



**MEDICOVER  
HOSPITALS**

A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD.

# Medicover Hospitals

VENKOJIPALAM VISAKHAPATNAM - 530017  
ANDHRA PRADESH - INDIA  
PHONE NO : 0891-6829999

**Dr. RAKESH P  
MD  
GENERAL PHYSICIAN**

NAME: M. Susanku AGE 15 | h

WT: 83.2 kg  
HT: 150 cm  
BP: 113/69 mmHg  
PR 77 min

No	REMARK
<u>Ulcus</u>	<u>found</u>



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ANDHRA PRADESH -INDIA

PHONO NO : 0891-6829999

## OPHTHALMOLOGIST CONSULTATION

NAME: Sushant Kumar AGE: 45/R

DATE: 25/5/24

AR R -0.50 X 61°  
L -0.25 -0.50 X 130°

SV R 6/6  
L 6/6 } MAG

NV +1.25 SPH 6/6

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ANDHRA PRADESH - INDIA  
PHONE NO : 0891-6829999

DIETICIAN CONSULTATION  
CONSULTANT DIETICIAN

NAME : M. Susanki

AGE : 45 / F

DATE : 25/05/24

wt - 83.2 kg

HT - 150 cm

Bp - 113/69 mmHg

PR - 77/min

- ① Well Balanced Diet.
- ① Avoid Junk foods / oily foods
- ① Avoid spicy foods / maida
- ① Avoid sugary foods.
- ① Drink 2-3 litres of water for hydration
- ① Liquid diet (e.g: Bailey water / Coconut water / fruit juices (without adding sugars))
- ① Suggested Green leafy vegetables for Iron rich diet

O. Patel  
25/05/2024



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## MEDICOVER HOSPITALS

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Dr. Tanuja Priyadarsini Velaga

MBBS, DGO, FMAS, FRM

**GYNAECOLOGY CONSULTATION**

Name : M. Susanthi Age : 45/f.

UMRNO :

25/5/24

NOC-1, LB-14 yrs, US

→ No family h/o malignancies - not on contraceptive  
med h/o - nil.

LMP: 29/4/24.

3 @/30, ~~irreg~~, MF alupain, ci

P/A soft

P/S - Cx hypertrophied

PV - ut AV, just bulky

USG pelvis

Pap Smear done



**Medicover Hospitals**  
VENKOJIPALAM VISAKHAPATNAM - 530017  
ANDHRA PRADESH - INDIA



### Lab Report

Patient Name	: Mrs. SUSANTHI MEDIDHI	Age /Gender	: 45 Y(s)/Female
Bill No/ UMR No	: V4BC237669/V4U188071	Referred By	: Dr. CMO
Received Dt	: 25-May-24 09:51 am	Report Date	: 25-May-24 11:19 am
Lab No	: 120000635768		

<u>Parameter</u>	<u>Result Values</u>	<u>Biological Reference</u>
<b>CBC (COMPLETE BLOOD COUNT)</b>		
<b>RBC</b>		
HAEMOGLOBIN	* 11.6	12.0 - 15.0 g/dl
R B C COUNT	4.2	3.8 - 4.8 $10^6/\mu\text{L}$
PCV/HCT	* 34	36 - 46 %
MCV	* 81	83 - 101 fl
MCH	27	27 - 32 pg
MCHC	34	31.5 - 34.5 g/dL
RDW(cv)	* 15.0	11.6 - 14.0 %
<b>WBC</b>		
TC (TOTAL LEUCOCYTE COUNT)	9200	4000 - 11000 cells/cumm
<b>DIFFERENTIAL COUNT</b>		
NEUTROPHILS	62	40 - 80 %
LYMPHOCYTES	32	20 - 40 %
MONOCYTES	04	02 - 10 %
EOSINOPHILS	02	00 - 06 %
BASOPHILS	00	00 - 01 %
<b>PLATELET COUNT</b>		
PLATELET COUNT	2.86	1.50 - 4.50 Lakhs/cumm
ESR	20	0 - 20 mm/1st hour

