MEDICOVER HOSPITALS

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : ~~Mr~~ / Mrs KASHISH SOMYA ---------- DATE: 11/04/24

AGE : 30yrs SEX: Male/(Female)

NMU: NMU000 50582 DOCTOR'S NAME:

HEALTH - PACKAGE

TEMP :	96 °f	BP :	110/90 mmHg
PULSE :	79 b/m	HEIGHT :	161 cm
RR :	20 b/m	WEIGHT :	73.1 kg
SPO2 :	98 %	HGT:	—

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 11/04/24

PATIENT NAME: Mrs. Kashish Sonyer AGE / SEX: 30/F. NAVI MUMBAI

UMR NO: NMU00505584.

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-0.75	-0.50	50°	6/6.
	O (L)	S	-1.25	———	———	6/6.

HISTORY :

- H/O using spectacle CDistances. : 6 yrs.
- NO H/O ocular trauma Allegies & surgeries.
- NO H/O systemic illness (DM, HTN, thyroid)

OCULAR FINDINGS :

(BE) - Ant Seg WNL
Lens - Dot Lenticular opacities.
(undilated) Disc (BE) - 0.2

ADVICE:

Refresh Tears eld qid 1777 x 1 month

Dr

Dr-ANUSHREE VANKAR

MEDICOVER HOSPITALS

Patient ID:	*NMU0050584*	*Patient Name:*	*KASHISH SOMYA*
Age:	*30 Years*	*Sex:*	*F*
Accession Number:	*NMBC65968*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*11-Apr-2024*	*Study Time:*	*11:36:50*

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

)th 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: 11-Apr-2024 15:08:35

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HOSPITALS

Patient ID:	*NMU0050584*	*Patient Name:*	*KASHISH SOMYA*
Age:	*30 Years*	*Sex:*	*F*
Accession Number:	*NMBC65968*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*11-Apr-2024*	*Study Time:*	*11:46:58*

ULTRASOUND EXAMINATION OF ABDOMEN & PELVIS

The Liver is normal in size (14.7 cm) 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.

ıe 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 11.3 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 10.5 x 4.2 cm.
Tiny 8 mm subcentimetric cyst is seen in mid pole of right kidney.
The Left Kidney measures 10.8 x 3.9 cm.
There is no evidence of renal calculi or hydronephrosis noted.

`ere 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 9.8 x 5.0 x 3.9 cm
The uterine myometrial echotexture is homogeneous. No focal lesion is seen.

The Endometrial thickness is 11 mm.

Both ovaries are well visualized and appear normal in size and reflectivity.
The Right ovary measures 2.2 x 1.2 cm.
The Left ovary measures 2.5 x 1.3 cm.

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

No evidence of any fluid collection in the pelvis.

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Age:	*30 Years*	*Sex:*	*F*
Accession Number:	*NMBC65968*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*11-Apr-2024*	*Study Time:*	*11:46:58*

IMPRESSION:

- **Tiny simple right renal cyst.**
- **No other significant abnormality is seen.**

Dr Garima Sharma
MD, DNB, FRCR
Consultant Radiologist.

