MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. DAS RIA	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63337/NMU0048857	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:38 am	**Report Date**	: 23-Mar-24 05:17 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	30 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.005	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	2-3	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		4-6	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
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

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DEPARTMENT OF LABORATORY

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Bill No/ UMR No	: NMBC63337/NMU0048857	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:38 am	**Report Date**	: 23-Mar-24 05:17 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. DAS RIA	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63337/NMU0048857	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:38 am	**Report Date**	: 23-Mar-24 10:09 am

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.55	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		13.7	12.0 - 15.0 g/dl	
PCV/HCT		40.9	40 - 50 % 36 - 46 %	
MCV		90	83 - 101 fl 83 - 101 fl	
MCH		30.1	27 - 32 pg	
MCHC		33.5	31.5 - 34.5 g/dL	
RDW(cv)		13.0	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	226	150 - 400 10^3/µL	
MPV		7.3	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.8	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	61	40 - 80 %	
LYMPHOCYTES		31	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		01	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	20	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" A "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. DAS RIA	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63337/NMU0048857	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:38 am	**Report Date**	: 23-Mar-24 02:29 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. DAS RIA	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63337/NMU0048857	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:38 am	**Report Date**	: 23-Mar-24 10:48 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.8	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		104	98 - 107 mmol/L	ISE INDIRECT
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.6	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		114	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		102	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.72	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.72	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		15.27	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)		25	<= 33 U/L	Method : UV without P5P
SGOT (AST)		25	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		75	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		8.0	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.1	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.76	1.2 - 2.5	

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. DAS RIA	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63337/NMU0048857	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:38 am	**Report Date**	: 23-Mar-24 11:40 am

Parameters	Specimen	Result	Biological Reference In	Method
GAMMA GLUTAMYL TRANSFERASE(GGT)		31	6 - 42 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		8.0	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		202	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		44	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		141	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		22		
SERUM TRYGLYCERIDES		111	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.59	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.2		
SERUM URIC ACID		6.2	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		95.6i	70 - 204 ng/dL	Method : ECLIA
T4		5.18	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.53	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		73	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

*** End Of Report ***

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DAS RIA 48857 3/23/2024 9:03:59 AM

32 Years Female

Rate	79	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Borderline short PR interval.....PR int <120mS
PR	119	. Baseline wander in lead(s) V5
QRSD	97	
QT	365	
QTc	419	