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

**Doctor Incharge**

**Dr.MUDUGANTI SRINIVAS**  
MBBS, MD  
CONSULTANT PATHOLOGIST

**Dr.SRUJANA**  
MBBS, MD PATHOLOGY  
CONSULTANT PATHOLOGIST

**Dr.MOHAMMAD SIMI IQBAL**  
M.B.B.S, M.D  
CONSULTANT BIOCHEMIST

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## Lab Report

Patient Name	: Mrs. SUSANTHI MEDIDHI	Age /Gender	: 45 Y(s)/Female
Bill No/ UMR No	: V4BC237669/V4U188071	Referred By	: Dr. CMO
Received Dt	: 25-May-24 09:51 am	Report Date	: 25-May-24 11:50 am
Lab No	: 120000635769		

Parameters	Result	Biological Reference In Method
SERUM ALBUMIN	4.2	NewBorn: 0-4 days : 2.8 - 4.4 g/dL Children: 4 days - 14 years : 3.8 - 5.4 g/dL 14-18 years : 3.2 - 4.5 g/dL Adults : 3.5- 5.2 g/dL
GLOBULINS	2.7	2.5 - 3.5 g/dL
A/G RATIO	1.56	1.2 - 2.5
<b>TOTAL PROTEIN</b>		
TOTAL PROTEINS	6.9	1-2 years : 5.6-7.5 g/dL > 3 years : 6.0-8.0 g/dL Adults : 6.4-8.3 g/dL
<b>HBA1C (GLYCOSYLATED HAEMOGLOBIN)</b>		
HBA1C	5.2	Non -Diabetic : <= 5.6 % Pre Diabetic : 5.7 - 6.4 % Diabetic : >= 6.5 %
<b>T3,T4 AND TSH</b>		
T3	1.35	0.8 - 2.0 ng/mL
T4	7.56	5.1 - 14.1 ug/dL
TSH(THYROID STIMULATING HORMONE)	3.75	0.270 - 4.20 uIU/mL
BUN(BLOOD UREA NITROGEN)	12.4	7.0 - 21.0 mg/dL
BUN(BLOOD UREA NITROGEN)	09	

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

Suggested Clinical Correlation \* If necessary, Please discuss

Verified By : : 25687

Test results related only to the item tested.

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*Md. Simi Iqbal*

Dr. MOHAMMAD SIMI IQBAL, M.B.B.S, M.D

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## Lab Report

Patient Name	: Mrs. SUSANTHI MEDIDHI	Age /Gender	: 45 Y(s)/Female
Bill No/ UMR No	: V4BC237669/V4U188071	Referred By	: Dr. CMO
Received Dt	: 25-May-24 09:51 am	Report Date	: 25-May-24 11:50 am
Lab No	: 120000635769		

<u>Parameters</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
<b>LIPID PROFILE</b>		
TOTAL CHOLESTEROL	152	No risk : < 200 mg/dL Moderate risk : 200 - 239 High risk : > 240
HDL CHOLESTEROL	36	<40 Low >60 High
LDL CHOLESTEROL	* 97	Border line : 100 - 130 mg/dL High : > 130 mg/dL Desirable : < 100 mg/dL 100 - 130 mg/dL
VLDL	20	
SERUM TRYGLYCERIDES	98	Very High : > 500 mg/dL High : >= 200 - 499 mg/dL Border line High : >= 150 - 199 mg/dL
CHO/HDL RATIO	4.22	Normal : < 150 mg/dL Normal : < 4.0 Low risk : 4.0 - 6.0 High risk : > 6.0
LDL/HDL RATIO	2.69	
<b>FBS (FASTING BLOOD GLUCOSE)</b>		
FASTING BLOOD GLUCOSE	96	Normal : 70-99 mg/dL Impaired : 100-125 mg/dL Diabetic : >= 126 mg/dL
CREATININE	0.7	0.6 - 1.1 mg/dL
<b>GAMMA GT</b>		
GAMMA GLUTAMYL TRANSFERASE(GGT)	27	6 - 42 U/L
<b>LFT(LIVER FUNCTION TEST)</b>		
TOTAL BILIRUBIN	0.4	< 1.2 mg/dL
DIRECT BILIRUBIN	0.1	<= 0.20 mg/dL
INDIRECT BILIRUBIN	0.3	<= 1.0 mg/dL
SGPT (ALT)	10	<= 33 U/L
SGOT (AST)	11	<= 32 U/L
ALKALINE PHOSPHATASE (ALP)	60	35 - 105 U/L
TOTAL PROTEINS	6.9	1-2 years : 5.6-7.5 g/dL > 3 years : 6.0-8.0 g/dL Adults : 6.4-8.3 g/dL



