MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MANASA SRINU PODETI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC60621/NMU0047037	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 10:33 am	**Report Date**	: 08-Mar-24 04:08 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.
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	4-6	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		10-12	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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Parameters	Specimen	Result	Biological Reference In	Method

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Bill No/ UMR No	: NMBC60621/NMU0047037	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 10:33 am	**Report Date**	: 08-Mar-24 01:53 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	07	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" A "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.86	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		14.0	12.0 - 15.0 g/dl	
PCV/HCT		40.7	40 - 50 % 36 - 46 %	
MCV		84	83 - 101 fl 83 - 101 fl	
MCH		28.9	27 - 32 pg	
MCHC		34.5	31.5 - 34.5 g/dL	
RDW(cv)		12.1	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	193	150 - 400 10^3/µL	
MPV		9.5	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	5.7	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	59	40 - 80 %	
LYMPHOCYTES		33	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MANASA SRINU PODETI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC60621/NMU0047037	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 10:33 am	**Report Date**	: 08-Mar-24 05:50 pm

Parameter	Specimen	Result Values	Biological Reference	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MANASA SRINU PODETI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC60621/NMU0047037	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 10:34 am	**Report Date**	: 08-Mar-24 05:44 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE	PLASMA AND URINE	82	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.5	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		91.54	70 - 204 ng/dL	Method : ECLIA
T4		8.08	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.44	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.55	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		6	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.55	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		10.9	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.5	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		19	<= 33 U/L	Method : UV without P5P
SGOT (AST)		20	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		97	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.6	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.0	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.6	2.5 - 3.5 g/dL	
A/G RATIO		1.92	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		14	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MANASA SRINU PODETI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC60621/NMU0047037	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 10:33 am	**Report Date**	: 08-Mar-24 05:44 pm

Specimen

BUN(BLOOD UREA NITROGEN)			
BUN (Blood Urea Nitrogen.)	6	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN			
TOTAL PROTEINS	7.6	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE			
TOTAL CHOLESTEROL	182	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL	60	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL	114	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	14		
SERUM TRYGLYCERIDES	71	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO	3.03	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO	1.9		
SERUM URIC ACID	4.3	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)			
PLBS (POST LUNCH BLOOD GLUCOSE)	90	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 ***

THIS IS A MODIFIED REPORT

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MANASA SRINU PODETI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC60621/NMU0047037	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 10:33 am	**Report Date**	: 09-Mar-24 09:12 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 022315

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DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 08/03/24

PATIENT NAME: Mrs Manasa Podeti AGE / SEX: 32/F

UMR NO: NAVU004037

	RE	LE
VA (DISTANCE)	6/6 cng	6/6 cng
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-1.50	-0.50	170°	6/6, N6
	O (L)	S	-1.50	———	———	6/6, N6

HISTORY :

- H/O using spectacle (for Distance). NH/O ocular trauma Allergies.
- NH/O systemic illness. H/O Thyroid d.c.r.s) - 6 yrs

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc <0.3 / 0.3

ADVICE:

Zivifresh eld qid (777 x 1 month

Dr. ANUSHREE VANKAR

Sector 10, Opp. Elite Enclave CHS, Kharghar, Navi Mumbai, Panvel - 410210
Ph: 040 6833 4455, info@medicoverhospitals.in
www.medicoverhospitals.in

MEDICOVER HOSPITALS

Patient ID:	*NMU0047037*	*Patient Name:*	*MANASA SRINU PODETI*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC60621*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*08-Mar-2024*	*Study Time:*	*12:55:38*

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 20:41:08

MEDICOVER HOSPITALS

Patient ID:	*NMU0047037*	*Patient Name:*	*MANASA SRINU PODETI*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC60621*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*08-Mar-2024*	*Study Time:*	*12:15:44*

USG ABDOMEN & PELVIS

The Liver is normal in size (13.4 cm) and shows normal echotexture. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. 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 echotexture.

The spleen is normal size (9.3 cm). No focal lesion is seen.

Both kidneys are normal in size, shape and echotexture. They shows normal cortical echogenicity with maintained cortico-medullary distinction.
The Right Kidney measures 9.8 x 3.4 cm.
The Left Kidney measures 9.4 x 4.6 cm.
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 6.3 x 4.6 x 3.7 cm.
No focal lesion is seen. The Endometrial thickness is 3.8 mm.

