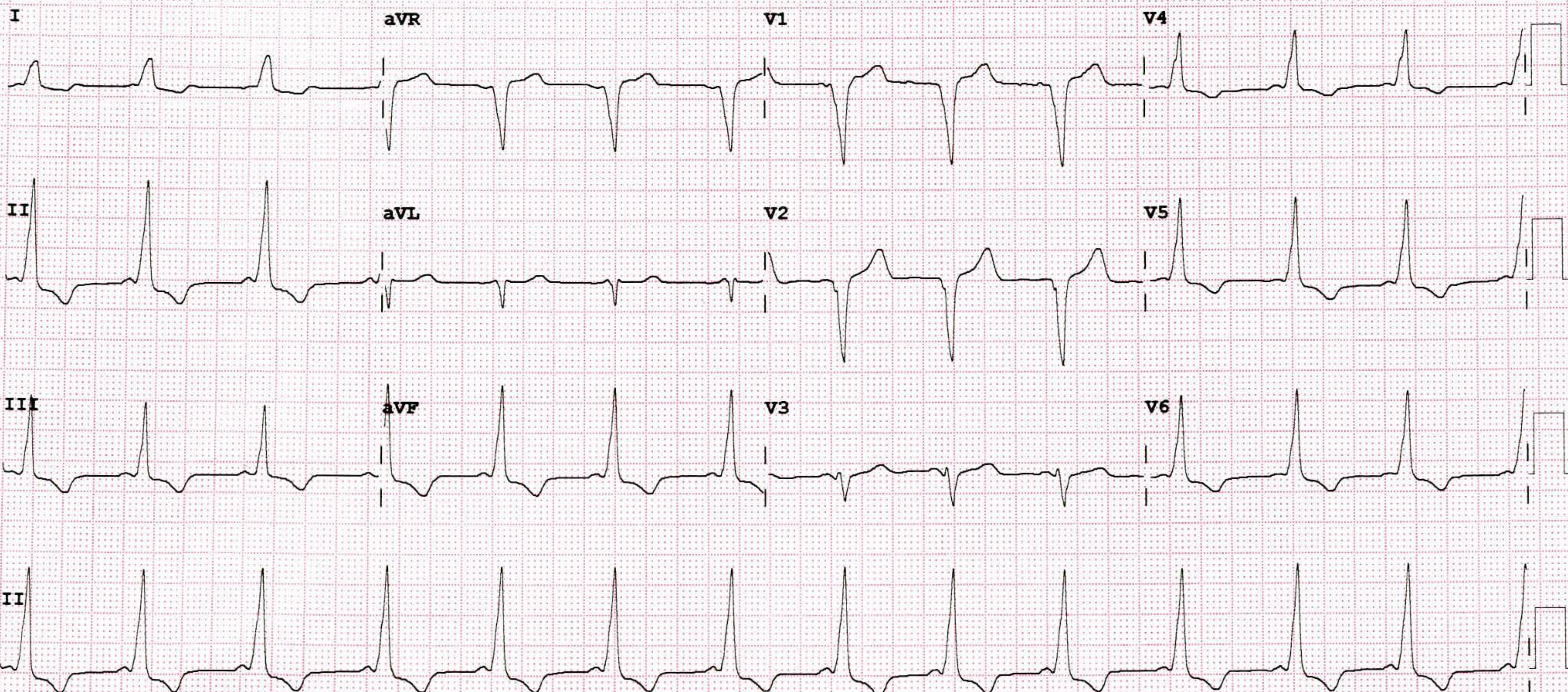
--AXIS--

P	72
QRS	65
T	259

- ABNORMAL 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 HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NILAM DADASA CHORMALE	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC65060/NMU0050026	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:49 am	**Report Date**	: 04-Apr-24 03:24 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	25ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.025	1.000 - 1.030	Dipstick
PH		5.0	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		1-2	0 - 5 /hpf	
EPITHELIAL CELLS		2-3	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		++		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NILAM DADASA CHORMALE	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC65060/NMU0050026	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:49 am	**Report Date**	: 04-Apr-24 03:24 pm

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

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NILAM DADASA CHORMALE	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC65060/NMU0050026	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:49 am	**Report Date**	: 04-Apr-24 03:23 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	EDTA Blood	4.60	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		13.2	12.0 - 15.0 g/dl	
PCV/HCT		40.4	40 - 50 %	
MCV		87.8	83 - 101 fl	
MCH		28.8	27 - 32 pg	
MCHC		32.8	31.5 - 34.5 g/dL	
RDW(cv)		13.6	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	EDTA Blood	226	150 - 400 10^3/µL	
MPV		9.4	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	5.14	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	59	40 - 80 %	
LYMPHOCYTES		33	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" B "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		32	0 - 20 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