**Lab Report**

Patient Name : Mrs. SUSANTHI MEDIDHI	Age /Gender : 45 Y(s)/Female
Bill No/ UMR No : V4BC237669/V4U188071	Referred By : Dr. CMO
Received Dt : 25-May-24 09:51 am	Report Date : 25-May-24 11:48 am
Lab No : 240503709	

<u>Parameters</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
<b>CUE (COMPLETE URINE EXAMINATION)</b>		
<b>CHEMISTRY TEST</b>		
UROBILINOGEN	NIL	Negative
BILIRUBIN	Negative	Negative
KETONE BODIES	Negative	Negative
BLOOD	Negative	Negative
PROTEIN	Negative	Negative
NITRITE	NIL	NIL
LEUCOCYTES	Negative	Negative
GLUCOSE	Negative	
SPECIFIC GRAVITY	NIL	NIL
PH	1.015	1.005 - 1.030
	6.0	5.0 8.0
<b>MICROSCOPY MORPHOLOGY</b>		
RBC	NIL	0 - 3 /HPF
WBC (WHITE BLOOD CELL)	* 1-2	0 - 5 /HPF
SQEP ( SQUAMOUS EPITHELIAL CELL)	* 2-3	0 - 5 /HPF
UNCC ( PATHOLOGICAL CAST)	NIL	0 - 0 /HPF
UNCX (UNCLASSIFIED CRYSTALS)	NIL	0 - 5 /HPF

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

**Doctor Incharge**

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CONSULTANT PATHOLOGIST

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### DEPARTMENT OF RADIOLOGY

Patient Name	: Mrs. SUSANTHI MEDIDHI	Age / Gender	: 45 Y(s)/Female
Bill No/ UMR No	: V4BC237669/V4U188071	Referred By	: Dr. CMO
Received Dt	: 25-May-24 09:27 am	Report Date	: 25-May-24 12:04 pm

### USG ABDOMEN AND PELVIS (FEMALE)

#### LIVER

Measuring 18.5 cm. Enlarged in size with increased echotexture.  
There is no evidence of IHBR/EHBR dilatation seen.  
The portal, hepatic vessels are normal. No S.O.L. noted.

#### GALL BLADDER

Normal in volume and wall thickness.  
No evidence of intraluminal calculi/ masses seen.  
C.B.D appears normal with no intraluminal mass/ calculi

#### PANCREAS

Head, Body & Tail are identified with normal echopattern & smooth outlines.  
The pancreatic duct system appears normal.  
The peri pancreatic fat planes are well preserved.

#### SPLEEN

Measuring 11.3 cm in cranio caudal directions with normal homogenous echotexture.

#### RIGHT KIDNEY

Measuring 11.6 x 5.5 cm. Normal in location, size, echopattern  
Cortico Medullary differentiation maintained.  
No evidence of mass / calculi / hydroureteronephrosis seen.

#### LEFT KIDNEY

Measuring 11.7 x 5.6 cm. Normal in location, size, echopattern.  
Cortico Medullary differentiation maintained.  
Cortical cyst measuring 3.8 x 4.4 cm noted in upper pole.  
No evidence of calculi / hydroureteronephrosis seen.  
No evidence of suprarenal / retroperitoneal mass noted.

#### URINARY BLADDER

Normal in volume and wall thickness.  
No intraluminal mass / calculi noted.

#### UTERUS

Measuring 14.5 x 9.3 x 7.1 cm. Bulky in size with fundal fibroid measuring 8.4 x 4.4 cm noted. The Endometrium measuring 12 mm in thickness with regular outlines and homogenous echopattern.

#### RIGHT OVARY

Measuring 3.7 x 3.0 cm, normal in size.

