DEPARTMENT OF LABORATORY

Patient Name	: Mr. VANJARAPU RAJENDRA KUMAR	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC60602/NMU0047020	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:54 am	**Report Date**	: 08-Mar-24 03:56 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	1.010	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	0-1	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		NIL	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. VANJARAPU RAJENDRA KUMAR	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC60602/NMU0047020	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:54 am	**Report Date**	: 08-Mar-24 03:56 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. VANJARAPU RAJENDRA KUMAR	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC60602/NMU0047020	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:54 am	**Report Date**	: 08-Mar-24 01:45 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	11	0 - 10 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.56	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		14.1	13.0 - 17.0 g/dl	
PCV/HCT		42.5	40 - 50 % 36 - 46 %	
MCV		76	83 - 101 fl 83 - 101 fl	
MCH		25.3	27 - 32 pg	
MCHC		33.1	31.5 - 34.5 g/dL	
RDW(cv)		13.9	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	270	150 - 400 10^3/µL	
MPV		7.3	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.6	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	43	40 - 80 %	
LYMPHOCYTES		48	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. VANJARAPU RAJENDRA KUMAR	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC60602/NMU0047020	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:54 am	**Report Date**	: 08-Mar-24 05:37 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE	PLASMA AND URINE	87	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		84.49	70 - 204 ng/dL	Method : ECLIA
T4		7.86	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.20	0.270 - 4.20 uIU/mL	Method : ECLIA
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.0	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		125	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
LFT(LIVER FUNCTION TEST)				
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)		23	<= 41 U/L	
SGOT (AST)		17	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		90	40 - 129 U/L 35 - 105 U/L	
TOTAL PROTEINS		7.6	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.0	3.5 - 5.2 g/dL	
GLOBULINS		2.6	2.5 - 3.5 g/dL	
A/G RATIO		1.92	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		26	10 - 71 U/L	
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	

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. VANJARAPU RAJENDRA KUMAR	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC60602/NMU0047020	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:54 am	**Report Date**	: 08-Mar-24 03:31 pm

Parameters	Specimen	Result	Biological Reference In	Method
HDL CHOLESTEROL		31	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		123	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	
VLDL		39		
SERUM TRYGLYCERIDES		193	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	
CHO/HDL RATIO		5.87	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.97		
SERUM CREATININE				
CREATININE		1.08	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		12	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		1.08	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		11.1	10 - 20	
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		12	7.0 - 21.0 mg/dL	Calculated
SERUM URIC ACID		8.7	3.4 - 7.0 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		99	110 - 180 mg/dL	Hexokinase
URINE SUGAR		SNR		Dipstick

*** End Of Report ***

THIS IS A MODIFIED REPORT

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. VANJARAPU RAJENDRA KUMAR	**Age /Gender**	: 32 Y(s)/Male
Bill No/ UMR No	: NMBC60602/NMU0047020	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 12:28 pm	**Report Date**	: 08-Mar-24 07:21 pm

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

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

Verified By : : 025493

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DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 08/03/24

PATIENT NAME: Mr. Vanjaragu kumar AGE / SEX: 32/M

UMR NO: NAVU0047020

	RE	LE
VA (DISTANCE)	6/6	6/6p.
VA(NEAR)	N6	N6
COLOUR VISION	Defective	Defective

			SPHERE	CYLINDER	AXIS	VA
MRx	O	D	Plano	———	———	6/6, N6
	O	S	±	-0.50	100	6/6, N6

HISTORY :

H/O. LASIK done (in 2018). NKA Other known Allergies.
H/O using spectacles. (For Distance) (Before surgery)

OCULAR FINDINGS :

(BE)- Ant seg WNL
(undilated) Disc < 0.5, deep cup
0.7, deep cup, Thin inf. rim

ADVICE:

Optive eld qid 1777 x 1 month.
Dilated fundus Examination (BE)

LDR. ANUSHREE VANKAR

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Patient ID:	*NMU0047020*	*Patient Name:*	*VANJARAPU RAJENDRA KUMAR*
Age:	*32 Years*	*Sex:*	*M*
Accession Number:	*NMBC60602*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*08-Mar-2024*	*Study Time:*	*11:28:47*

USG WHOLE ABDOMEN

LIVER is normal in size (12.5 cm), normal in shape with bright 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 mildly enlarged in size (13.0 cm) and normal in 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.

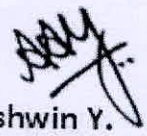
PROSTATE is normal in size, shape & echotexture. It ms15 gms. Small prostatic cyst is seen.

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 –

- **Grade I fatty liver.**
- **Mild splenomegaly.**



Dr. Ashwin Y.
M.D. (Radio-Diagnosis)

MEDICOVER HOSPITALS

Patient ID:	*NMU0047020*	*Patient Name:*	*VANJARAPU RAJENDRA KUMAR*
Age:	*32 Years*	*Sex:*	*M*
Accession Number:	*NMBC60602*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*08-Mar-2024*	*Study Time:*	*10:45:12*

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 20:27:00

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mr. Vanjarapu Kumar**	**Date:-08/03/2024**
Age / Sex	: **32 Yrs / Male**	**UMR No. 0047020**
Referred By	: **Health Check-up**	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I left ventricle diastolic dysfunction.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot / vegetation / pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **Grade I left ventricle diastolic dysfunction.**
- **Trivial MR.**
- **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 Cardiologitst

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M-MODE MEASURMENTS:

LA	33	mm
AO root	28	mm
AO CUSP SEP	17	mm
LVID(s)	33	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	09	mm
RVID(d)	31	mm
RA	30	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	8.4			Nil
TRICUSPID	N			Nil
PULMONERY	4.3			Nil

NMU0047020
32 Years

VANJARAPU KUMAR
Male

3/8/2024 1:18:11 PM

Rate	77
PR	164
QRSD	95
QT	359
QTc	407

. Sinus rhythm.....normal P axis, V-rate 50- 99
. ST elev, probable normal early repol pattern.....ST elevation, age<55

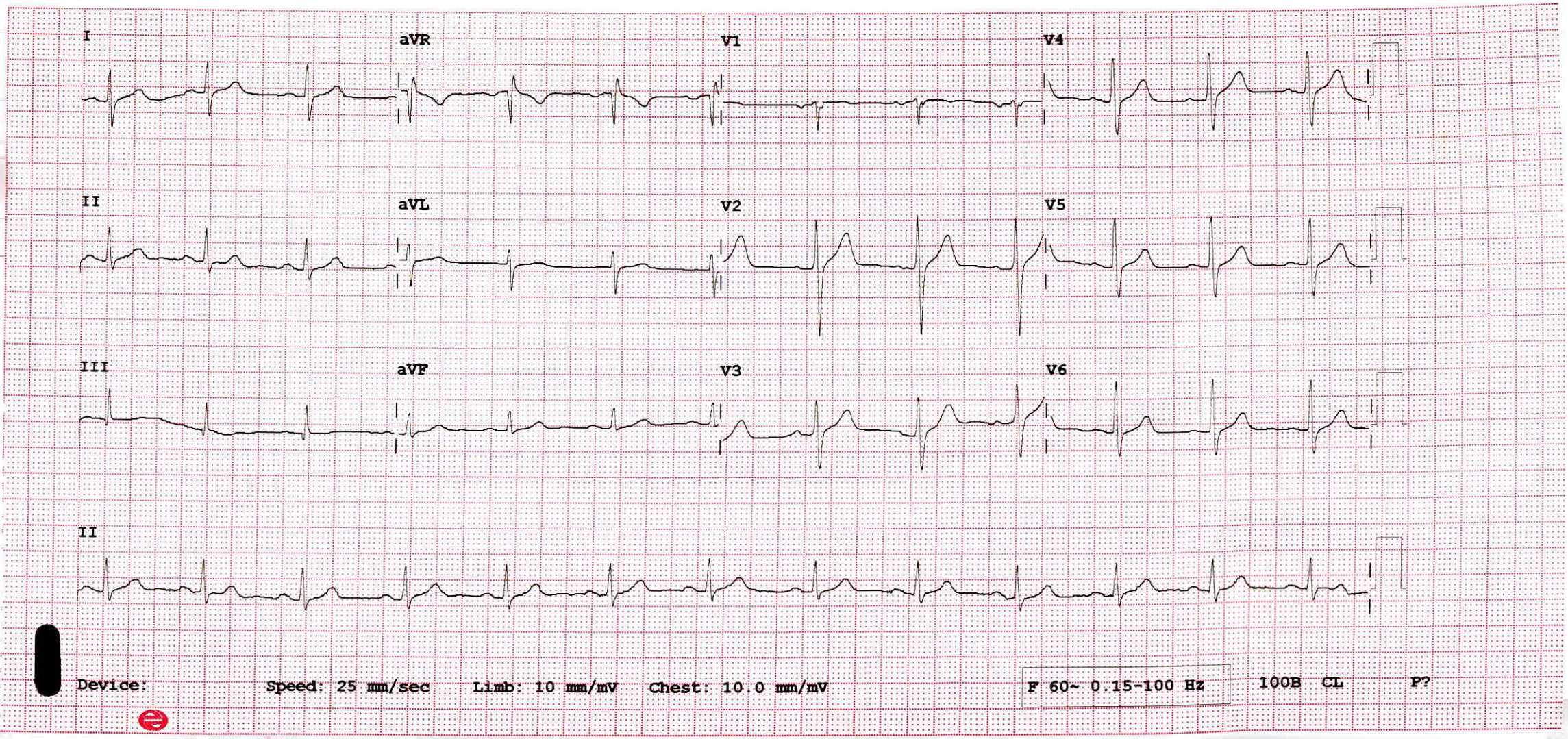
--AXIS--

P	47
QRS	70
T	32

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



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