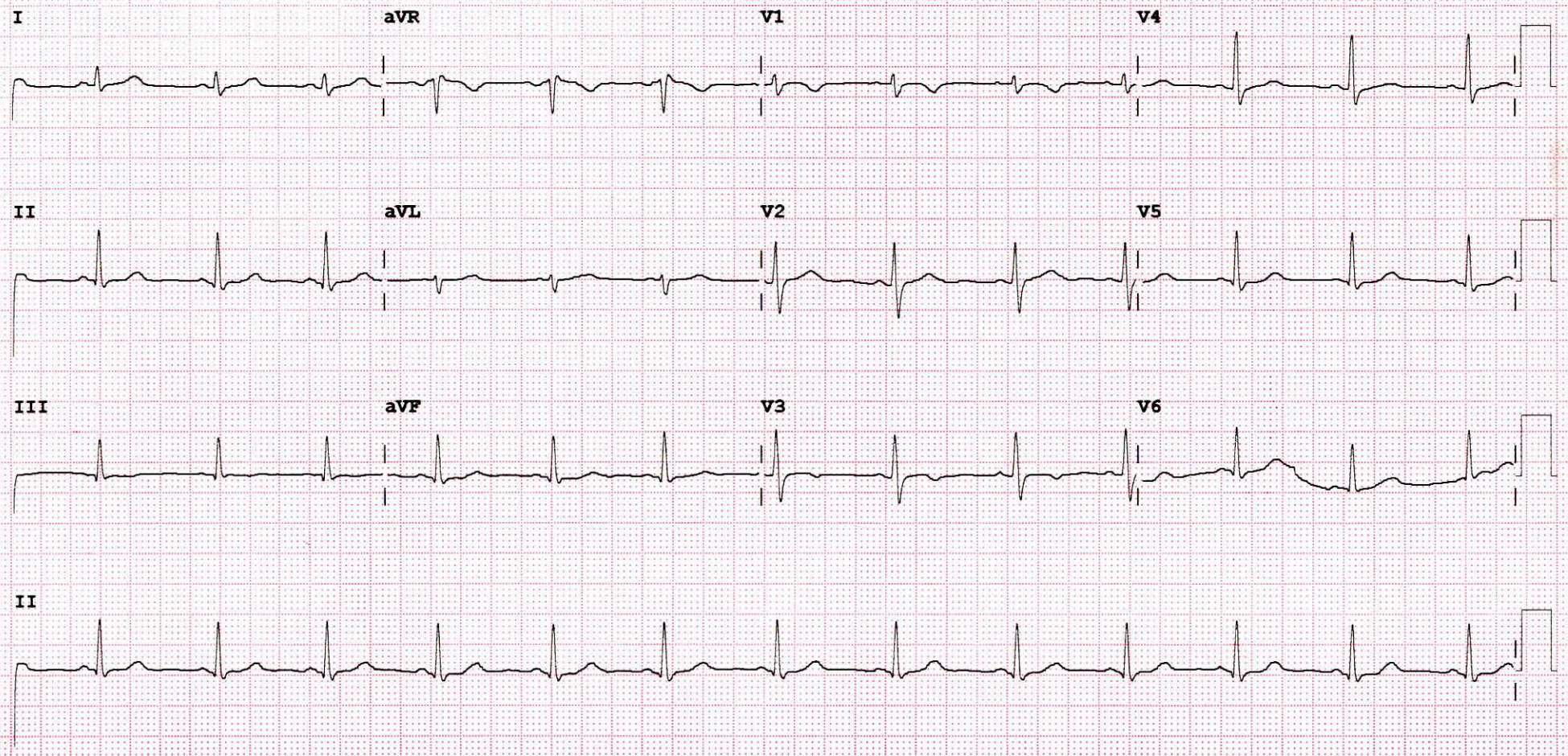
--AXIS--

P	26
QRS	75
T	20

- 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~ 0.50- 40 Hz W 100B CL P?

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: Mrs. Ria Das	Date:- 23/03/2024
Age / Sex	: 32 Yrs / Female	UMR No. 0048857
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.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- No left ventricle clot / vegetation.
- Intact IAS and IVS.
- 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.**
- **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 MEASURMENTS:

LA	35	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	43	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	N			Nil
PULMONERY	5.3			Nil

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HOSPITALS

Patient ID:	*NMU0048857*	*Patient Name:*	*DAS RIA*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC63337*	*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 17:19:44

MEDICOVER
HOSPITALS

Patient ID:	*NMU0048857*	*Patient Name:*	*DAS RIA*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC63337*	*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 a normal parenchymal reflectivity. No focal lesion is seen. The Hepatic veins appear normal. There is no evidence of any dilated IHBR. 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. There is no evidence of any calcification or ductal dilatation.

The spleen is normal in size and shows a homogeneous echotexture. It measures 9.7 cm in long axis. There is no evidence of any focal lesion.

Both kidneys are normal in position and size. They show normal cortical reflectivity and cortico-medullary distinction.
The Right Kidney measures 10.9 x 3.6 cm.
The Left Kidney measures 9.5 x 3.6 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 uterus is Anteverted.
It measures 7.8 x 4.9 x 3.9 cm
The uterine myometrial echotexture is homogeneous. No focal lesion is seen.

The Endometrial thickness is 9.0 mm.

Both ovaries are well visualized and appear normal in size and reflectivity.
The Right ovary measures 4.5 x 2.7 cm. **A 2.4 x 2.1 cm sized hemorrhagic cyst is seen in right ovary.**
The Left ovary measures 3.3 x 1.9 cm.

There is no evidence of any ovarian or adnexal mass lesion.

No evidence of any fluid collection in the pelvis.

MEDICOVER HOSPITALS

Patient ID:	*NMU0048857*	*Patient Name:*	*DAS RIA*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC63337*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*23-Mar-2024*		

IMPRESSION:

- **Right ovarian hemorrhagic cyst.**
- **No other significant abnormality is seen.**

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 23-Mar-2024 12:23:11

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NAVI MUMBAI

Ria Das.

S/B:.. Dr. Mandira Kamble

O/E :- faulty restoration $\bar{1}$ $\frac{1}{7}$.

Stain+ Calculus +++,

Advice :- Oral prophylaxis.

Restoration $\bar{1}$ $\frac{1}{7}$

Dr. Mandira Kamble

Dr Mandira Sushil Kamble
MDS In Conservative Dentistry And Endodontics
Reg. No. A-43282

MEDICOVER HOSPITALS

MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : ~~Mr / Mrs~~ Miss Das: Ria DATE: 23/3/24

SEX: Male/(Female)

AGE : ~~32 yrs~~

NMU: NMU000 48857

DOCTOR'S NAME: Health-Package

TEMP :	97 °f	BP :	120/70 mmHg
PULSE :	75 b/m	HEIGHT :	158 cm
RR :	18 b/m	WEIGHT :	70.8 kg
SPO2 :	99 % RA	HGT:	—

REMARK: