



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. SHUKLA PREETESH KUMAR **Age /Gender** : 32 Y(s)/Male
Bill No/ UMR No : NMBC63382/NMU0048863 **Referred By** : Dr. DMO
Received Dt : 23-Mar-24 09:42 am **Report Date** : 23-Mar-24 05:30 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
CUE (COMPLETE URINE EXAMINATION)				
<u>PHYSICAL EXAMINATION</u>				
VOLUME	Urine	30 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.020	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/Microscopy
BILIRUBIN		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
BILE SALT		NEGATIVE	NEGATIVE	Hay's sulphur powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
<u>MICROSCOPIC EXAMINATION</u>				
PUS CELLS	Urine	1-2	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		0-1	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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Parameters Specimen Result Biological Reference In Method

*** End Of Report ***





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Patient Name : Mr. SHUKLA PREETESH KUMAR **Age / Gender** : 32 Y(s)/Male
Bill No/ UMR No : NMBC63382/NMU0048863 **Referred By** : Dr. DMO
Received Dt : 23-Mar-24 09:42 am **Report Date** : 23-Mar-24 02:26 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.06	4.5 - 5.5 $10^6/\mu\text{L}$	
HEMOGLOBIN		15.0	13.0 - 17.0 g/dl	
PCV/HCT		44.1	40 - 50 % 36 - 46 %	
MCV		87	83 - 101 fl 83 - 101 fl	
MCH		29.6	27 - 32 pg	
MCHC		34.0	31.5 - 34.5 g/dL	
RDW(cv)		13.0	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	229	150 - 400 $10^3/\mu\text{L}$	
MPV		10.1	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.4	4.0 - 11.0 $10^3/\mu\text{l}$	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	66	40 - 80 %	
LYMPHOCYTES		26	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	02	0 - 10 mm/1st hour	WESTERGREN'S METHOD

*** End Of Report ***





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Bill No/ UMR No : NMBC63382/NMU0048863 **Referred By** : Dr. DMO
Received Dt : 23-Mar-24 09:42 am **Report Date** : 23-Mar-24 01:54 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		89	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM CREATININE				
CREATININE		0.82	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		0.82	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		13.4	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.5	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		27	<= 41 U/L	Method : UV without P5P
SGOT (AST)		16	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		74	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.1	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.9	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.2	2.5 - 3.5 g/dL	
A/G RATIO		2.23	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		21	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.1	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		170	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric





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Bill No/ UMR No : NMBC63382/NMU0048863	Referred By : Dr. DMO
Received Dt : 23-Mar-24 09:42 am	Report Date : 23-Mar-24 05:51 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
HDL CHOLESTEROL		28	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		118	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		32		
SERUM TRYGLYCERIDES		162	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		6.07	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		4.21		
SERUM URIC ACID		5.9	3.4 - 7.0 mg/dL	uricase
T3,T4 AND TSH				
T3		157.8	70 - 204 ng/dL	Method : ECLIA
T4		6.50	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.24	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		99	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

*** End Of Report ***

Lab Incharge

Ambedkar
Dr. VISHAL MEHROTRA, MD Pathology
Consultant in Pathology Services

Verified By : : 022633

Test results related only to the item tested.

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Age: 32 yrs

Rate 63 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation
 PR 176 . Sinus rhythm.....normal P axis, V-rate 50- 99
 QRS 95 . Left axis deviation.....QRS axis (-30,-90)
 QT 401 . RSR' in V1 or V2, probably normal variant.....small R' only
 QTc 411 . ST elev, probable normal early repol pattern.....ST elevation, age<55
 . Baseline wander in lead(s) V3

