DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

NAVI MUMBAI

DATE: 29/03/24

PATIENT NAME: Mrs Jyoti gurav.

AGE / SEX 36/F

UMR NO : NMM000049396

	RE	LE
VA (DISTANCE)	6/12	6/6 (B).
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-0.50	-0.75	20°	6/6, N6
	O (L)	S	±	-0.50	160°	6/6, N6

HISTORY :

- No H/O. Spectacle use. — No H/O Ocular trauma Allergies & surgeries.
- H/O H-TN [illegible] : 4 1-8 months.

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc @ < 0.3 / 0.2-0.3

ADVICE:

- Refraction at next visit

Dr. ANUSHREE VANWAK.

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Jyoti Gawai DATE: 29/3/24

AGE : 36yrs SEX: Male/ Female

NMU: NMU00049396 DOCTOR'S NAME: Health - Package

TEMP :	96.8 °f	BP :	148/102 mmHg
PULSE :	90 b/m	HEIGHT :	156 cm
RR :	18 b/m	WEIGHT :	94.6 kg
SPO2 :	98 % RA	HGT:	—

REMARK:

Jyoti Gaurav 29/03/24

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Routine health check up
No ENT complaints

Ear (N)

Nose DNS to (L)

Throat (N)

Hearing normal clinically (N)

Dr. Rajendra Waghela
M.B.B.S,MS ENT
Consultatnt - ENT & Endoscopic Surgery
Regd. No.: MMC 2009/09/3178

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NAVI MUMBAI

Jyoti Gurav.

S/B :- Dr. Mandira Kamble

O/E :- Caries c̄ $\dfrac{7|}{8|}$

Advice :- Restoration c̄ $\dfrac{7|}{8.|}$

Oral prophylaxis.

Dr Mandira Sushil Kamble
MDS In Conservative Dentistry And Endodontics
Reg. No. A-43262

MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. JYOTI GAURAV	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC64136/NMU0049396	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:10 am	**Report Date**	: 29-Mar-24 06:08 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	20ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.010	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	2-3	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
SPERMATOZOA				MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. JYOTI GAURAV	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC64136/NMU0049396	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:10 am	**Report Date**	: 29-Mar-24 06:08 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. JYOTI GAURAV	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC64136/NMU0049396	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:10 am	**Report Date**	: 29-Mar-24 03:06 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	45	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	EDTA Blood	4.25	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		11.8	12.0 - 15.0 g/dl	
PCV/HCT		34.0	40 - 50 %	
MCV		80.0	83 - 101 fl	
MCH		27.7	27 - 32 pg	
MCHC		34.6	31.5 - 34.5 g/dL	
RDW(cv)		15.7	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	EDTA Blood	245	150 - 400 10^3/µL	
MPV		13.5	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	7.82	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	59	40 - 80 %	
LYMPHOCYTES		29	20 - 40 %	
MONOCYTES		03	02 - 10 %	
EOSINOPHILS		09	00 - 06 %	
BASOPHILS		00	00 - 01 %	
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" B "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. JYOTI GAURAV	Age /Gender	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC64136/NMU0049396	Referred By	: Dr. DMO
Received Dt	: 29-Mar-24 10:10 am	Report Date	: 29-Mar-24 05:23 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. JYOTI GAURAV	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC64136/NMU0049396	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:09 am	**Report Date**	: 29-Mar-24 02:11 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		85	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM ELECTROLYTES				
SERUM SODIUM		143	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.7	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		106	98 - 107 mmol/L	ISE INDIRECT
SERUM CREATININE				
CREATININE		0.76	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		0.76	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		14.4	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		25	<= 33 U/L	Method : UV without P5P
SGOT (AST)		20	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		88	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.5	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.3	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.2	2.5 - 3.5 g/dL	
A/G RATIO		1.34	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		59	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		7.5	6.0 - 8.0 g/dL	Method : Biuret method

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. JYOTI GAURAV	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC64136/NMU0049396	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:10 am	**Report Date**	: 29-Mar-24 05:00 pm

Parameters	**Specimen**	**Result**	**Biological Reference In**	**Method**
LIPID PROFILE				
TOTAL CHOLESTEROL		217	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		41	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		137	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		57		
SERUM TRYGLYCERIDES		283	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		5.29	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.34		
SERUM URIC ACID		5.8	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		107.8	70 - 204 ng/dL	Method : ECLIA
T4		5.80	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		5.95	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		98	110 - 180 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.6	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		114	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. JYOTI GAURAV	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC64136/NMU0049396	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:10 am	**Report Date**	: 30-Mar-24 09:42 am

Parameters	Specimen	Result	Biological Reference In	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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HOSPITALS

Patient ID:	NMU0049396	Patient Name:	JYOTI GAURAV
Age:	36 Years	Sex:	F
Accession Number:	NMBC64136	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	29-Mar-2024	Study Time:	10:48:42

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:	NMU0049396	Patient Name:	JYOTI GAURAV
Age:	36 Years	Sex:	F
Accession Number:	NMBC64136	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	29-Mar-2024	Study Time:	12:30:53

USG ABDOMEN & PELVIS

The Liver is mildly enlarged in size (19.5 cm) and shows grade I fatty change. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

The gall bladder is not visualized-post cholecystectomy status. C.B.D. is of normal caliber.

The Pancreas is normal in size and echotexture.

The spleen is normal size. No focal lesion is seen.

Both kidneys are normal in size, shape and echotexture. They shows normal cortical echogenicity with maintained cortico-medullary distinction.

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.

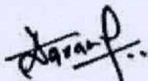
The uterus is normal in size and echotexture. It measures 7.5 x 5.3 x 4.1 cm.
No focal lesion is seen. The Endometrial thickness is 10 mm.

Both ovaries are well visualized and appear normal in size and echotexture.
The Right ovary measures 2.5 x 2.0 cm
The Left ovary measures 2.8 x 1.6 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:

- **Mild hepatomegaly with grade I fatty change.**
- **No other significant abnormality is seen.**



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 29-Mar-2024 12:52:03

MEDICOVER
HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: Mrs. Jyoti Gaurav	Date:-29/03/2024
Age / Sex	: 36 Yrs / Female	UMR No. 0049396
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 = 20 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	20			Trivial
PULMONERY	4.4			Nil

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49396 JYOTI GURAV 3/29/2024 2:44:12 PM
36 Years Female

Rate	85	. Sinus rhythm......................................normal P axis, V-rate 50- 99
		. Abnormal R-wave progression, early transition...................QRS area>0 in V2
PR	135	
QRSD	84	
QT	374	
QTc	445	

--AXIS--

P	31
QRS	22
T	13

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

II

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