MEDICOVER HOSPITALS

MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Manjeet Kumar DATE: 9/3/24

AGE : 27yrs SEX: Male / Female

NMU: NMU000 47175 DOCTOR'S NAME: Health - Package

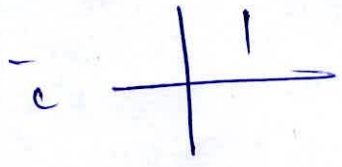
TEMP :	96.2 °f	**BP :**	120/76 mmHg
PULSE :	75 b/m	**HEIGHT :**	169 cm
RR :	20 b/m	**WEIGHT :**	84.1 kg
SPO2 :	97 % RA	**HGT:**	–

REMARK:

MEDICOVER HOSPITALS
NAVI MUMBAI

Manjeet

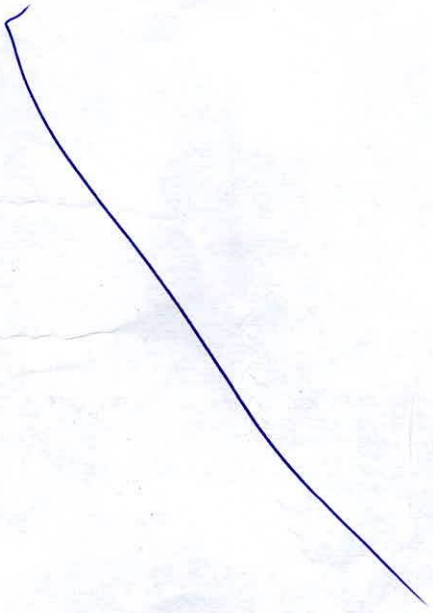
O/E: H/O trauma : 12yrs back



Stains +

calculus

Adv: complete Oral prophylaxis



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

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 09/03/24

PATIENT NAME: Mr. Manjeet Kumar AGE / SEX: 27/m

UMR NO: NAVU0047175

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

			SPHERE	CYLINDER	AXIS	VA
MRX	O (R)	D	-3.50	-1.00	180	6/6
	O (L)	S	-3.75	-0.75	180	6/6

HISTORY :

- H/o. using spectacle for Distance. No H/o systemic illness. Comorbidity
- No H/o ocular trauma Allegies & surgeries

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc 0.5
0.3-0.4

ADVICE:

Refresh Tears eld qid 1 1 1 x 1 month

Dr

CDR. ANUSHREE VANKAR

Sector 10, Opp. Elite Enclave CHS, Kharghar, Navi Mumbai, Panvel - 410210
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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. MANJEET KUMAR	**Age /Gender**	: 27 Y(s)/Male
Bill No/ UMR No	: NMBC60791/NMU0047175	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 08:42 am	**Report Date**	: 09-Mar-24 12:47 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.18	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		15.3	13.0 - 17.0 g/dl	
PCV/HCT		44.2	40 - 50 %	
MCV		85	36 - 46 % 83 - 101 fl	
MCH		29.6	83 - 101 fl 27 - 32 pg	
MCHC		34.6	31.5 - 34.5 g/dL	
RDW(cv)		12.6	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	318	150 - 400 10^3/µL	
MPV		7.7	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	8.6	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	46	40 - 80 %	
LYMPHOCYTES		40	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		08	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	13	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. MANJEET KUMAR	**Age /Gender**	: 27 Y(s)/Male
Bill No/ UMR No	: NMBC60791/NMU0047175	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 08:42 am	**Report Date**	: 09-Mar-24 12:43 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		95	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.94	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		11.7	7.0 - 21.0 mg/dL	Calculated
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.7	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.5	<= 1.0 mg/dL	
SGPT (ALT)		72	<= 41 U/L	Method : UV without P5P
SGOT (AST)		39	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		125	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)		54	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
TOTAL PROTEIN				
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		213	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		40	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. MANJEET KUMAR	**Age /Gender**	: 27 Y(s)/Male
Bill No/ UMR No	: NMBC60791/NMU0047175	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 08:42 am	**Report Date**	: 09-Mar-24 12:43 pm

Parameters	Specimen	Result	Biological Reference In	Method
LDL CHOLESTEROL		163	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		17		
SERUM TRYGLYCERIDES		83	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		5.33	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		4.08		
SERUM URIC ACID		7.3	3.4 - 7.0 mg/dL	uricase
T3,T4 AND TSH				
T3		116.9	70 - 204 ng/dL	Method : ECLIA
T4		7.83	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.70	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		93	110 - 180 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.1	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		100	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	: Mr. MANJEET KUMAR	**Age /Gender**	: 27 Y(s)/Male
Bill No/ UMR No	: NMBC60791/NMU0047175	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 08:42 am	**Report Date**	: 11-Mar-24 08:30 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 022633

Test results related only to the item tested.

