MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. ANJALI TEWARI	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC59457/NMU0046141	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 12:56 pm	**Report Date**	: 02-Mar-24 04:46 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	25ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.005	1.000 - 1.030	Dipstick
PH		7.0	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	1-2	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
SPERMATOZOA				MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

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Received Dt	: 02-Mar-24 12:56 pm	**Report Date**	: 02-Mar-24 04:46 pm

Parameters	**Specimen**	**Result**	**Biological Reference In**	**Method**

*** End Of Report ***

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Bill No/ UMR No	: NMBC59457/NMU0046141	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 12:56 pm	**Report Date**	: 02-Mar-24 04:39 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	08	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.30	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		12.7	12.0 - 15.0 g/dl	
PCV/HCT		38.1	40 - 50 % 36 - 46 %	
MCV		89	83 - 101 fl 83 - 101 fl	
MCH		29.6	27 - 32 pg	
MCHC		33.4	31.5 - 34.5 g/dL	
RDW(cv)		11.9	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	178	150 - 400 10^3/µL	
MPV		10.8	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.7	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	58	40 - 80 %	
LYMPHOCYTES		33	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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Patient Name	: Mrs. ANJALI TEWARI	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC59457/NMU0046141	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 12:56 pm	**Report Date**	: 04-Mar-24 01:27 pm

Parameters	**Specimen**	**Result**	**TUBE AGGLUTINATI**

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. ANJALI TEWARI	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC59457/NMU0046141	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 12:56 pm	**Report Date**	: 02-Mar-24 02:50 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		142	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.2	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		102	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		91.37	70 - 204 ng/dL	Method : ECLIA
T4		4.32	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.09	0.270 - 4.20 uIU/mL	Method : ECLIA
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		76	Normal Range : 70 - 99 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.2	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		102	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
SERUM CREATININE				
CREATININE		0.52	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		0.52	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		13.5	10 - 20	
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)		10	<= 33 U/L	Method : UV without P5P
SGOT (AST)		17	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		71	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

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. ANJALI TEWARI	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC59457/NMU0046141	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 12:56 pm	**Report Date**	: 04-Mar-24 08:46 am

Parameters	Specimen	Result	Biological Reference In	Method
SERUM ALBUMIN		4.9	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.6	2.5 - 3.5 g/dL	
A/G RATIO		1.88	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		11	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				
TOTAL PROTEINS		7.5	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		174	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		69	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		96	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		13		
SERUM TRYGLYCERIDES		67	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		2.52	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		1.39		
SERUM URIC ACID		3.1	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		105	110 - 180 mg/dL	Hexokinase

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. ANJALI TEWARI	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC59457/NMU0046141	**Referred By**	: Dr. DMO
Received Dt	: 02-Mar-24 12:10 pm	**Report Date**	: 04-Mar-24 08:46 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 Anjali -- DATE: 2/3/2024

AGE : 33 yr SEX: Male/ Female

NMU: NMU00046141 DOCTOR'S NAME: Health package.

TEMP :	97 °f	BP :	110/60. mmHg
PULSE :	64 b/m	HEIGHT :	164 cm
RR :	20 b/m	WEIGHT :	64.9 kg
SPO2 :	99 % R.A	HGT:	–

REMARK:

MEDICOVER
HOSPITALS

Patient ID:	NMU0046141	Patient Name:	ANJALI TEWARI 33YRS
Age:		Sex:	F
Accession Number:		Modality:	US
Referring Physician:		Study:	
Study Date:	02-Mar-2024		

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size (15.5 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 (9.2 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 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; No focal lesion seen. It measures 5.2 x 3.4 x 4.9 cm; ET measures 5.3 mm.

Both ovaries are normal in size, shape and position.
RIGHT OVARY: 3.7 x 4.0. cm, LEFT OVARY: 3.3 x 2.5 cm.

