MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. NITESH PANCHAL	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC59372/NMU0046132	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 08:51 am	**Report Date**	: 02-Mar-24 04:28 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	1.030	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.
BLOOD		NEGATIVE	NEGATIVE	Dipstick/Microcsopy
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		2-3	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

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Parameters	Specimen	Result	Biological Reference In	Method
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment. .		

*** End Of Report ***

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Bill No/ UMR No	: NMBC59372/NMU0046132	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 08:51 am	**Report Date**	: 02-Mar-24 10:08 am

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.43	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		17.0	13.0 - 17.0 g/dl	
PCV/HCT		49.7	40 - 50 % 36 - 46 %	
MCV		92	83 - 101 fl 83 - 101 fl	
MCH		31.3	27 - 32 pg	
MCHC		34.2	31.5 - 34.5 g/dL	
RDW(cv)		12.4	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	296	150 - 400 10^3/µL	
MPV		7.9	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.1	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	56	40 - 80 %	
LYMPHOCYTES		32	20 - 40 %	
MONOCYTES		08	02 - 10 %	
EOSINOPHILS		04	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	05	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. NITESH PANCHAL	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC59372/NMU0046132	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 08:51 am	**Report Date**	: 02-Mar-24 10:27 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
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	
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		88	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		1.00	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		1.00	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		11.0	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.6	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.5	<= 1.0 mg/dL	
SGPT (ALT)		30	<= 41 U/L	Method : UV without P5P
SGOT (AST)		22	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		82	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.0	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.72	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		24	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. NITESH PANCHAL	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC59372/NMU0046132	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 08:51 am	**Report Date**	: 02-Mar-24 10:40 am

Parameter	Specimen	Result Values	Biological Reference	Method
TOTAL PROTEIN				
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		252	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		39	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		176	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		64		
SERUM TRYGLYCERIDES		319	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		6.46	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		4.51		
SERUM URIC ACID		10.6	3.4 - 7.0 mg/dL	uricase
NOTE		Rechecked for serum Uric acid.		
T3,T4 AND TSH				
T3		133.0	70 - 204 ng/dL	Method : ECLIA
T4		7.19	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		4.30	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		100	110 - 180 mg/dL	Hexokinase

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. NITESH PANCHAL	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC59372/NMU0046132	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 11:19 am	**Report Date**	: 04-Mar-24 08:43 am

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

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

Verified By : : 022633

Test results related only to the item tested.

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Nitesh DATE: 2/3/2024

AGE : 38 yr SEX: Male/ Female

NMU: NMU000 DOCTOR'S NAME: Health Package.

TEMP :	97 °f	**BP :**	110/60 mmHg
PULSE :	64 b/m	**HEIGHT :**	166. cm
RR :	20 b/m	**WEIGHT :**	93. kg
SPO2 :	97 % R.A	**HGT:**	—

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 21/08/24

PATIENT NAME: Mr. Nitesh Panchal AGE / SEX: 38/m

UMR NO: NMU00046132

	RE	LE
VA (DISTANCE)	6/18	6/9
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRX	OD (R)	D	±	-1.25	90°	6/6, N6
	OS (L)	S	±	-1.00	80°	6/6 IN6

HISTORY :

No Hx DM / HTN / Thyroid.
- Hx Thrombus in BVS of heart in Aug 2023 & pt is on Tab Ecosprin 1 tab od

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc < 0.3
0.3

ADVICE:

Refresh Tears 1 dd 1 gtt 7 x 1 month

AJ
(DR. ANUSHREE VANKAR)

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Nitesh

O/E: prosthesis ⏐ 7

Stain +++

Calculus ++

Adv: Complete Oral
Prophylaxis.

Dr. Sayali Vasant Mandekar
MDS In Conservative Dentistry
And Endodontics
Reg. No. A-32634.

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MEDICOVER HOSPITALS

Patient ID:	NMU0046132	Patient Name:	NITESH PANCHAL
Age:	38 Years	Sex:	M
Accession Number:	NMBC59372	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	02-Mar-2024		

USG WHOLE ABDOMEN

LIVER is normal in size (14.2 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 normal in size (12.2 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.
A 16 mm simple cortical cyst seen in interpolar region of left kidney.