Patient Name	: Mrs. NILAM DADASA CHORMALE	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC65060/NMU0050026	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:49 am	**Report Date**	: 04-Apr-24 03:23 pm

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NILAM DADASA CHORMALE	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC65060/NMU0050026	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:49 am	**Report Date**	: 04-Apr-24 12:34 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		145	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.5	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		88	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.69	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.69	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		15.9	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.8	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.3	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.5	<= 1.0 mg/dL	
SGPT (ALT)		19	<= 33 U/L	Method : UV without P5P
SGOT (AST)		20	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		132	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.0	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.7	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.3	2.5 - 3.5 g/dL	
A/G RATIO		2.04	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		13	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.0	6.0 - 8.0 g/dL	Method : Biuret method

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MEDICOVER
HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NILAM DADASA CHORMALE	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC65060/NMU0050026	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 10:49 am	**Report Date**	: 04-Apr-24 12:50 pm

Parameters	Specimen	Result	Biological Reference In	Method
LIPID PROFILE				
TOTAL CHOLESTEROL		148	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		51	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		89	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		12		
SERUM TRYGLYCERIDES		62	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		2.9	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		1.75		
SERUM URIC ACID		5.1	2.4 - 5.7 mg/dL	uricase
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	
T3,T4 AND TSH				
T3		125.4	70 - 204 ng/dL	Method : ECLIA
T4		8.40	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		5.06	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		100	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NILAM DADASA CHORMALE	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC65060/NMU0050026	**Referred By**	: Dr. DMO
Received Dt	: 04-Apr-24 01:21 pm	**Report Date**	: 04-Apr-24 03:16 pm

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

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

Verified By : : 022633

Test results related only to the item tested.

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DEPARTMENT OF OPHTHALMOLOGY

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NAVI MUMBAI

DATE: 04/04/24

PATIENT NAME: Mrs Nilam chormale AGE / SEX 34/F

UMR NO : NMU00 50026.

	RE	LE
VA (DISTANCE)	6/18p.	6/18p.
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-1.00	-0.75	90	6/6, N6
	O (L)	S	-1.25	-0.50	70.	6/6, N6

HISTORY :

- H/O Using spectacle (Distance).
- NO H/O systemic illness (DM, HTN, thyroid)
- NO H/O ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

(BE) - Ant Seg WNL.

(undilated) Disc < 0.3 / 0.2

ADVICE:

Refresh Tears e/d qid (???) X 1 month.

(DR. ANUSHREE VANKAR)

MEDICOVER
HOSPITALS
NAVI MUMBAI

2 D Transthoracic Echocardiography and Color Doppler

NAME	UMR No	REF. BY
MRS NILAM CHORMALE	50026	HEALTH CHECK UP

DATE	AGE	SEX
04/04/2024	34 YRS.	FEMALE

ECHO FINDINGS :

Jerky motion of IVS.

LVEF is 60%.

No Diastolic Dysfunction.

Trivial mitral regurgitation.

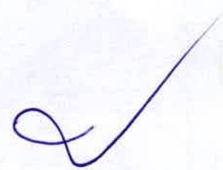
No aortic regurgitation. No aortic stenosis.

Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 28 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

MEDICOVER
HOSPITALS
NAVI MUMBAI

M-MODE MEASUREMENTS (in Cm)

LA	3.5
AORTA	2.7
LVID (d)	4.3
LVID (s)	3.2
IVS (d)	1.0
PW (d)	0.9
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

MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Nilam .c DATE:

AGE : 34 yr SEX: Male/ Female ✓

NMU: NMU000 DOCTOR'S NAME:

TEMP :	98.2 °f	BP :	100/60 mmHg
PULSE :	87 b/m	HEIGHT :	161 cm
RR :	28 b/m	WEIGHT :	75.8 kg
SPO2 :	100 %	HGT:	

REMARK:

MEDICOVER
HOSPITALS

Patient ID:	NMU0050026	Patient Name:	NILAM DADASA CHORMALE
Age:	34 Years	Sex:	F
Accession Number:	NMBC65060	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	04-Apr-2024		

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

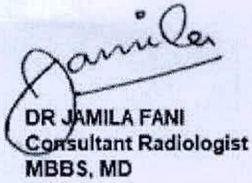
E ı hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

- **No significant abnormality is seen.**



DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 04-Apr-2024 12:36:14

MEDICOVER
HOSPITALS

Patient ID:	NMU0050026	Patient Name:	NILAM DADASA CHORMALE
Age:	34 Years	Sex:	F
Accession Number:	NMBC65060	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	04-Apr-2024	Study Time:	10:54:56

USG WHOLE ABDOMEN (TAS)

LIVER is mildly enlarged in size (17 cm), normal in shape and shows bright 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 empty.

UTERUS is retroverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures 6.0 mm.

Both adnexa appear clear.

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 –

- **Mild hepatomegaly with grade I fatty liver.**
- **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)