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. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

MEDICOVER
HOSPITALS

Patient ID:	NMU0046141	Patient Name:	ANJALI TEWARI
Age:	33 Years	Sex:	F
Accession Number:		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 15:39:51

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : **Mrs. Anjali Tewari**	**Date:-02/03/2024**
Age / Sex : **33 Yrs / Female**	**UMR No. 0046141**
Referred By : **Health Check up**	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No diastolic dysfunction.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
  PASP = 20 mmHg.
- 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 MR and TR. No PH.**
- **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	20			Trivial
PULMONERY	4.3			Nil

HC 46139 ANJALI TEWARI 3/2/2024 11:30:18 AM

33 Years Female

Rate	84	. Sinus rhythm.......................................normal P axis, V-rate 50- 99
		. RSR' in V1 or V2, right VCD or RVH..................QRS area positive & R' V1/V2
PR	145	
QRSD	87	
QT	360	
QTc	426	

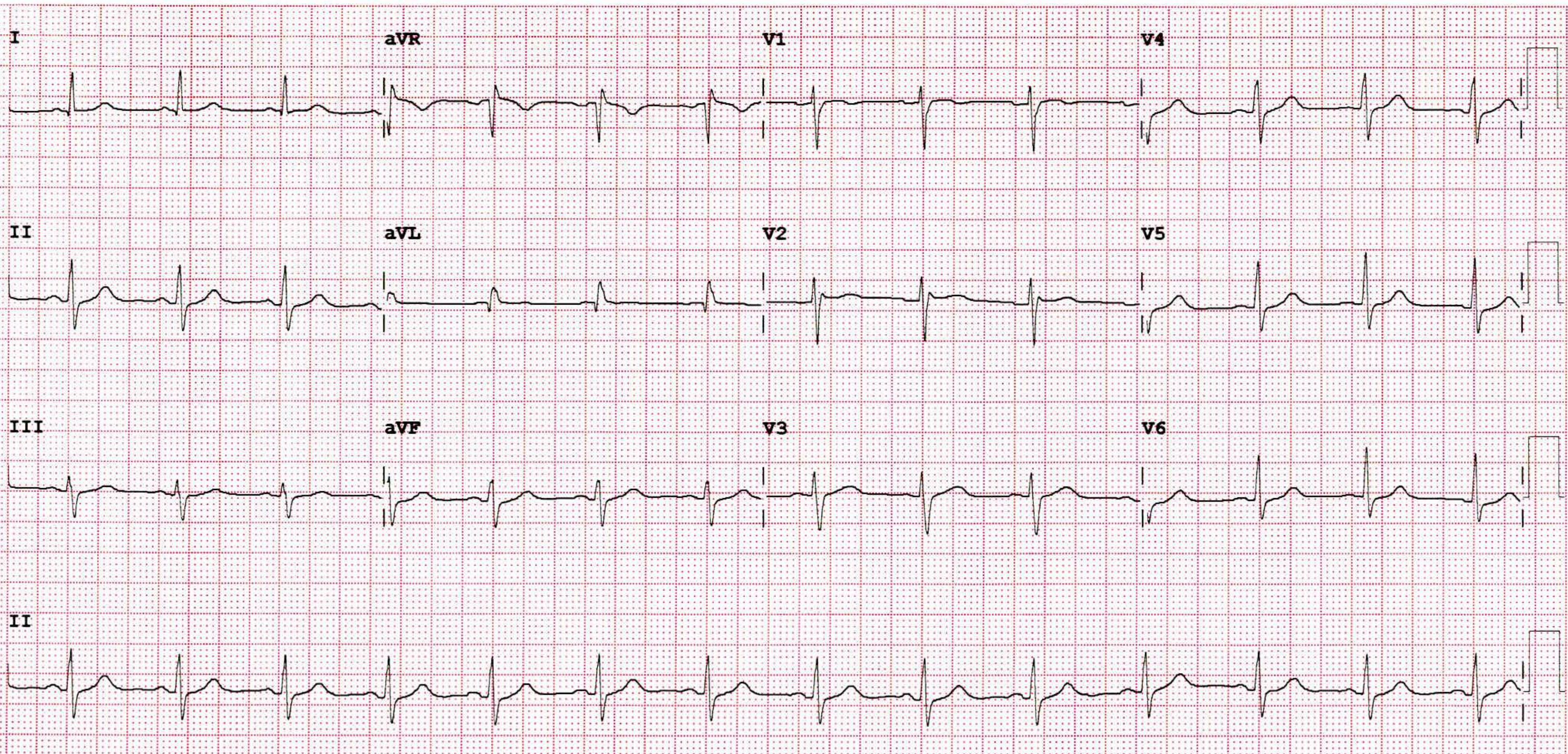
--AXIS--

P	59
QRS	2
T	55

12 Lead; Standard Placement

- OTHERWISE 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?