DEPARTMENT OF LABORATORY

Patient Name	: Mr. NAVTEJ SINGH	**Age / Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC60645/NMU0047051	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 11:09 am	**Report Date**	: 08-Mar-24 04:12 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	30 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.025	1.000 - 1.030	Dipstick
PH		6.0	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		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		0-1	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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MEDICOVER
HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. NAVTEJ SINGH	**Age /Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC60645/NMU0047051	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 11:09 am	**Report Date**	: 08-Mar-24 04:12 pm

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

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. NAVTEJ SINGH	**Age /Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC60645/NMU0047051	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 11:09 am	**Report Date**	: 08-Mar-24 01:48 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	35	0 - 10 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.62	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		13.8	13.0 - 17.0 g/dl	
PCV/HCT		41.5	40 - 50 % 36 - 46 %	
MCV		90	83 - 101 fl 83 - 101 fl	
MCH		29.8	27 - 32 pg	
MCHC		33.2	31.5 - 34.5 g/dL	
RDW(cv)		12.8	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	190	150 - 400 10^3/µL	
MPV		11.6	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	11.3	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	70	40 - 80 %	
LYMPHOCYTES		21	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		04	00 - 06 %	
BASOPHILS		00	00 - 01 %	

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. NAVTEJ SINGH	**Age /Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC60645/NMU0047051	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 11:09 am	**Report Date**	: 08-Mar-24 03:22 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE	PLASMA AND URINE	96	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		108.2	70 - 204 ng/dL	Method : ECLIA
T4		8.21	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.24	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.93	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.93	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		8.60	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.8	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.6	<= 1.0 mg/dL	
SGPT (ALT)		16	<= 41 U/L	Method : UV without P5P
SGOT (AST)		18	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		91	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		5.2	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.8	2.5 - 3.5 g/dL	
A/G RATIO		1.86	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		13	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. NAVTEJ SINGH	**Age /Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC60645/NMU0047051	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 11:09 am	**Report Date**	: 08-Mar-24 05:46 pm

Parameter	Specimen	Result Values	Biological Reference	Method
TOTAL PROTEINS		8.0	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		177	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		38	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		118	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		36		
SERUM TRYGLYCERIDES		181	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.66	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.11		
SERUM URIC ACID		8.6	3.4 - 7.0 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		93	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.4	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		108	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. NAVTEJ SINGH	Age /Gender	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC60645/NMU0047051	Referred By	: Dr. DMO
Received Dt	: 08-Mar-24 11:09 am	Report Date	: 09-Mar-24 09:14 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 022315

Test results related only to the item tested.

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Navtej singh

DATE: /3/24

AGE : 35

SEX: Male/ Female ✓

NMU: NMU00047057

DOCTOR'S NAME: Health package

TEMP :	97.2 °f	**BP :**	130/90 mmHg
PULSE :	71 b/m	**HEIGHT :**	160 cm
RR :	20 b/m	**WEIGHT :**	66.4 kg
SPO2 :	98 % RA	**HGT:**	-

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 08/03/24
PATIENT NAME: Mr. Navtej Singh AGE / SEX : 35/M
UMR NO : NMU0004705?

	RE	LE
VA (DISTANCE)	6/6 c̄ P4	6/6 c̄ P4.
VA(NEAR)	N6 c̄ P4	N6 c̄ P4.
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O	D	-6.00	———	———	6/6, N6.
	O	S	-6.00	-0.50.	170.	6/6, N6

HISTORY :

No h/o HT/DM/ Thyroid
No h/o ocular Trauma
h/o spectacle use - 3 yrs.

OCULAR FINDINGS :

(BE) - Ant seg WNL
(undilated) Disc 0.6
0.7

ADVICE:

- Refresh Tears e/d qid 1 7 7 7 X 1 month
- IOP measurements & Dilated fundus Examination.

(DR. ANUSHREE VANKAR)

MEDICOVER
HOSPITALS

Patient ID:	NMU0047051	Patient Name:	NAVTEJ SINGH
Age:	35 Years	Sex:	M
Accession Number:	NMBC60645	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	08-Mar-2024	Study Time:	12:28:11

USG WHOLE ABDOMEN

LIVER is normal in size (15.8 cm), normal in shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal 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 or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

SPLEEN is normal in size (9.0 cm) and echotexture. No focal lesion seen. SV 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 adequately distended; no e/o wall thickening or mass or calculi seen.
Post-void residue is not significant.

PROSTATE is normal in size, shape & echotexture. It ms 15 gms.

