MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHARMISHTHA	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC63346/NMU0048875	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:54 am	**Report Date**	: 23-Mar-24 05:20 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		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	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
MICROSCOPIC EXAMINATION				
PUS CELLS	Urine	2-3	0 - 5 /hpf	
RBC		1-2	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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Bill No/ UMR No	: NMBC63346/NMU0048875	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:54 am	**Report Date**	: 23-Mar-24 05:20 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHARMISHTHA	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC63346/NMU0048875	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:54 am	**Report Date**	: 23-Mar-24 10:51 am

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.09	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		12.3	12.0 - 15.0 g/dl	
PCV/HCT		37.5	40 - 50 % 36 - 46 %	
MCV		92	83 - 101 fl 83 - 101 fl	
MCH		30.1	27 - 32 pg	
MCHC		32.8	31.5 - 34.5 g/dL	
RDW(cv)		13.2	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	156	150 - 400 10^3/µL	
MPV		10.8	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	5.3	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	64	40 - 80 %	
LYMPHOCYTES		28	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" A "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		25	0 - 20 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHARMISHTHA	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC63346/NMU0048875	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:54 am	**Report Date**	: 23-Mar-24 04:05 pm

Parameters	Specimen	Result	Biological Reference In	Method

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHARMISHTHA	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC63346/NMU0048875	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:54 am	**Report Date**	: 23-Mar-24 10:51 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.2	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
SERUM CREATININE				
CREATININE		0.65	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		0.65	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		10.76	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		13	<= 33 U/L	Method : UV without P5P
SGOT (AST)		15	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		79	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
SERUM ALBUMIN		4.8	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.7	2.5 - 3.5 g/dL	
A/G RATIO		1.78	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		17	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				

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHARMISHTHA	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC63346/NMU0048875	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:54 am	**Report Date**	: 23-Mar-24 11:43 am

Parameters	Specimen	Result	Biological Reference In	Method
TOTAL CHOLESTEROL		203	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		41	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		148	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		26		
SERUM TRYGLYCERIDES		129	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.95	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.61		
SERUM URIC ACID		4.9	2.4 - 5.7 mg/dL	uricase
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		76	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		106.2	70 - 204 ng/dL	Method : ECLIA
T4		9.16	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		5.29	0.270 - 4.20 uIU/mL	Method : ECLIA
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.4	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		108	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)		84	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHARMISHTHA	**Age /Gender**	: 33 Y(s)/Female
Bill No/ UMR No	: NMBC63346/NMU0048875	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 12:43 pm	**Report Date**	: 25-Mar-24 10:14 am

Parameter	Specimen	Result Values	Biological Reference	Method

*** End Of Report ***

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head- Laboratory Services
Consultant Hematopathologist

Verified By : : 022633

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2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: Mrs. Sharmishtha	Date:- 23/03/2024
Age / Sex	: 33 Yrs / Female	UMR No. 0048975
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.
- No 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 left atrium and left ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **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 MEASURMENTS:

LA	35	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	31	mm
LVID(d)	44	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	7			Nil
TRICUSPID	20			TRIVIAL
PULMONERY	4.4			Nil

hc48875 sharmishtha 1/7/2008 2:58:52 AM

Female

Age: 33yrs

Rate	81	. Age not entered, assumed to be 50 years old for purpose of ECG interpretation
		. Sinus rhythm.....normal P axis, V-rate 50- 99
PR	138	. Borderline T abnormalities, anterior leads.....T flat or neg, V2-V4
QRSD	76	
QT	369	
QTc	429	

