MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL PRAVIN POPLE	**Age /Gender**	: 29 Y(s)/Female
Bill No/ UMR No	: NMBC63372/NMU0048853	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 09:40 am	**Report Date**	: 23-Mar-24 05:30 pm

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		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.005	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.
BLOOD		NEGATIVE	NEGATIVE	Dipstick/Microcsopy
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		3-4	0 - 5 /hpf	
EPITHELIAL CELLS		NIL	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		+		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL PRAVIN POPLE	**Age /Gender**	: 29 Y(s)/Female
Bill No/ UMR No	: NMBC63372/NMU0048853	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 09:40 am	**Report Date**	: 23-Mar-24 05:30 pm

Parameters	Specimen	Result	Biological Reference In	Method
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. SHITAL PRAVIN POPLE	**Age /Gender**	: 29 Y(s)/Female
Bill No/ UMR No	: NMBC63372/NMU0048853	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 09:40 am	**Report Date**	: 23-Mar-24 03:47 pm

FINAL REPORT

Parameters	Specimen	Result		TUBE AGGLUTINATI
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" B "		TUBE AGGLUTINATION
RH TYPE		NEGATIVE		
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	3.58	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		10.5	12.0 - 15.0 g/dl	
PCV/HCT		30.9	40 - 50 % 36 - 46 %	
MCV		86	83 - 101 fl 83 - 101 fl	
MCH		29.4	27 - 32 pg	
MCHC		34.1	31.5 - 34.5 g/dL	
RDW(cv)		12.4	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	236	150 - 400 10^3/µL	
MPV		8.4	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.7	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	60	40 - 80 %	
LYMPHOCYTES		25	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		10	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	35	0 - 20 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL PRAVIN POPLE	**Age /Gender**	: 29 Y(s)/Female
Bill No/ UMR No	: NMBC63372/NMU0048853	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 09:40 am	**Report Date**	: 23-Mar-24 04:08 pm

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL PRAVIN POPLE	**Age /Gender**	: 29 Y(s)/Female
Bill No/ UMR No	: NMBC63372/NMU0048853	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 09:41 am	**Report Date**	: 23-Mar-24 01:53 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		86	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		167.5	70 - 204 ng/dL	Method : ECLIA
T4		10.96	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.84	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		68	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
SERUM CREATININE				
CREATININE		0.59	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.59	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		13.5	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		1.0	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.8	<= 1.0 mg/dL	
SGPT (ALT)		9	<= 33 U/L	Method : UV without P5P
SGOT (AST)		14	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		60	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		4.7	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.3	2.5 - 3.5 g/dL	
A/G RATIO		1.42	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		13	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHITAL PRAVIN POPLE	**Age /Gender**	: 29 Y(s)/Female
Bill No/ UMR No	: NMBC63372/NMU0048853	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 09:40 am	**Report Date**	: 25-Mar-24 10:24 am

Specimen

BUN(BLOOD UREA NITROGEN)			
BUN (Blood Urea Nitrogen.)	8	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	170	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL	36	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL	112	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	27		
SERUM TRYGLYCERIDES	134	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO	4.72	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO	3.11		
SERUM URIC ACID	4.4	2.4 - 5.7 mg/dL	uricase
SERUM ELECTROLYTES			
SERUM SODIUM	139	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM	4.2	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES	102	98 - 107 mmol/L	ISE INDIRECT
HBA1C (GLYCOSYLATED HAEMOGLOBIN)			
HBA1C	5.2	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)	102	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 PRAVIN POPLE	**Age /Gender**	: 29 Y(s)/Female
Bill No/ UMR No	: NMBC63372/NMU0048853	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 09:40 am	**Report Date**	: 25-Mar-24 10:24 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 026560

Test results related only to the item tested.

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2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: Mrs. Shital Pople	Date:- 23/03/2024
Age / Sex	: 29 Yrs / Female	UMR No. 0048853
Referred By	: Health Checkup	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Mild tricuspid regurgitation. No pulmonary hypertension. PASP = 28 mm Hg.
- No left ventricle clot / vegetation.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **Trivial MR. Mild TR. No PH.**
- **Normal LV and RV systolic function.**

DR. KESHAV KALE
DNB (Cardiology), MD (Medicine), MBBS
PhD (Cardiology), MNAMS, LL.B (Law)
FSCAI (USA), AFACC (USA), FESC (EU)
Consultant & Interventional Cardiologist

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M-MODE MEASURMENTS:

LA	35	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	32	mm
LVID(d)	41	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	4.1			Nil
TRICUSPID	28			Mild
PULMONERY	2.1			Nil

