NMU0047193 KOMMANA HARIKA 3/9/2024 11:14:02 AM
28 Years Female

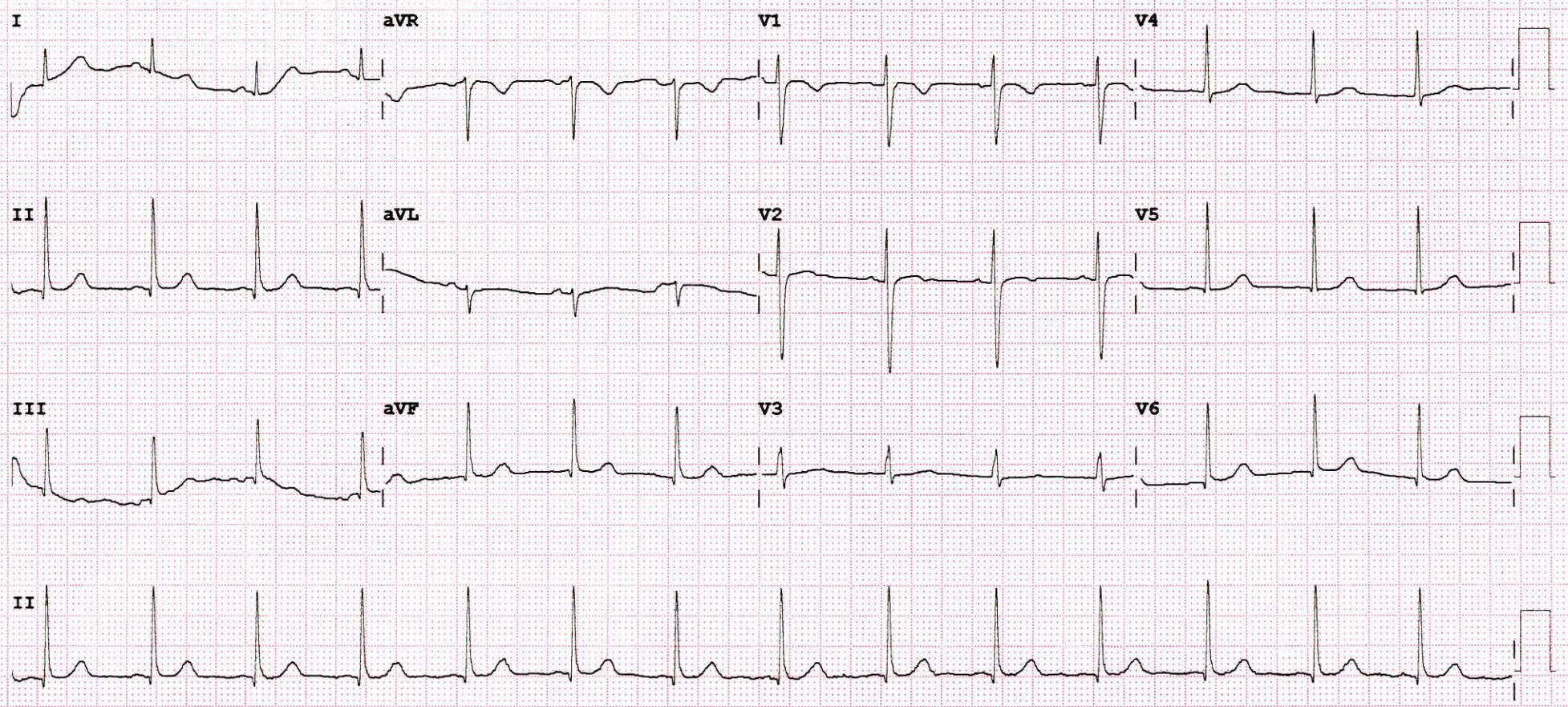
Rate 86 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 121
QRSD 80
QT 345
QTc 413

