

**MEDICAL HEALTH CHECK- UP ASSESMENT FORM**

NAME : Mr / Mrs BHUPENDRA KUMAR

DATE: 13/04/24

AGE : 37yrs

SEX: Male / Female

NMU: NMU000 50737

DOCTOR'S NAME:

HEALTH - PACKAGE

<b>TEMP :</b>	<u>96</u>	<b>° f</b>	<b>BP :</b>	<u>111/69</u>	<b>mmHg</b>
<b>PULSE :</b>	<u>65</u>	<b>b/m</b>	<b>HEIGHT :</b>	<u>163</u>	<b>cm</b>
<b>RR :</b>	<u>20</u>	<b>b/m</b>	<b>WEIGHT :</b>	<u>65.9</u>	<b>kg</b>
<b>SPO2 :</b>	<u>99</u>	<b>%</b>	<b>HGT:</b>	<u>—</u>	

**REMARK:**



**DEPARTMENT OF LABORATORY**

**NAVI MUMBAI**

<b>Patient Name</b> : Mr. BHUPENDRA KUMAR	<b>Age /Gender</b> : 37 Y(s)/Male
<b>Bill No/ UMR No</b> : NMBC66232/NMU0050739	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 13-Apr-24 09:34 am	<b>Report Date</b> : 13-Apr-24 04:08 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
<b>CUE(COMPLETE URINE EXAMINATION)</b>				
<b><u>PHYSICAL EXAMINATION</u></b>				
<b>VOLUME</b>	Urine	20ML		
<b>COLOUR</b>		PALE YELLOW	PALE YELLOW	
<b>APPEARANCE</b>		SLIGHTLY HAZY	CLEAR	
<b>DEPOSIT</b>		ABSENT	ABSENT	
<b><u>CHEMICAL EXAMINATION</u></b>				
<b>SPECIFIC GRAVITY</b>	Urine	1.010	1.000 - 1.030	Dipstick
<b>PH</b>		6.0	5.0 - 8.0	Dipstick
<b>PROTEIN</b>		NEGATIVE	NEGATIVE	Dipstick/Heat coagulation test
<b>GLUCOSE</b>		ABSENT	ABSENT	Dipstick/Benedict's test
<b>UROBILINOGEN</b>		NORMAL	NORMAL	Dipstick
<b>KETONE</b>		NEGATIVE	NEGATIVE	Dipstick/Rothera's Nitroprusside test.
<b>BILIRUBIN</b>		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
<b>BILE SALT</b>		NEGATIVE	NEGATIVE	Hay's sulphur powder test
<b>BILE PIGMENT</b>		NEGATIVE	NEGATIVE	Fouchet test
<b>NITRITE</b>		NEGATIVE	NEGATIVE	Dipstick
<b>LEUCOCYTE ESTERASE</b>		NEGATIVE	NEGATIVE	
<b><u>MICROSCOPIC EXAMINATION</u></b>				
<b>PUS CELLS</b>	Urine	1-2	0 - 5 /hpf	MICROSCOPIC EXAMINATION
<b>RBC</b>		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
<b>EPITHELIAL CELLS</b>		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
<b>CRYSTALS</b>		NIL	NIL	MICROSCOPIC EXAMINATION
<b>CASTS</b>		NIL	NIL	MICROSCOPIC EXAMINATION
<b>BACTERIA</b>		ABSENT		
<b>YEAST</b>		ABSENT		
<b>AMORPHOUS DEPOSITS</b>		ABSENT		

**NOTE**

Microscopic examination of urine is carried out on centrifuged urinary sediment.

\*\*\* End Of Report \*\*\*





**MEDICOVER**  
HOSPITALS

**DEPARTMENT OF LABORATORY**

**NAVI MUMBAI**

**Patient Name** : Mr. BHUPENDRA KUMAR  
**Bill No/ UMR No** : NMBC66232/NMU0050739  
**Received Dt** : 13-Apr-24 09:34 am

**Age / Gender** : 37 Y(s)/Male  
**Referred By** : Dr. DMO  
**Report Date** : 13-Apr-24 04:08 pm

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





**DEPARTMENT OF LABORATORY**

**NAVI MUMBAI**

<b>Patient Name</b> : Mr. BHUPENDRA KUMAR	<b>Age / Gender</b> : 37 Y(s)/Male
<b>Bill No/ UMR No</b> : NMBC66232/NMU0050739	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 13-Apr-24 09:34 am	<b>Report Date</b> : 13-Apr-24 12:17 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
<b>ESR</b>	CITRATED BLOOD	03	0 - 10 mm/1st hour	WESTERGREN'S METHOD

**COMPLETE BLOOD COUNT**

**RBC**

R B C COUNT	EDTA Blood	5.13	4.5 - 5.5 $10^6/\mu\text{L}$
HEMOGLOBIN		14.6	13.0 - 17.0 g/dl
PCV/HCT		45.4	40 - 50 %
MCV		88.3	83 - 101 fl
MCH		28.5	27 - 32 pg
MCHC		32.2	31.5 - 34.5 g/dL
RDW(cv)		14.1	11.6 - 14.0 %