WNL

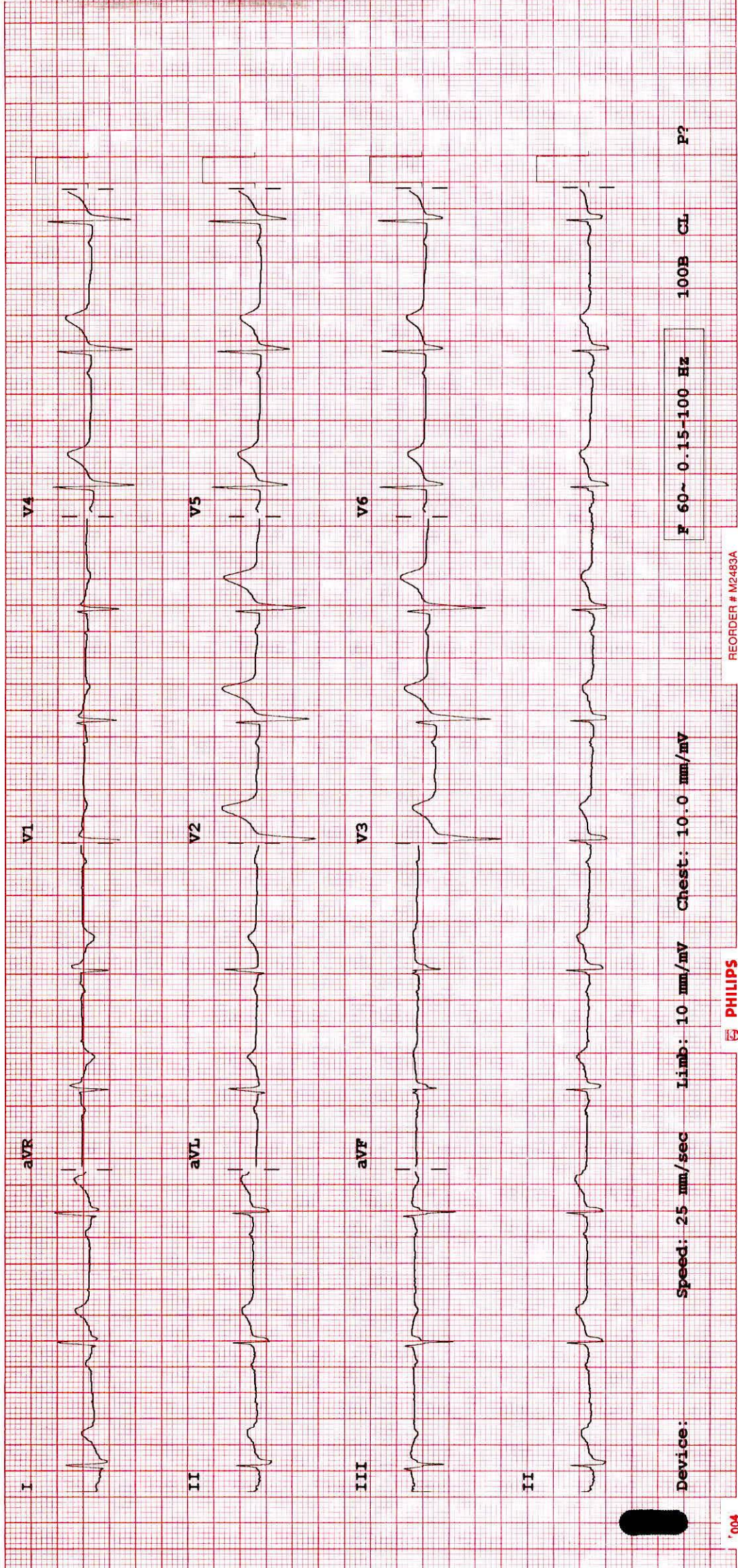
EW

--AXIS--
 P -7
 QRS -39
 T 17

- OTHERWISE 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

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name : Mr. Preetesh Shukla

Date:- 23/03/2024

Age / Sex : 32 Yrs / Male

UMR No. 0048863

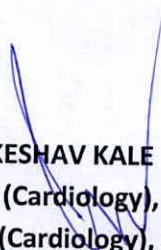
Referred By : Health Checkup

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Mild mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 20 mm Hg.
- No left ventricle clot / vegetation.
- Intact IAS and IVS.
- 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. KESHAV KALE
DNB (Cardiology), MD (Medicine), MBBS
PhD (Cardiology), MNAMS, LL.B (Law)
FSCAI (USA), AFACC (USA), FESC (EU)
Consultant & Interventional Cardiologist





M-MODE MEASUREMENTS:

LA	33	mm
AO root	28	mm
AO CUSP SEP	17	mm
LVID(s)	32	mm
LVID(d)	44	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			Mild
AORTIC	09			Nil
TRICUSPID	20			Trivial
PULMONERY	5.3			Nil



Patient ID:	NMU0048863	Patient Name:	SHUKLA PREETESH KUMAR
Age:	32 Years	Sex:	M
Accession Number:	NMBC63382	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	23-Mar-2024		

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

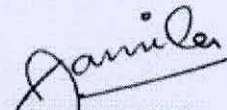
Both hilar shadows are normal in position and density.

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: 25-Mar-2024 17:22:52

Patient ID:	NMU0048863	Patient Name:	SHUKLA PREETESH KUMAR
Age:	32 Years	Sex:	M
Accession Number:	NMBC63382	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	23-Mar-2024		

ULTRASOUND EXAMINATION OF ABDOMEN & PELVIS

The Liver is normal in size and shows mild increase in parenchymal reflectivity. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

The gall bladder is physiologically distended with normal wall thickness. There is no evidence of gallstones. C.B.D. is of normal caliber.

The Pancreas is normal in size and shows homogeneous reflectivity.

The spleen is normal size. It measures 9.4 cm in long axis. No focal lesion is seen.

Both kidneys are normal in position and size. They show normal cortical reflectivity and cortico-medullary distinction.

The Right Kidney measures 10.4 x4.0 cm.

The Left Kidney measures 11.7 x 4.7 cm.

There is no evidence of renal calculi, hydronephrosis, or mass noted.

There is no evidence of ascites or para aortic lymphadenopathy.

The Urinary bladder is adequately distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

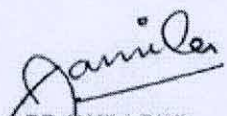
The Prostate gland is normal in size.

It has smooth outlines and normal reflectivity.

It measures 3.5 x3.1 x 2.6 cm corresponding to an estimated weight of 15.2 gms.

IMPRESSION:

- Mild fatty infiltration of liver.
- No other significant abnormality is seen.



DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 23-Mar-2024 12:29:02