MEDICOVER HOSPITALS

NAVI MUMBA

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. P V VINUTHA	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: NMBC60820/NMU0047204	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:53 am	**Report Date**	: 09-Mar-24 06:56 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	10 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.
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		1-2	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.		

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. P V VINUTHA	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: NMBC60820/NMU0047204	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:53 am	**Report Date**	: 09-Mar-24 06:56 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. P V VINUTHA	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: NMBC60820/NMU0047204	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:53 am	**Report Date**	: 09-Mar-24 03:17 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	30	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.71	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		11.2	12.0 - 15.0 g/dl	
PCV/HCT		35.5	40 - 50 % 36 - 46 %	
MCV		75	83 - 101 fl 83 - 101 fl	
MCH		23.8	27 - 32 pg	
MCHC		31.6	31.5 - 34.5 g/dL	
RDW(cv)		14.2	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	326	150 - 400 10^3/µL	
MPV		8.8	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.9	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	57	40 - 80 %	
LYMPHOCYTES		30	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		07	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisopoikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes and some target cells.		
WBC		Normal morphology.		
PLATELETS		Adequate in smear.		
ADVISED		Serum iron studies.		

*** End Of Report ***

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MEDICOVER HOSPITALS

NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. P V VINUTHA	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: NMBC60820/NMU0047204	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:53 am	**Report Date**	: 09-Mar-24 04:00 pm

Parameter	Specimen	Result Values	Biological Reference	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. P V VINUTHA	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: NMBC60820/NMU0047204	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:53 am	**Report Date**	: 09-Mar-24 01:56 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM	Serum	141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.4	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		110	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM CREATININE				
CREATININE		0.56	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dl	Calculated
SERUM CREATININE		0.56	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		12.5	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.2	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.1	<= 1.0 mg/dL	
SGPT (ALT)		36	<= 33 U/L	Method : UV without P5P
SGOT (AST)		20	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		64	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.8	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.7	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.1	2.5 - 3.5 g/dL	
A/G RATIO		1.52	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		37	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. P V VINUTHA	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: NMBC60820/NMU0047204	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:53 am	**Report Date**	: 09-Mar-24 06:00 pm

Parameter	Specimen	Result Values	Biological Reference	Method
TOTAL PROTEINS		7.8	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		220	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		35	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		145	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		55		
SERUM TRYGLYCERIDES		276	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		6.29	Normal : : < 3.5 High Risk : : > 5.0	
LDL/HDL RATIO		4.14		
SERUM URIC ACID		5.5	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		143.9	70 - 204 ng/dL	Method : ECLIA
T4		8.46	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		6.30	0.270 - 4.20 uIU/mL	Method : ECLIA
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		7.3	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	HPLC-IFCC
MPG(Mean Plasma Glucose)		163	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		120	110 - 180 mg/dL	Hexokinase

*** End Of Report ***

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MEDICOVER HOSPITALS

NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. P V VINUTHA	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: NMBC60820/NMU0047204	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 12:54 pm	**Report Date**	: 11-Mar-24 08:35 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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NMU0047204 P V VINUTHA 3/9/2024 1:39:20 PM
39 Years Female