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 27 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 –

- **Grade I fatty liver.**
- **No other 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. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

MEDICOVER HOSPITALS

Patient ID:	*NMU0046132*	*Patient Name:*	*NITESH PANCHAL*
Age:	*38 Years*	*Sex:*	*M*
Accession Number:	*NMBC59372*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*02-Mar-2024*		

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. Sofiya I Modak
MBBS, MD Radiology
Consultant Radiologist

Date: 02-Mar-2024 15:33:05

NITESH PANCHAL 46132 3/2/2024 10:30:50 AM

38 Years Male

Rate	79	. Sinus rhythm	normal P axis, V-rate 50- 99
		. Right bundle branch block	QRSd>120, terminal axis(90,270)
PR	139	. Inferior infarct, old	Q >35mS, II III aVF
QRSD	134		
QT	376		
QTc	432		

--AXIS--

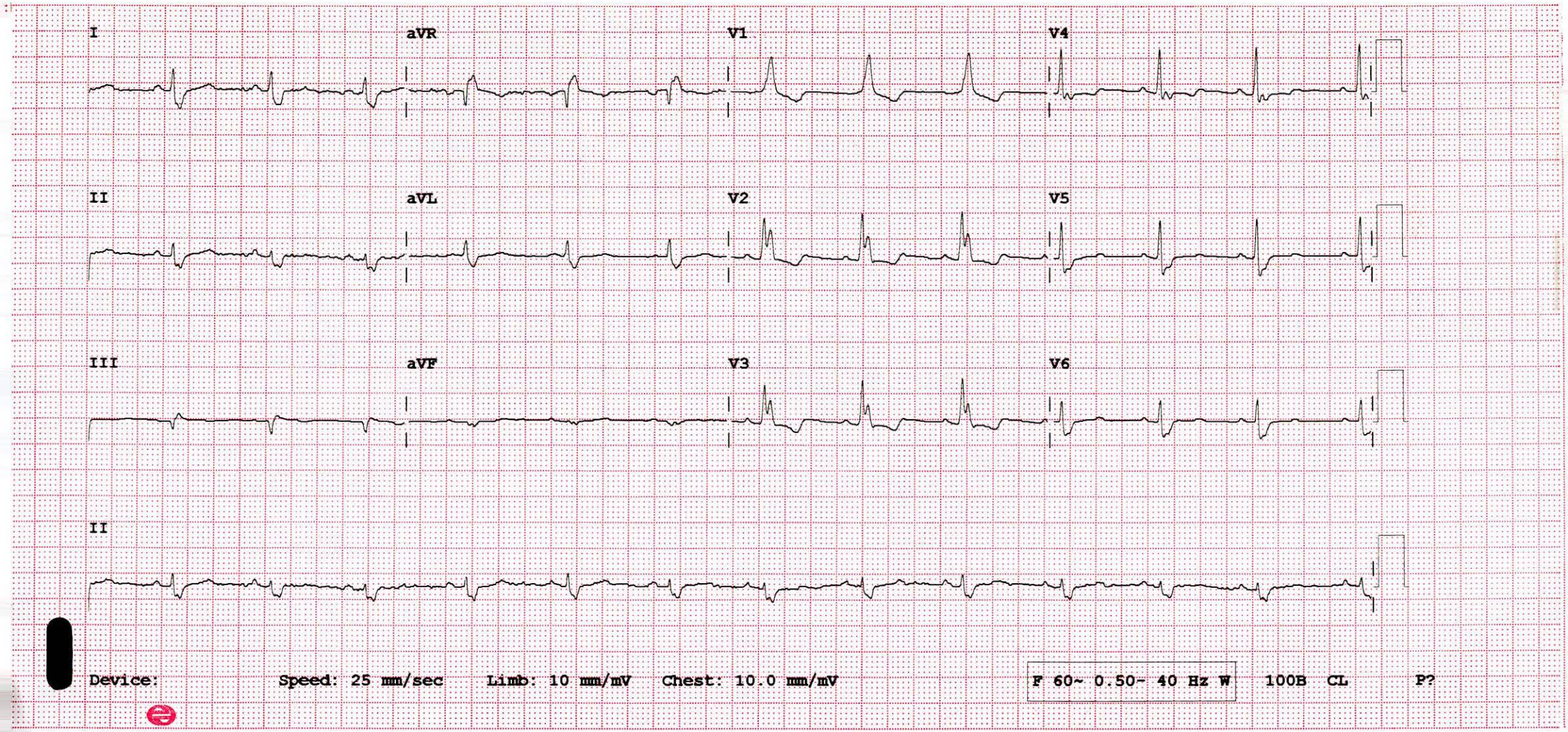
P	13
QRS	-51
T	2

- ABNORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

NIR RBB.



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

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : **Mr. Nitesh Panchal**	**Date:-02/03/2024**
Age / Sex : **38 Yrs / Male**	**UMR No. 0046132**
Referred By : **Health Check up**	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I 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 diastolic dysfunction.**
- **Trivial MR.**
- **Normal LV and RV systolic function.**

DR. SAMEER VANKAR
MD DM CARDIOLOGY

M MODE MEASURMENTS:

LA	35	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	32	mm
LVID(d)	44	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	7			Nil
TRICUSPID	N			Nil
PULMONERY	4.3			Nil