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### DEPARTMENT OF RADIOLOGY

<b>Patient Name</b> : Mrs. SUSANTHI MEDIDHI	<b>Age / Gender</b> : 45 Y(s)/Female
<b>Bill No/ UMR No</b> : V4BC237669/V4U188071	<b>Referred By</b> : Dr. CMO
<b>Received Dt</b> : 25-May-24 09:27 am	<b>Report Date</b> : 25-May-24 12:04 pm

#### LEFT OVARY

Not visualised.

No adnexal mass lesion could be seen.  
No evidence of ascites / pleural effusion seen.  
No detectable bowel pathology seen.

#### IMPRESSION

- \* Fatty hepatomegaly.
- \* Left renal cortical cyst.
- \* Bulky uterus with fundal fibroid.

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

**Dr. VULAPU CHENNAI KRISHNA RAO, .**  
**MBBS, DNB**  
**CONSULTANT RADIOLOGIST**

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### DEPARTMENT OF RADIOLOGY

<b>Patient Name</b> : Mrs. SUSANTHI MEDIDHI	<b>Age /Gender</b> : 45 Y(s)/Female
<b>Bill No/ UMR No</b> : V4BC237669/V4U188071	<b>Referred By</b> : Dr. CMO
<b>Received Dt</b> : 25-May-24 09:27 am	<b>Report Date</b> : 25-May-24 11:44 am

### X-RAY CHEST PA VIEW

#### FINDINGS

The cardiac size & configuration appear normal.

The Aorta and pulmonary vasculature appear normal.

There is no evidence of mediastinal widening.

Both the lungs and CP angles are clear.

The soft tissues and the bones of the rib cage displayed no abnormality.

#### IMPRESSION

\* Normal study.

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

Dr. VULAPU CHENNAKRISHNA RAO, .  
MBBS, DNB  
CONSULTANT RADIOLOGIST

#### Medicover Unit - I

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#### Medicover - MVP

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VI



# Medicover Hospitals

VENKOJIPALAM VISAKHAPATNAM - 5300  
ANDHRA PRADESH - INDIA

## Lab Report

Patient Name : Mrs. SUSANTHI M  
 Bill No/ UMR No : V4BC237669/V4U188071  
 Received Dt : 25-May-24 09:27  
 Lab No : 0

Patient Name : Mrs. SUSANTHI MEDIDHI Age /Gender  
 Bill No/ UMR No : V4BC237669/V4U188071 Referred By  
 Received Dt : 25-May-24 01:30 pm Report Date  
 Lab No : 120000635982

### PLBS ( POST LUNCH BLOOD GLUCOSE )

Parameters	Result	Biological Interpretation
PLBS (POST LUNCH BLOOD GLU)	105	Normal Impaired Diabetic

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

### 2D ECHO WITH COLOUR DOPPLER MEASUREMENTS

LVID(D)  
 LVID(s)  
 LVEF  
 IVS (d)  
 PWD (d)

#### VALVES

MITRAL VALVE  
 AORTIC VALVE  
 TRICUSPID VALVE  
 PULMONARY VALVE

#### CHAMBER

RIGHT ATRIUM  
 RIGHT VENTRICLE  
 LEFT ATRIUM  
 LEFT VENTRICLE  
 RWMA  
 SYSTOLIC FUNCTION  
 DIASTOLIC DYSFUNCTION  
 CLOT

#### SEPTAE

INTER ATRIAL SEPTUM  
 INTER VENTRICULAR SEPTUM

#### GREAT ARTERY AND OTHERS

AORTA  
 PULMONARY ARTERY  
 PERICARDIUM  
 IVC/SVC/CS

#### DOPPLER STUDY

MITRAL FLOW  
 AORTIC FLOW  
 PULMONARY FLOW  
 TRICUSPID FLOW  
 OTHER FLOWS

#### COLOUR DOPPLER

MR  
 AR  
 TR  
 PR

#### FINAL IMPRESSION

Suggested Clinical Correlation \* If necessary, Please discuss

Verified By : : 25687

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Dr. M

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Dr. M

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 Sry.  
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 Visa  
 Ph:

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### Lab Report

Patient Name	: Mrs. SUSANTHI MEDIDHI	Age /Gender	: 45 Y(s)/Female
Bill No/ UMR No	: V4BC237669/V4U188071	Referred By	: Dr. CMO
Received Dt	: 25-May-24 09:27 am	Report Date	: 25-May-24 12:19 pm
Lab No	: 0		

--  
\* NO RWMA OF LV  
\* GOOD LV / RV SYSTOLIC FUNCTION ( EF : 68 % )  
\* MILD TR / NO PAH  
\*\*\* End Of Report \*\*\*

### Doctor Incharge

**Dr.ARCHANA BEHRA**  
MD.,DNB(CARDIOLOGY)  
CONSULTANT CARDIOLOGIST

**Dr.BODEPUDI SRIKANTH**  
MD DM  
CONSULTANT CARDIOLOGIST

**Dr.K P RANGANAYAKULU**  
MD., DM.  
INTERVENTIONAL CARDIOLOGIST

**Dr.S.SRIKARA SAMIR NANDAN**  
MD., DM.  
INTERVENTIONAL CARDIOLOGIST

**Dr.RAVIKUMAR GURUGUBELLI**  
MD, DM  
CONSULTANT CARDIOLOGIST

**Dr.A.SURESH**  
MBBS,MD(GM),DM-CARDIOLOGY,  
SENIOR CONSULTANT

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M SUSANTHI  
Female

45 Years

25/05/2024 09:27:08

MEDCOVER HOSPITALS MVP VZAG

WELLNESS

Rate 72 . SINUS RHYTHM.....normal P axis, V-rate 50- 99

PR 128  
QRS 82  
QT 368  
QTc 403

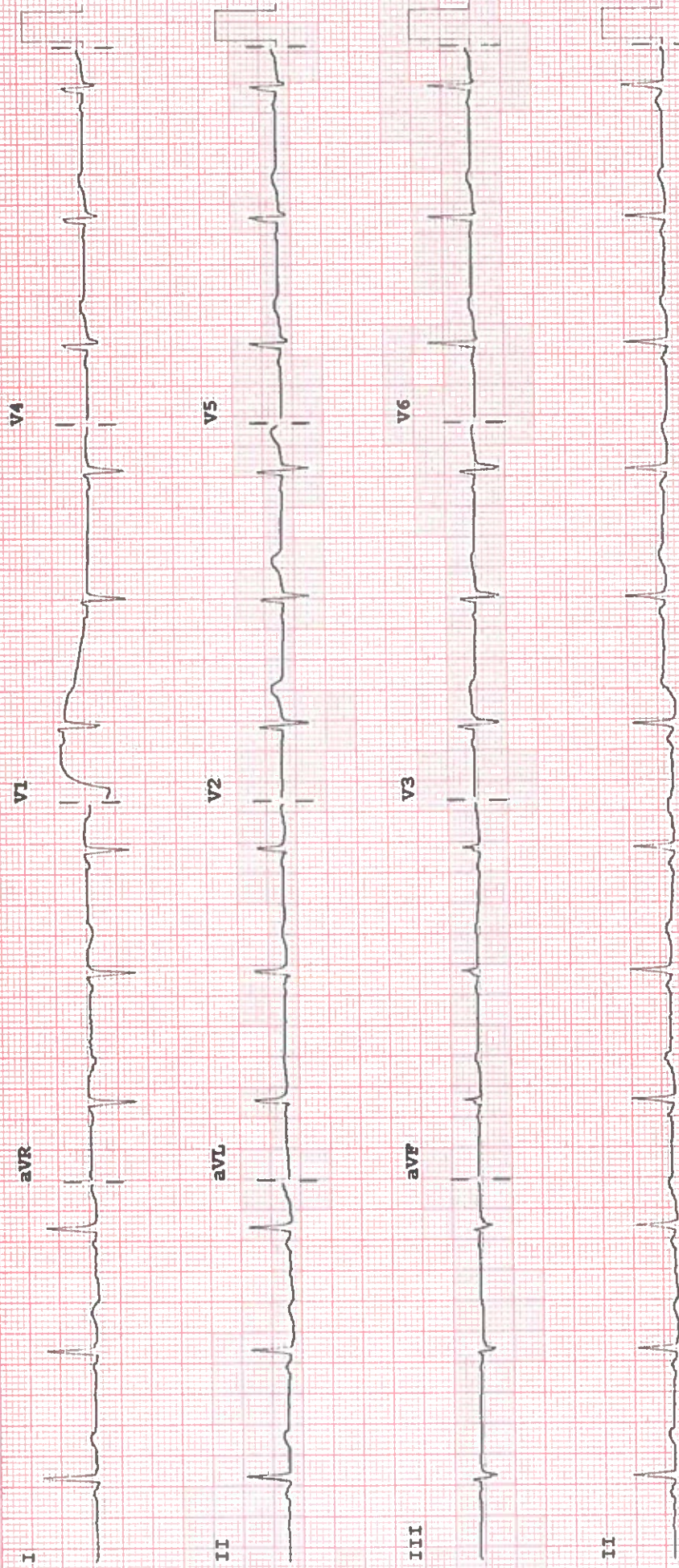
--AXIS--

P 58  
QRS 20  
T 24

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 50~ 0.50~ 40 Hz W

PH090A CL?



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<b>Bill No/ UMR No</b> : V4BC237669/V4U188071	<b>Referred By</b> : Dr. CMO
<b>Received Dt</b> : 25-May-24 09:27 am	<b>Report Date</b> : 25-May-24 03:31 pm

### MAMMOGRAM

#### HISTORY

Screening study of Both Breasts.

#### PROCEDURE

Bilateral digital mammogram was performed with standard CC and MLO views of the breasts.

Both breasts displayed fibroglandular parenchyma.

#### RIGHT BREAST

Skin and nipple areolar complex are normal.  
There is no evidence of mass or cystic lesion / architectural distortion seen.  
There is no evidence of abnormal micro / macro calcifications seen.  
There is no evidence of ductal dilatation seen.  
Retro mammary region is normal.  
There is no evidence of axillary lymph nodes seen.