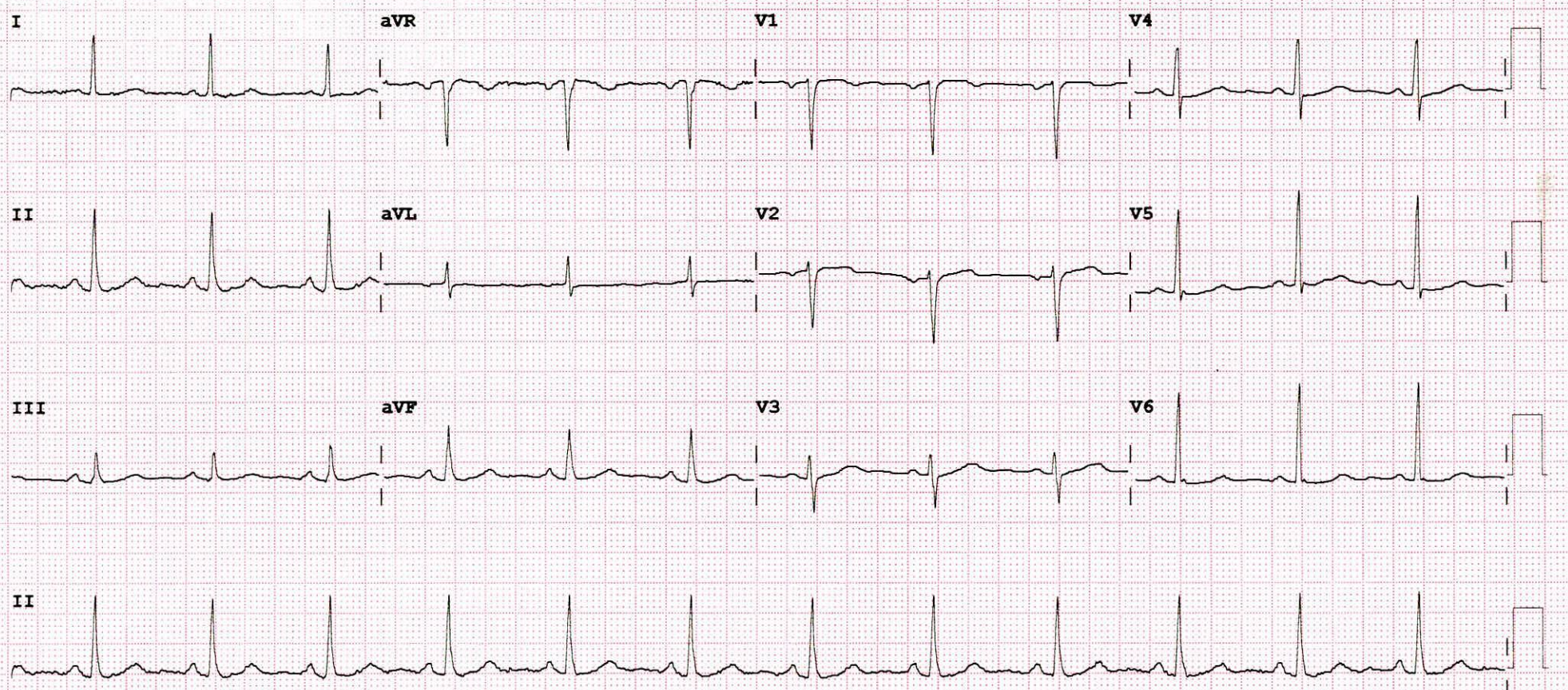
Rate 75 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Probable left atrial enlargement.....P >50mS, <-0.10mV V1
PR 161
QRSD 88
QT 386
QTc 432

--AXIS--
P 78
QRS 55
T 63
12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

NIR
WW
Σ



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

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mrs. P V Vinutha**	**Date:-09/03/2024**
Age / Sex	: **39 Yrs /Female**	**UMR No. 0047204**
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.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 20 mm Hg.
- 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.**
- **Trivial MR and 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)	10	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

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

MEDICOVER HOSPITALS

Patient ID:	*NMU0047204*	*Patient Name:*	*P V VINUTHA*
Age:	*39 Years*	*Sex:*	*F*
Accession Number:	*NMBC60820*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*09-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 JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 10-Mar-2024 14:06:50

MEDICOVER HOSPITALS

Patient ID:	*NMU0047204*	*Patient Name:*	*P V VINUTHA*
Age:	*39 Years*	*Sex:*	*F*
Accession Number:	*NMBC60820*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*09-Mar-2024*	*Study Time:*	*11:14:44*

USG WHOLE ABDOMEN (TAS)

LIVER is moderately enlarged in size (19.8 cm) with bright 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 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 is adequately distended; no e/o wall thickening or mass or calculi seen. Post-void residue is not significant.

UTERUS is anteverted and is normal in size, shape and echotexture; ET measures – 5.4 mm. 17 x 15 mm sized fibroid is seen in anterior wall. A 2.8 x 1.8 cm myometrial fibroid is seen in posterior wall. Another 5.5 mm sized fibroid at fundus.

Both ovaries are normal in size, shape and position.
LEFT OVARY: 1.9 x 1.2 cm.
A 15 x 8 mm sized dominant follicle is seen in right ovary.
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 –

- **Moderate hepatomegaly with grade I fatty liver.**
- **Uterine fibroids.**

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

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 09/03/24

PATIENT NAME: Mrs. P V Vinutha AGE / SEX: 39/F

UMR NO: NAMU0047204

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-2.00	-0.50	60°	6/6
	O (L)	S	-2.25	——	——	6/6

HISTORY :

W/o HT :- 2 months on Rx

W/o thyroid :- 4yrs on Rx

W/o spectacle use ⊕.

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc (BE) - appear (W)

ADVICE:

Refresh Tears eld qid 1-1-1 x 1 month.

F/u for Dilated AR and fundus Examination (BE)

Dr

CDR. ANUSHREE VANKAR)

MEDICOVER HOSPITALS

MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / (Mrs) P. V Vinutha ---------- DATE: 09/03/24

AGE : 39Y0S/F SEX: Male/ (Female)

NMU: NMU00047204 DOCTOR'S NAME:

TEMP :	97.4 °f	**BP :**	110/80 mmHg
PULSE :	80 b/m	**HEIGHT :**	158 cm
RR :	20 b/m	**WEIGHT :**	84.4 kg
SPO2 :	98 %	**HGT:**	—

REMARK:

MEDICOVER
HOSPITALS
NAVI MUMBAI

Vinutha

O/E: H/O SAF ☹ 6

Stains +++

Calculus +++

Adv: Complete Oral prophylaxis.

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