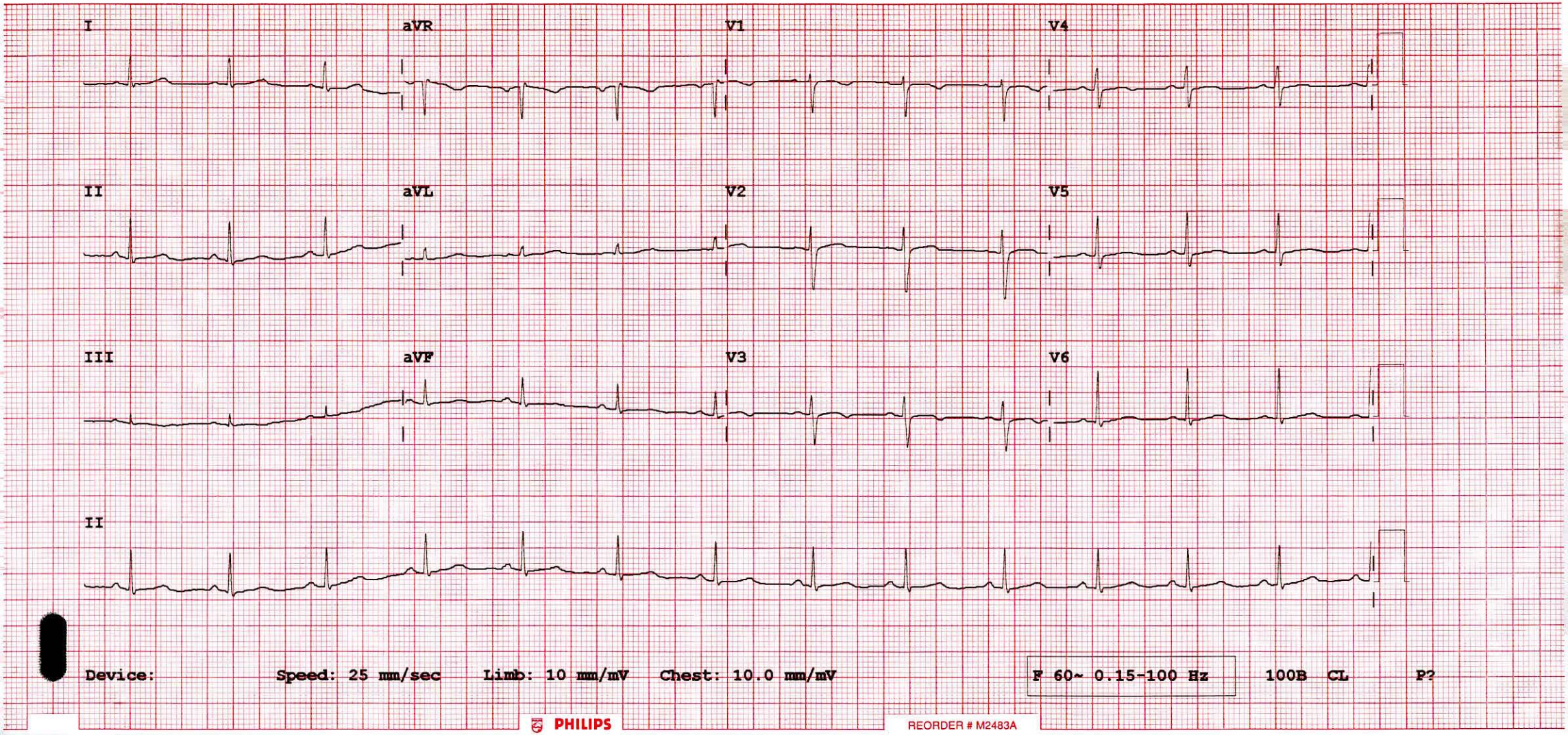
--AXIS--

P	60
QRS	37
T	9

- BORDERLINE 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?

PHILIPS REORDER # M2483A

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 23/03/24

PATIENT NAME: Miss Shormishtha AGE / SEX : 33/F

UMR NO : NMU 00 4 8875

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O	D	Plano	———		6/6, N6
	O	S	Plano	———		6/6, N6

HISTORY :

No h/o HT / DM
h/o Thyroid on Rx : 5 yrs.
No h/o spectacle use.
- h/o headache (+).

OCULAR FINDINGS :

(BE) - Ant seg WNL
Disc (BE) - 0.3

ADVICE:

Refresh Tears 1d qid 1/7/7 X 1 month.

DR. ANUSHREE VANKAR

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MEDICOVER
HOSPITALS

Patient ID:	*NMU0048875*	*Patient Name:*	*SHARMISHTHA*
Age:	*33 Years*	*Sex:*	*F*
Accession Number:	*NMBC63346*	*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. A 18 mm calculus is seen in mid body region of gall bladder. 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 9.8 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 9.4 x 3.3 cm.
The Left Kidney measures 10.2 x 4.1 cm.
A simple cortical cyst measuring 11 mm is seen in upper pole of left kidney.
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 8.4 x 3.7 x 4.4 cm.
The uterine myometrial echotexture is homogeneous. No focal lesion is seen.

The Endometrial thickness is 5.8 mm.

Both ovaries are well visualized and appear normal in size and reflectivity.
The Right ovary measures 2.3 x 0.9 cm.
The Left ovary measures 2.7 x 1.0 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:	*NMU0048875*	*Patient Name:*	*SHARMISHTHA*
Age:	*33 Years*	*Sex:*	*F*
Accession Number:	*NMBC63346*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*23-Mar-2024*		

IMPRESSION:

- **Cholelithiasis without any signs of cholecystitis.**
- **Left renal simple cortical cyst.**

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 23-Mar-2024 12:24:40

MEDICOVER HOSPITALS
NAVI MUMBAI

Patient ID:	NMU0048875	Patient Name:	SHARMISHTHA
Age:	33 Years	Sex:	F
Accession Number:	NMBC63346	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 17:18:42