DEPARTMENT OF LABORATORY

Patient Name	: Mrs. DHANALAKSHMI TURIMELLI	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60595/NMU0047012	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:23 am	**Report Date**	: 08-Mar-24 03:53 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	30 ML		
COLOUR		YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.030	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	3-4	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
SPERMATOZOA				MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. DHANALAKSHMI TURIMELLI	Age /Gender	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60595/NMU0047012	Referred By	: Dr. DMO
Received Dt	: 08-Mar-24 09:23 am	Report Date	: 08-Mar-24 03:53 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. DHANALAKSHMI TURIMELLI	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60595/NMU0047012	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:23 am	**Report Date**	: 08-Mar-24 01:48 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	75	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" AB "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.73	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		9.2	12.0 - 15.0 g/dl	
PCV/HCT		31.4	40 - 50 % 36 - 46 %	
MCV		66	83 - 101 fl 83 - 101 fl	
MCH		19.4	27 - 32 pg	
MCHC		29.3	31.5 - 34.5 g/dL	
RDW(cv)		18.4	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	443	150 - 400 10^3/µL	
MPV		9.2	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.7	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	65	40 - 80 %	
LYMPHOCYTES		26	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		04	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Moderate anisopoikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes,tear drop cells, and some target cells.		
WBC		Normal morphology.		
PLATELETS		Mildly increased in smear.		
ADVISED		Serum iron studies. Haemoglobin electrophoresis/ HPLC assay.		

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. DHANALAKSHMI TURIMELLI	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60595/NMU0047012	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:23 am	**Report Date**	: 09-Mar-24 12:25 pm

Parameter	Specimen	Result Values	Biological Reference	Method

*** End Of Report ***

MEDICOVER
HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. DHANALAKSHMI TURIMELLI	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60595/NMU0047012	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:24 am	**Report Date**	: 08-Mar-24 05:38 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE	PLASMA AND URINE	98	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		138	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.9	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		139.6	70 - 204 ng/dL	Method : ECLIA
T4		10.66	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.36	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.72	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.72	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		11.1	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		13	<= 33 U/L	Method : UV without P5P
SGOT (AST)		12	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		63	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.5	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.3	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.2	2.5 - 3.5 g/dL	
A/G RATIO		1.34	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		16	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. DHANALAKSHMI TURIMELLI	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60595/NMU0047012	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:23 am	**Report Date**	: 08-Mar-24 05:38 pm

Specimen

BUN(BLOOD UREA NITROGEN)			
BUN (Blood Urea Nitrogen.)	8	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN			
TOTAL PROTEINS	7.5	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE			
TOTAL CHOLESTEROL	142	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL	43	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL	87	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	3.3	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO	2.02		
SERUM URIC ACID	4.1	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)			
PLBS (POST LUNCH BLOOD GLUCOSE)	103	110 - 180 mg/dL	Hexokinase
URINE SUGAR	NIL		Dipstick
HBA1C (GLYCOSYLATED HAEMOGLOBIN)			
HBA1C	5.8	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)	120	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

THIS IS A MODIFIED REPORT

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. DHANALAKSHMI TURIMELLI	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60595/NMU0047012	**Referred By**	: Dr. DMO
Received Dt	: 08-Mar-24 09:23 am	**Report Date**	: 09-Mar-24 09:10 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 ASSESEMENT FORM

NAME : Mr / Mrs Dhanalakshmi T

DATE: 8/3/24

AGE : 35

SEX: Male/ Female ✓

NMU: NMU00017012

DOCTOR'S NAME: Health package

TEMP :	98.2 °f	BP :	130/84 mmHg
PULSE :	92 b/m	HEIGHT :	158.1 cm
RR :	20 b/m	WEIGHT :	91.4 kg
SPO2 :	99 % RA	HGT:	—

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 08/08/24

PATIENT NAME: Mrs Dhanalakshmi T. AGE / SEX 35/F. NAVI MUMBAI

UMR NO: NMMU004012.

	RE	LE
VA (DISTANCE)	6/12	6/12
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-0.75	————		6/6, N6
	O (L)	S	-0.75	————		6/6, N6

HISTORY :

. NH/o systemic illness (DM, HTN, Thyroid) . NH/o spectacle. (For Distance).
. NH/o ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

(BE) – Ant seg WNL

(undilated) Disc < 0.3 / 0.3

ADVICE:

Zivifresh e/d tds 1 ↑ ↑ × 1 month

AS

(DR. ANUSHREE VANKAR)

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MEDICOVER
HOSPITALS

Patient ID:	NMU0047012	Patient Name:	DHANALAKSHMI TURIMELLI
Age:	35 Years	Sex:	F
Accession Number:	NMBC60595	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	08-Mar-2024	Study Time:	10:31:33

X RAY CHEST PA VIEW

Patient in rotation.

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

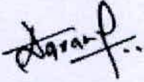
Both hilar shadows are normal in position and density.

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 20:24:47

MEDICOVER
HOSPITALS

Patient ID:	NMU0047012	Patient Name:	DHANALAKSHMI TURIMELLI
Age:	35 Years	Sex:	F
Accession Number:	NMBC60595	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	08-Mar-2024	Study Time:	10:11:55

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size (12.8 cm), normal in shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal 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. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal.

SPLEEN is normal in size (10.6 cm) and echotexture. No focal lesion seen. Splenic vein 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 empty.

UTERUS is retroverted and is normal in size, shape and echotexture; No focal lesion seen. It measures 7.1 x 5.6 x 4.0 cm; ET measures – 8.0 mm.

Bilateral adnexa appear unremarkable.

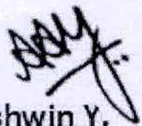
Visualised bowel loops appear normal. There is no free fluid seen.

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)

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mrs. Dhanalakshmi Turimelli**	**Date:-08/03/2024**
Age / Sex	: **35 Yrs / Female**	**UMR No. 0047012**
Referred By	: **Health Check-up**	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
  PASP = 20 mm Hg.
- 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.**
- **Trivial 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 Cardiologitst

M-MODE MEASURMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	34	mm
LVID(d)	45	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	32	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	8.4			Nil
TRICUSPID	20			Trivial
PULMONERY	4.3			Nil

NMU0047012 DHANALAKSHMI 3/8/2024 12:55:38 PM
35 Years Male

Rate 105 . Sinus tachycardia...rate> 99

PR 126
QRSD 79
QT 313
QTc 414

--AXIS--
P 62
QRS 40
T 23

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

mild ST-T change

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

II

Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.50- 40 Hz W 100B CL P?