**PLATELETS**

PLATELET COUNT	EDTA Blood	211	150 - 400 $10^3/\mu\text{L}$
MPV		10.2	7.5 - 11.5 fl

**WBC**

TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	4.14	4.0 - 11.0 $10^3/\mu\text{l}$
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**DIFFERENTIAL COUNT**

NEUTROPHILS	EDTA Blood	52	40 - 80 %
LYMPHOCYTES		41	20 - 40 %
MONOCYTES		04	02 - 10 %
EOSINOPHILS		03	00 - 06 %
BASOPHILS		00	00 - 01 %

**BLOOD GROUPING AND RH**

<b>BLOOD GROUP</b>	Blood	" A "	TUBE AGGLUTINATION
<b>RH TYPE</b>		POSITIVE	

\*\*\* End Of Report \*\*\*





**MEDICOVER**  
HOSPITALS

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<b>Bill No/ UMR No</b> : NMBC66232/NMU0050739	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 13-Apr-24 09:34 am	<b>Report Date</b> : 13-Apr-24 03:30 pm

Parameters

Specimen    Result

TUBE AGGLUTINATI





**DEPARTMENT OF LABORATORY**

NAVI MUMBAI

<b>Patient Name</b> : Mr. BHUPENDRA KUMAR	<b>Age / Gender</b> : 37 Y(s)/Male
<b>Bill No/ UMR No</b> : NMBC66232/NMU0050739	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 13-Apr-24 09:34 am	<b>Report Date</b> : 13-Apr-24 12:17 pm

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)</b>				
FASTING BLOOD GLUCOSE		102	Normal Range : 70 - 99 mg/dL	Hexokinase
<b>HBA1C (GLYCOSYLATED HAEMOGLOBIN)</b>				
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	
<b>T3,T4 AND TSH</b>				
T3		88.20	70 - 204 ng/dL	Method : ECLIA
T4		6.31	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.99	0.270 - 4.20 uIU/mL	Method : ECLIA
<b>SERUM CREATININE</b>				
CREATININE		0.81	0.8 - 1.3 mg/dl	Method : jaffe
<b>BUN / CREATININE RATIO</b>				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.81	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		13.58	10 - 20	
<b>LFT(LIVER FUNCTION TEST)</b>				
TOTAL BILIRUBIN		0.6	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.4	<= 1.0 mg/dL	
SGPT (ALT)		15	<= 41 U/L	Method : UV without P5P
SGOT (AST)		17	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		87	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.1	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.3	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.8	2.5 - 3.5 g/dL	
A/G RATIO		1.54	1.2 - 2.5	





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<b>Bill No/ UMR No</b> : NMBC66232/NMU0050739	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 13-Apr-24 09:34 am	<b>Report Date</b> : 13-Apr-24 01:52 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
GAMMA GLUTAMYL TRANSFERASE(GGT)		12	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
<b>BUN(BLOOD UREA NITROGEN)</b>				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
<b>TOTAL PROTEIN</b>				
TOTAL PROTEINS		7.1	6.0 - 8.0 g/dL	Method : Biuret method
<b>LIPID PROFILE</b>				
TOTAL CHOLESTEROL		164	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		42	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		104	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		20		
SERUM TRYGLYCERIDES		99	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.9	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.48		
SERUM URIC ACID		5.8	3.4 - 7.0 mg/dL	uricase
<b>PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)</b>				
PLBS (POST LUNCH BLOOD GLUCOSE)		94	110 - 180 mg/dL	Hexokinase
URINE SUGAR		Absent		Dipstick

\*\*\* End Of Report \*\*\*





**MEDICOVER**  
HOSPITALS

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NAVI MUMBAI

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<b>Bill No/ UMR No</b> : NMBC66232/NMU0050739	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 13-Apr-24 12:49 pm	<b>Report Date</b> : 15-Apr-24 08:15 am

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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**Lab Incharge**

  
**Dr. VISHAL MEHROTRA, MD Pathology**  
Head of Laboratory 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.





HC 50739  
37 Years

BHUPENDRA KUMAR  
Male

4/13/2024 10:23:48 AM

Rate 74 . Sinus rhythm.....normal P axis, V-rate 50- 99  
. ST elevation suggests acute pericarditis.....ST >0.10mV, ant/lat/inf