hc48853 shital pravin pople 1/7/2008 1:22:58 AM

Female

Age : 29 yrs

Rate 77 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation

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

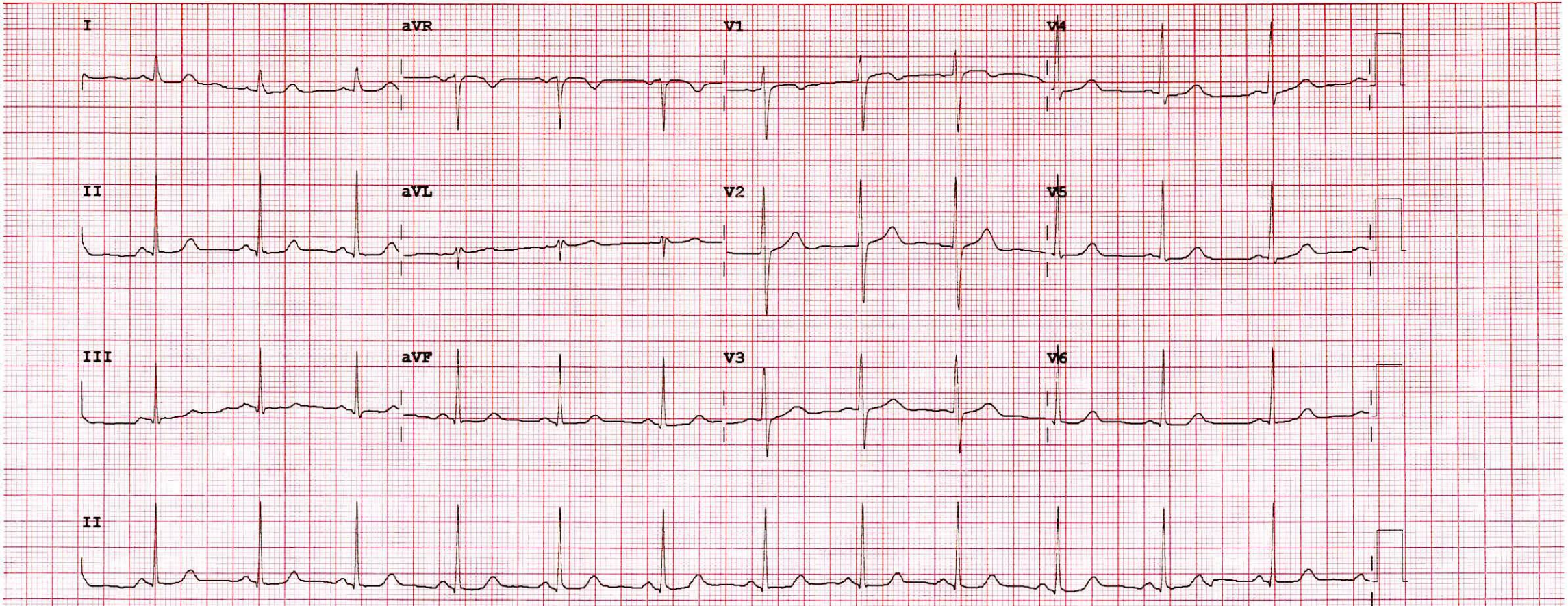
PR 137
QRSD 89
QT 383
QTc 434

--AXIS--
P 67
QRS 57
T 45

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



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

PHILIPS REORDER # M2483A

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Shital.

S/B :- Dr. mandira kamble

O/E :- faulty prosthesis ē $\frac{1|1}{}$

Stain⁺ calculus⁺

Advice :- Prosthesis ē $\frac{1|1}{}$

Oral prophylaxis.

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

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Shital Pople DATE: 23/3/24

AGE : 29 yrs SEX: Male/ Female ✓

NMU: NMU000 48853 DOCTOR'S NAME:

Health Package

TEMP :	97.4 °f	**BP :**	100/60 mmHg
PULSE :	83 b/m	**HEIGHT :**	160 cm
RR :	20 b/m	**WEIGHT :**	63.7 kg
SPO2 :	99 % RA	**HGT:**	—

REMARK:

MEDICOVER
HOSPITALS

Patient ID:	*NMU0048853*	*Patient Name:*	*SHITAL PRAVIN POPLE*
Age:	*29 Years*	*Sex:*	*F*
Accession Number:	*NMBC63372*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*23-Mar-2024*		

ULTRASOUND EXAMINATION OF ABDOMEN & PELVIS

The Liver is normal in size and shows a normal parenchymal reflectivity. No focal lesion is seen. The Hepatic veins appear normal. There is no evidence of any dilated IHBR. 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 shows homogeneous reflectivity. There is no evidence of any calcification or ductal dilatation.

The spleen is normal in size and shows a homogeneous echotexture. It measures 10.7 cm in long axis. A splenunculus measuring 10 mm is seen at spelnic hilum.

Both kidneys are normal in position and size. They show normal cortical reflectivity and cortico-medullary distinction.
The Right Kidney measures 10.8 x 2.2 cm.
The Left Kidney measures 10.6 x 3.5 cm.
There is no evidence of renal calculi, hydronephrosis, or mass noted.

There is no evidence of ascites or para aortic lymphadenopathy.

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

The uterus is Anteverted. It measures 8.1 x 3.7 x 4.2 cm.
The uterine myometrial echotexture is homogeneous. No focal lesion is seen.

The Endometrial thickness is 6 mm.

Both ovaries are well visualized and appear normal in size and reflectivity.
The Right ovary measures 4.2 x 3.5 cm. A hemorrhagic cyst measuring 3.2 x 3.1 cm is seen in right ovary.
The Left ovary measures 2.0 x 1.2 cm.

There is no evidence of any adnexal mass lesion.

No evidence of any fluid collection in the pelvis.

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HOSPITALS

Patient ID:	*NMU0048853*	*Patient Name:*	*SHITAL PRAVIN POPLE*
Age:	*29 Years*	*Sex:*	*F*
Accession Number:	*NMBC63372*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*23-Mar-2024*		

IMPRESSION:

Right ovarian hemorrhagic cyst.
No other significant abnormality is seen.

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 23-Mar-2024 13:52:13