#### LEFT BREAST

Skin and nipple areolar complex are normal.  
There is no evidence of mass or cystic lesion / architectural distortion seen.  
There is no evidence of abnormal micro / macro calcifications seen.  
There is no evidence of ductal dilatation seen.  
Retro mammary region is normal.  
There is no evidence of axillary lymph nodes seen.

#### IMPRESSION

**\* NO SIGNIFICANT ABNORMALITY DETECTED IN BILATERAL BREASTS - BIRADS - 1.**

#### **\*BIRADS CRITERIA - FOR REFERENCE:**

Category 0 : Means an Incomplete exam.  
Category 1: Means a Negative exam routine screening recommended.  
Category 2: Means a Definite benign finding; routine screening recommended.  
Category 3: Means a Probably benign finding six - month short interval follow  
Category 4: Means a Suspicious abnormality - biopsy should be considered.  
4a: Low Suspicious for malignancy - biopsy should be considered.  
4b: Moderate suspicious for malignancy - biopsy should be considered.  
4c: High suspicious for malignancy - biopsy should be considered.  
Category 5: Means a Highly suspicious lesion - biopsy to be done.  
Category 6: Means a Known malignancy - biopsy proven lesion.

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

#### Medicover Unit - I

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## Medicover Hospitals

VENKOJPALAM VISAKHAPATNAM - 530017  
ANDHRA PRADESH - INDIA



# MEDICOVER HOSPITALS

A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD.

### DEPARTMENT OF RADIOLOGY

<b>Patient Name</b> : Mrs. SUSANTHI MEDIDHI	<b>Age /Gender</b> : 45 Y(s)/Female
<b>Bill No/ UMR No</b> : V4BC237669/V4U188071	<b>Referred By</b> : Dr. CMO
<b>Received Dt</b> : 25-May-24 09:27 am	<b>Report Date</b> : 25-May-24 03:31 pm

  
Dr. P LAVANYA, MD

CONSULTANT RADIOLOGIST

1. This report is not valid for medico-legal purpose.

2. In case of any discrepancy due to machine error or typing error, please get it rectified immediately.

Medicover Unit - I

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