PR 143  
QRSD 81  
QT 372  
QTc 413

--AXIS--

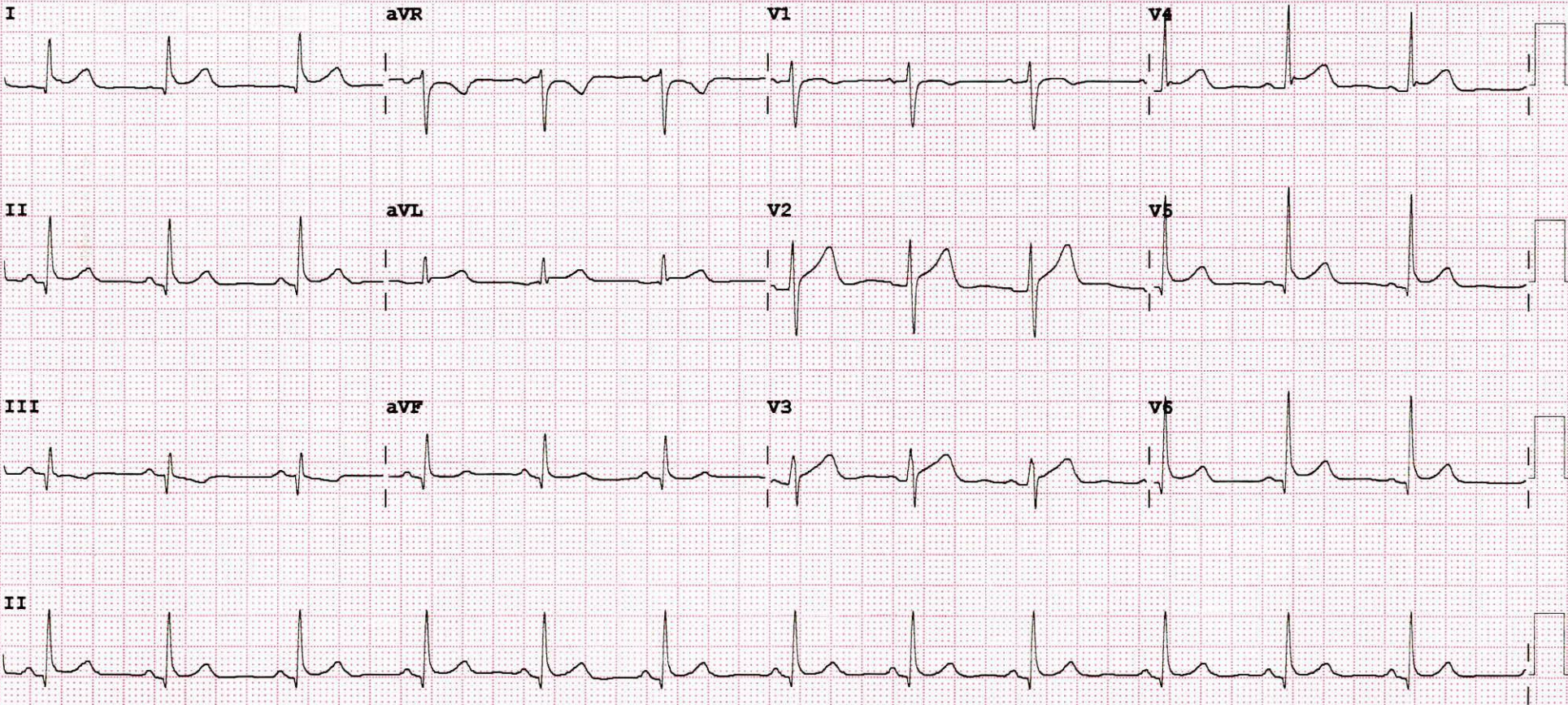
P 83  
QRS 36  
T 11

- ABNORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

*Handwritten notes:*  
X in II, III, aVF  
UPT ↑ in II, III, aVF  
V4, V5, V6



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 60~ 0.50~ 40 Hz W

100B CL

P?

<i>Patient ID:</i>	<i>NMU0050739</i>	<i>Patient Name:</i>	<i>BHUPENDRA KUMAR</i>
<i>Age:</i>	<i>37 Years</i>	<i>Sex:</i>	<i>M</i>
<i>Accession Number:</i>	<i>NMBC66232</i>	<i>Modality:</i>	<i>DX</i>
<i>Referring Physician:</i>	<i>DR.DMO</i>	<i>Study:</i>	<i>CHEST</i>
<i>Study Date:</i>	<i>13-Apr-2024</i>	<i>Study Time:</i>	<i>09:39:23</i>

**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 Garima Sharma**  
**MD, DNB, FRCR**  
**Consultant Radiologist.**



# DEPARTMENT OF OPHTHALMOLOGY

# MEDICOVER HOSPITALS

DATE: 11/4/24

PATIENT NAME: Mr. Bhupendra Kumar ✓ AGE / SEX:

NAVI MUMBAI

UMR NO: N MU 0050739

37/M

	RE	LE
VA (DISTANCE) <u>6/6</u>	6/6	6/6
VA (NEAR) <u>6/6</u>	NG	NG
COLOUR VISION	Normal	Normal

		SPHERE	CYLINDER	AXIS	VA
MRx	O D Ⓡ	-2.00	-0.75 0.50	90°	6/6, NG
	O S Ⓛ	-1.50	—	—	6/6, NG

### HISTORY :

W/o Thyroid on Rx ∴ 10 years

No W/o HT/DM

- No W/o Ocular Trauma (BE)

W/o spectacle use ⊕ ∴ 15 years

### OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc (BE) - 0.1

### ADVICE:

Refresh Tears 4x/d 1777 X 1 month

AP  
CDR-ANUSHREE VANJAR