Both ovaries are well visualized and appear normal in size and echotexture.
The Right ovary measures 3.2 x 1.9 cm
The Left ovary measures 2.5 x 1.3 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:

- **No significant abnormality is seen.**

DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 08-Mar-2024 13:22:25

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mr. Mansa Podeti**	**Date:-08/03/2024**
Age / Sex	: **32 Yrs / Male**	**UMR No. 0047037**
Referred By	: **Health Checkup**	

FINDINGS:

- Mild concentric left ventricle hypertrophy.
- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I 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 = 30 mm of Hg.
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **Mild LVH.**
- **No RWMA.**
- **Grade I left ventricle diastolic dysfunction.**
- **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

M-MODE MEASURMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	44	mm
IVS(d)	13	mm
LVPW(d)	12	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	11			Nil
TRICUSPID	30			Mild
PULMONERY	5.3			Nil

HC 47037 MANASA PODETI 3/8/2024 1:54:57 AM
32 Years Female

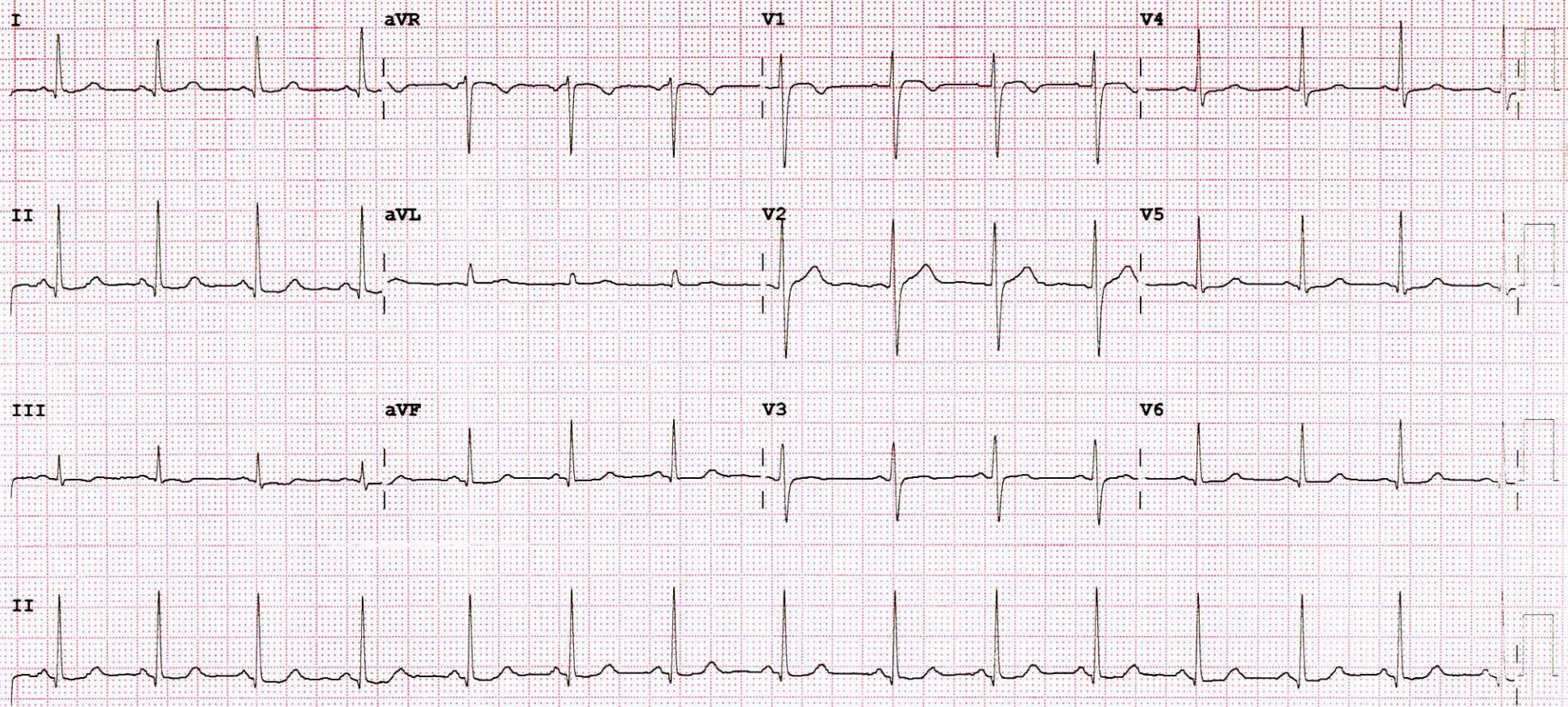
Rate 88 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 120
QRSD 86
QT 354
QTc 429

--AXIS--
P 57
QRS 37
T 21

- 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?