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 –

- **No 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)

MEDICOVER
HOSPITALS

Patient ID:	NMU0047051	Patient Name:	NAVTEJ SINGH
Age:	35 Years	Sex:	M
Accession Number:	NMBC60645	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	08-Mar-2024	Study Time:	12:51:04

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

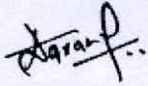
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

No significant abnormality is seen.



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 08-Mar-2024 20:41:24

hc 47057 navtej singh 3/8/2024 2:41:21 AM
35 Years Male

Rate	66	. Sinus rhythm.......................................normal P axis, V-rate 50- 99
		. Baseline wander in lead(s) II,III,aVF,V1
PR	161	
QRSD	74	
QT	379	
QTc	398	

Sinusbrady.

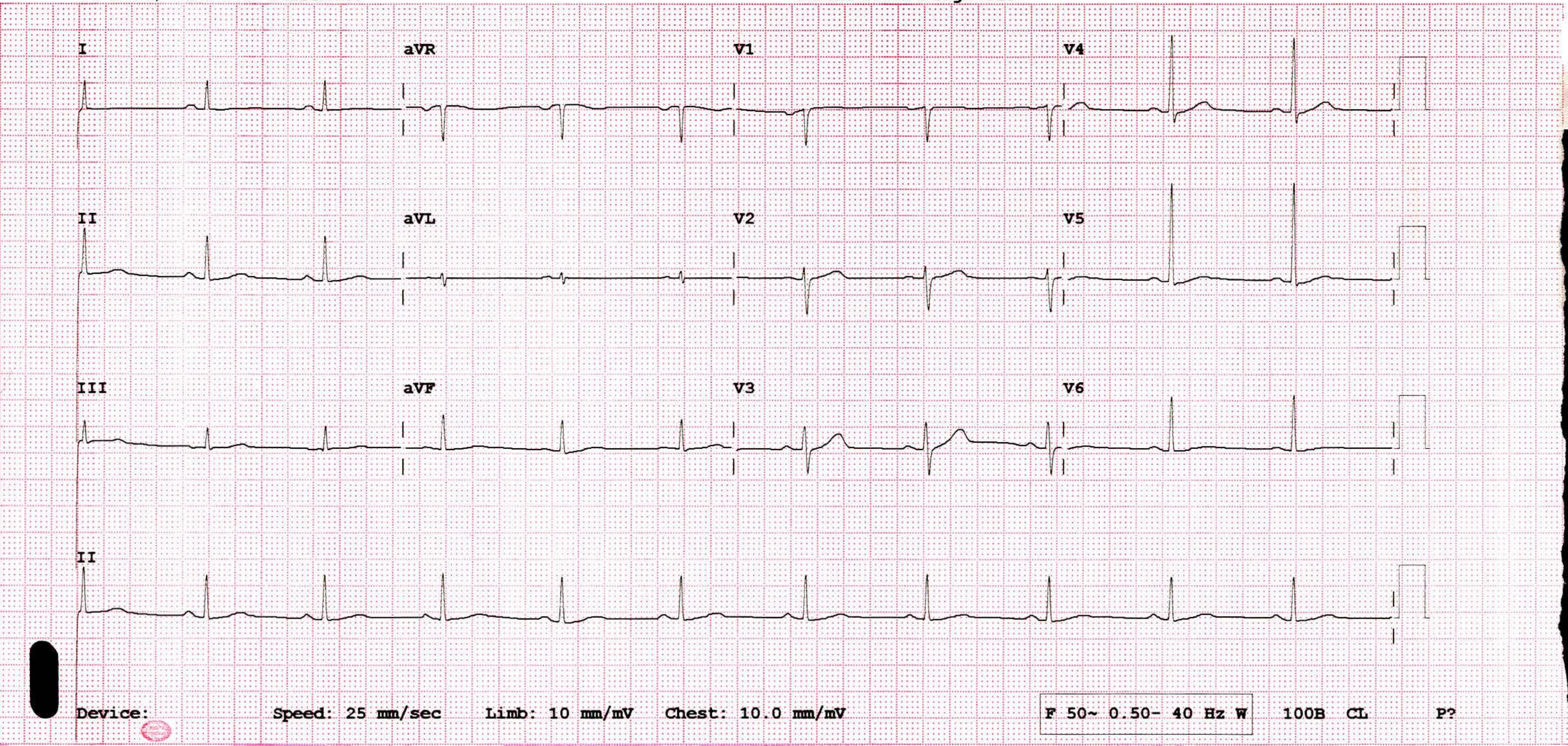
--AXIS--

P	27
QRS	57
T	67

- 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 100B CL P?