[redacted] KASHISH SOMYA 4/11/2024 10:55:56 AM

30 Years Female

Rate 78 . Sinus rhythm.....normal P axis, V-rate 50- 99

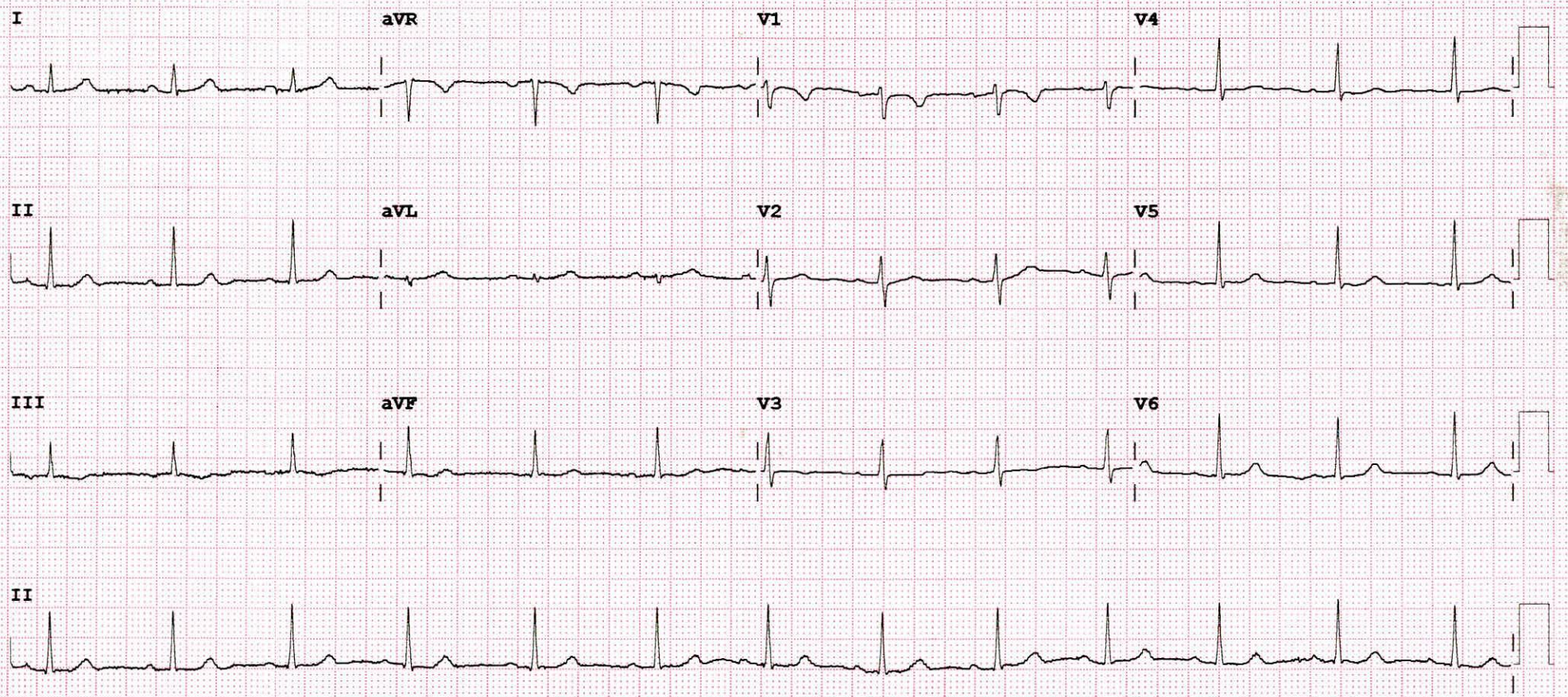
PR 158
QRSD 90
QT 350
QTc 399

--AXIS--
P 6
QRS 61
T 8

WNL A

- 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?

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2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: **Mrs. Kashish Somya**	**Date:-11/04/2024**
Age / Sex	: **41 Yrs / Female**	**UMR No. 0050584**
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.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- 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 MR.**
- **Normal LV and RV systolic function.**

DR. RISHI BHARGAVA
MD DM CARDIOLOGY

M-MODE MEASURMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	31	mm
LVID(d)	41	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			Trivial
AORTIC	5.1			Nil
TRICUSPID	N			Nil
PULMONERY	4.1			Nil

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. KASHISH SOMYA	**Age /Gender**	: 30 Y(s)/Female
Bill No/ UMR No	: NMBC65968/NMU0050584	**Referred By**	: Dr. DMO
Received Dt	: 11-Apr-24 10:08 am	**Report Date**	: 11-Apr-24 03:36 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	30ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.010	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		OCCASIONAL	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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Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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Bill No/ UMR No	: NMBC65968/NMU0050584	**Referred By**	: Dr. DMO
Received Dt	: 11-Apr-24 10:08 am	**Report Date**	: 11-Apr-24 02:38 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	EDTA Blood	4.76	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		11.3	12.0 - 15.0 g/dl	
PCV/HCT		36.0	40 - 50 %	
MCV		75.5	83 - 101 fl	
MCH		23.7	27 - 32 pg	
MCHC		31.4	31.5 - 34.5 g/dL	
RDW(cv)		15.9	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	EDTA Blood	398	150 - 400 10^3/µL	
MPV		10.5	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	6.47	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	67	40 - 80 %	
LYMPHOCYTES		26	20 - 40 %	
MONOCYTES		04	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisopoikilocytosis. Microcytic hypochromic with ovalocytes and elliptocytes.		
WBC		Normal morphology.		
PLATELETS		Adequate in smear.		
ADVISED		1. Serum iron studies. 2. Haemoglobin electrophoresis/ HPLC assay.		
ESR	CITRATED BLOOD	50	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" B "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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Bill No/ UMR No	: NMBC65968/NMU0050584	**Referred By**	: Dr. DMO
Received Dt	: 11-Apr-24 10:08 am	**Report Date**	: 11-Apr-24 03:29 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. KASHISH SOMYA	**Age /Gender**	: 30 Y(s)/Female
Bill No/ UMR No	: NMBC65968/NMU0050584	**Referred By**	: Dr. DMO
Received Dt	: 11-Apr-24 10:11 am	**Report Date**	: 11-Apr-24 11:57 am

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		91	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.6	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		110.0	70 - 204 ng/dL	Method : ECLIA
T4		8.64	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.76	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		84	110 - 180 mg/dL	Hexokinase
URINE SUGAR		Nil		Dipstick
SERUM CREATININE				
CREATININE		0.65	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.65	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		12.30	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.6	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.4	<= 1.0 mg/dL	
SGPT (ALT)		26	<= 33 U/L	Method : UV without P5P
SGOT (AST)		26	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		123	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.4	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.3	2.5 - 3.5 g/dL	

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Patient Name	: Mrs. KASHISH SOMYA	**Age /Gender**	: 30 Y(s)/Female
Bill No/ UMR No	: NMBC65968/NMU0050584	**Referred By**	: Dr. DMO
Received Dt	: 11-Apr-24 10:08 am	**Report Date**	: 11-Apr-24 04:29 pm

Parameters	Specimen	Result	Biological Reference In	Method
A/G RATIO		1.33	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		18	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		151	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		46	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		90	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		14		
SERUM TRYGLYCERIDES		72	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.28	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		1.96		
SERUM URIC ACID		3.2	2.4 - 5.7 mg/dL	uricase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.3	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		105	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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Bill No/ UMR No	: NMBC65968/NMU0050584	**Referred By**	: Dr. DMO
Received Dt	: 11-Apr-24 10:11 am	**Report Date**	: 12-Apr-24 08:33 am

Parameters	Specimen	Result	Biological Reference In	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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