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MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mr. Manjeet Kumar**	**Date:-09/03/2024**
Age / Sex	: **27 Yrs / Male**	**UMR No. 0047175**
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.
- Mild mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP – 20 mmHg.
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal left atrium and left ventricle dimensions.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **Mild MR. Trivial TR. No PH.**
- **Normal LV and RV systolic function.**

DR. SAMEER VANKAR
MD DM CARDIOLOGY

M-MODE MEASURMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	09	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Mild
AORTIC	5			Nil
TRICUSPID	20			Trivial
PULMONERY	4.4			Nil

MEDICOVER HOSPITALS

Patient ID:	*NMU0047175*	*Patient Name:*	*MANJEET KUMAR*
Age:	*27 Years*	*Sex:*	*M*
Accession Number:	*NMBC60791*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*09-Mar-2024*	*Study Time:*	*08:55:29*

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: 09-Mar-2024 14:30:29

MEDICOVER HOSPITALS

Patient ID:	*NMU0047175*	*Patient Name:*	*MANJEET KUMAR*
Age:	*27 Years*	*Sex:*	*M*
Accession Number:	*NMBC60791*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*09-Mar-2024*	*Study Time:*	*08:58:40*

USG WHOLE ABDOMEN

LIVER is normal in size, 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 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 mass seen.
A 5 mm non-obstructing calyceal calculus seen in mid pole 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.

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 –

- **Left renal non-obstructing calyceal calculus.**
- **No other significant abnormality detected.**

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

NMU0047175 MANJEET KUMAR 3/9/2024 9:24:03 AM
27 Years Male

Rate 62 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Borderline T wave abnormalities.....T/QRS ratio < 1/20 or flat T

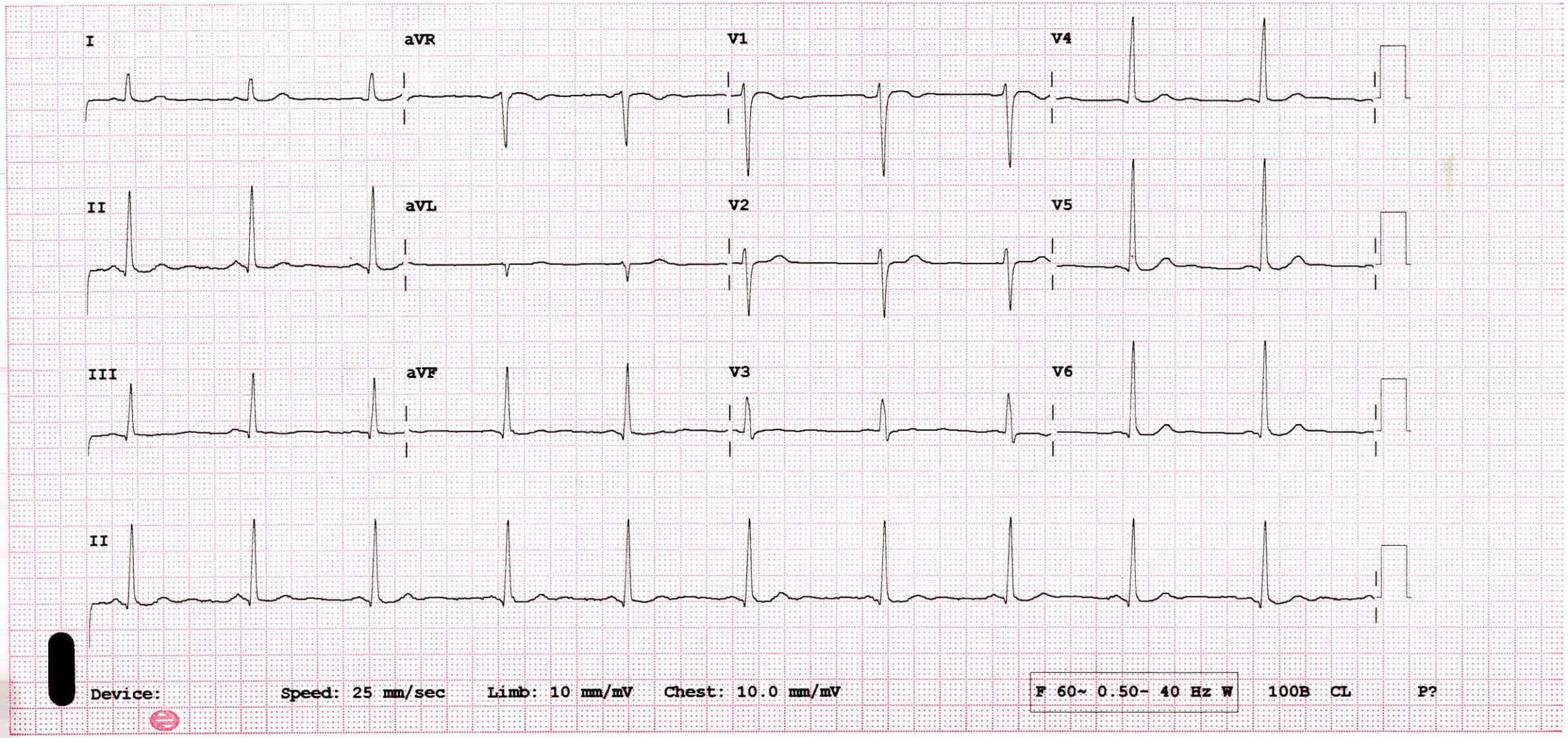
PR 139
QRSD 92
QT 388
QTc 394

--AXIS--
P 60
QRS 67
T 20

NIR
WN
E

- BORDERLINE ECG -

12 Lead; Standard Placement Unconfirmed Diagnosis



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