--AXIS--
P -18
QRS 75
T 44

- NORMAL ECG -

12 Lead; Standard Placement 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?

MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. KOMMANA HARIKA	**Age /Gender**	: 28 Y(s)/Female
Bill No/ UMR No	: NMBC60807/NMU0047193	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:20 am	**Report Date**	: 09-Mar-24 07:01 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	1.020	1.000 - 1.030	Dipstick
PH		6.0	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	Dipstick
LEUCOCYTE ESTERASE		+	NEGATIVE	
MICROSCOPIC EXAMINATION				
PUS CELLS	Urine	18-20	0 - 5 /hpf	
RBC		8-10	0 - 5 /hpf	
EPITHELIAL CELLS		30-35	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		+++		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. KOMMANA HARIKA	**Age /Gender**	: 28 Y(s)/Female
Bill No/ UMR No	: NMBC60807/NMU0047193	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:20 am	**Report Date**	: 09-Mar-24 07:01 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. KOMMANA HARIKA	**Age /Gender**	: 28 Y(s)/Female
Bill No/ UMR No	: NMBC60807/NMU0047193	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:20 am	**Report Date**	: 09-Mar-24 12:53 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	36	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.24	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		13.3	12.0 - 15.0 g/dl	
PCV/HCT		39.6	40 - 50 % 36 - 46 %	
MCV		76	83 - 101 fl 83 - 101 fl	
MCH		25.3	27 - 32 pg	
MCHC		33.5	31.5 - 34.5 g/dL	
RDW(cv)		13.5	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	277	150 - 400 10^3/µL	
MPV		7.9	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	8.9	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	68	40 - 80 %	
LYMPHOCYTES		22	20 - 40 %	
MONOCYTES		08	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" A "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. KOMMANA HARIKA	**Age /Gender**	: 28 Y(s)/Female
Bill No/ UMR No	: NMBC60807/NMU0047193	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:20 am	**Report Date**	: 09-Mar-24 04:42 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. KOMMANA HARIKA	**Age /Gender**	: 28 Y(s)/Female
Bill No/ UMR No	: NMBC60807/NMU0047193	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:20 am	**Report Date**	: 09-Mar-24 01:12 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		142	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.5	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		105	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		107.0	70 - 204 ng/dL	Method : ECLIA
T4		7.01	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.38	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.63	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.63	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		15.87	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		12	<= 33 U/L	Method : UV without P5P
SGOT (AST)		14	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		73	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		4.8	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.1	2.5 - 3.5 g/dL	
A/G RATIO		1.55	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		12	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. KOMMANA HARIKA	**Age /Gender**	: 28 Y(s)/Female
Bill No/ UMR No	: NMBC60807/NMU0047193	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:20 am	**Report Date**	: 09-Mar-24 06:24 pm

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		184	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		124	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		29		
SERUM TRYGLYCERIDES		147	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		5.26	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.54		
SERUM URIC ACID		5.2	2.4 - 5.7 mg/dL	uricase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.7	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		117	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)		117	110 - 180 mg/dL	Hexokinase
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		84	Normal Range 70 - 99 mg/dL	Hexokinase

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. KOMMANA HARIKA	**Age /Gender**	: 28 Y(s)/Female
Bill No/ UMR No	: NMBC60807/NMU0047193	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 09:21 am	**Report Date**	: 11-Mar-24 12:49 pm

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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MEDICOVER HOSPITALS

Patient ID:	*NMU0047193*	*Patient Name:*	*KOMMANA HARIKA*
Age:	*28 Years*	*Sex:*	*F*
Accession Number:	*NMBC60807*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*09-Mar-2024*	*Study Time:*	*09:34:50*

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 14:38:58

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 09/03/24

PATIENT NAME: Kommana Harika AGE / SEX: 28/F

UMR NO: NMU0047193.

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-1.50	———	———	6/6, N6
	O (L)	S	-3.00	———	———	6/6, N6

HISTORY :

- NH/O systemic illness (DM, HTN). H/O using spectacles (Distance).
- NH/O Ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

(BE) - Ant seg WNL

(Undilated) Disc ↑ appear tilted, 0.3
appear tilted 0.3

ADVICE:

- Refresh Tears eld qid 1 / 7 / 7 x 1 month.
- Dilated fundus Examination (BE)

DR. ANUSHREE VANJARI

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MEDICOVER HOSPITALS
NAVI MUMBAI

Komamma

O/E: prosthesis = 6 | 67 / 6 | 567

Malaligned teeth in upper & lower jaw.

Stains +

Adv: Orthodontic treatment

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

MEDICOVER HOSPITALS

MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs ---Kommana---------- DATE: 9/3/24

AGE : 28 yrs SEX: Male/ Female

NMU: NMU000 DOCTOR'S NAME:

Health Package

TEMP :	98 °f	**BP :**	110/70 mmHg
PULSE :	86 b/m	**HEIGHT :**	142 cm
RR :	20 b/m	**WEIGHT :**	42.9 kg
SPO2 :	99 % RA	**HGT:**	—

REMARK:

MEDICOVER
HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mrs. Kommana Karika**	**Date:-09/03/2024**
Age / Sex	: **28 Yrs /Female**	**UMR No. 0047193**
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 = 28 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 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			Nil
AORTIC	5			Nil
TRICUSPID	28			Trivial
PULMONERY	4.4			Nil

MEDICOVER HOSPITALS

Patient ID:	NMU0047193	Patient Name:	KOMMANA HARIKA
Age:	28 Years	Sex:	F
Accession Number:	NMBC60807	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	09-Mar-2024	Study Time:	09:40:17

USG WHOLE ABDOMEN (TAS)

LIVER is mildly enlarged in size (17 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 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 empty.

UTERUS is retroverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures – 7.8 mm.

Both ovaries are normal in size, shape and position.

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 –

- **Mild hepatomegaly.**
- **No other significant abnormality detected.**

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