DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PATIL SONALI KALPESH	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC63356/NMU0048864	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:59 am	**Report Date**	: 23-Mar-24 05:36 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	1.015	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	3-4	0 - 5 /hpf	
RBC		15-18	0 - 5 /hpf	
EPITHELIAL CELLS		8-10	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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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PATIL SONALI KALPESH	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC63356/NMU0048864	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:59 am	**Report Date**	: 23-Mar-24 05:36 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PATIL SONALI KALPESH	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC63356/NMU0048864	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:57 am	**Report Date**	: 23-Mar-24 03:00 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	3.79	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		11.0	12.0 - 15.0 g/dl	
PCV/HCT		33.3	40 - 50 % 36 - 46 %	
MCV		88	83 - 101 fl 83 - 101 fl	
MCH		29.1	27 - 32 pg	
MCHC		33.2	31.5 - 34.5 g/dL	
RDW(cv)		11.7	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	382	150 - 400 10^3/µL	
MPV		10.2	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	4.9	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	67	40 - 80 %	
LYMPHOCYTES		30	20 - 40 %	
MONOCYTES		01	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	17	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PATIL SONALI KALPESH	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC63356/NMU0048864	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:57 am	**Report Date**	: 23-Mar-24 06:18 pm

Parameters **Specimen** **Result** **TUBE AGGLUTINATI**

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PATIL SONALI KALPESH	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC63356/NMU0048864	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:58 am	**Report Date**	: 23-Mar-24 01:53 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		93	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.0	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		105	98 - 107 mmol/L	ISE INDIRECT
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	
T3,T4 AND TSH				
T3		133.6	70 - 204 ng/dL	Method : ECLIA
T4		6.45	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.84	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.58	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		0.58	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		17.24	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.2	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.1	<= 1.0 mg/dL	
SGPT (ALT)		11	<= 33 U/L	
SGOT (AST)		12	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		88	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PATIL SONALI KALPESH	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC63356/NMU0048864	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:57 am	**Report Date**	: 25-Mar-24 10:17 am

Parameters	Specimen	Result	Biological Reference In	Method
SERUM ALBUMIN		4.8	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.6	2.5 - 3.5 g/dL	
A/G RATIO		1.85	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		16	6 - 42 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		165	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		114	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		18		
SERUM TRYGLYCERIDES		90	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.02	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.78		
SERUM URIC ACID		5.0	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		88	110 - 180 mg/dL	Hexokinase

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PATIL SONALI KALPESH	**Age /Gender**	: 34 Y(s)/Female
Bill No/ UMR No	: NMBC63356/NMU0048864	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:56 am	**Report Date**	: 25-Mar-24 10:17 am

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

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

Verified By : : 026560

Test results related only to the item tested.

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2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

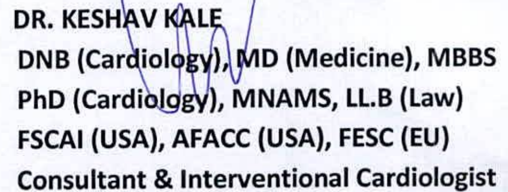
Name	: Mrs. Sonali Patil	**Date:- 23/03/2024**
Age / Sex	: 32 Yrs / Female	**UMR No. 0048862**
Referred By	: Health Checkup	

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.
- Mild tricuspid regurgitation. No pulmonary hypertension.
  PASP = 28 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 MR. Mild 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	34	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	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	7			Nil
TRICUSPID	28			Mild
PULMONERY	4.1			Nil

48864 sonali patil 1/7/2008 2:30:25 AM
Female

Age: 34yrs

Rate	61	. Age not entered, assumed to be 50 years old for purpose of ECG interpretation
		. Sinus rhythm.....................................normal P axis, V-rate 50- 99
PR	151	. Abnormal R-wave progression, early transition..................QRS area>0 in V2
QRSD	91	
QT	389	
QTc	392	

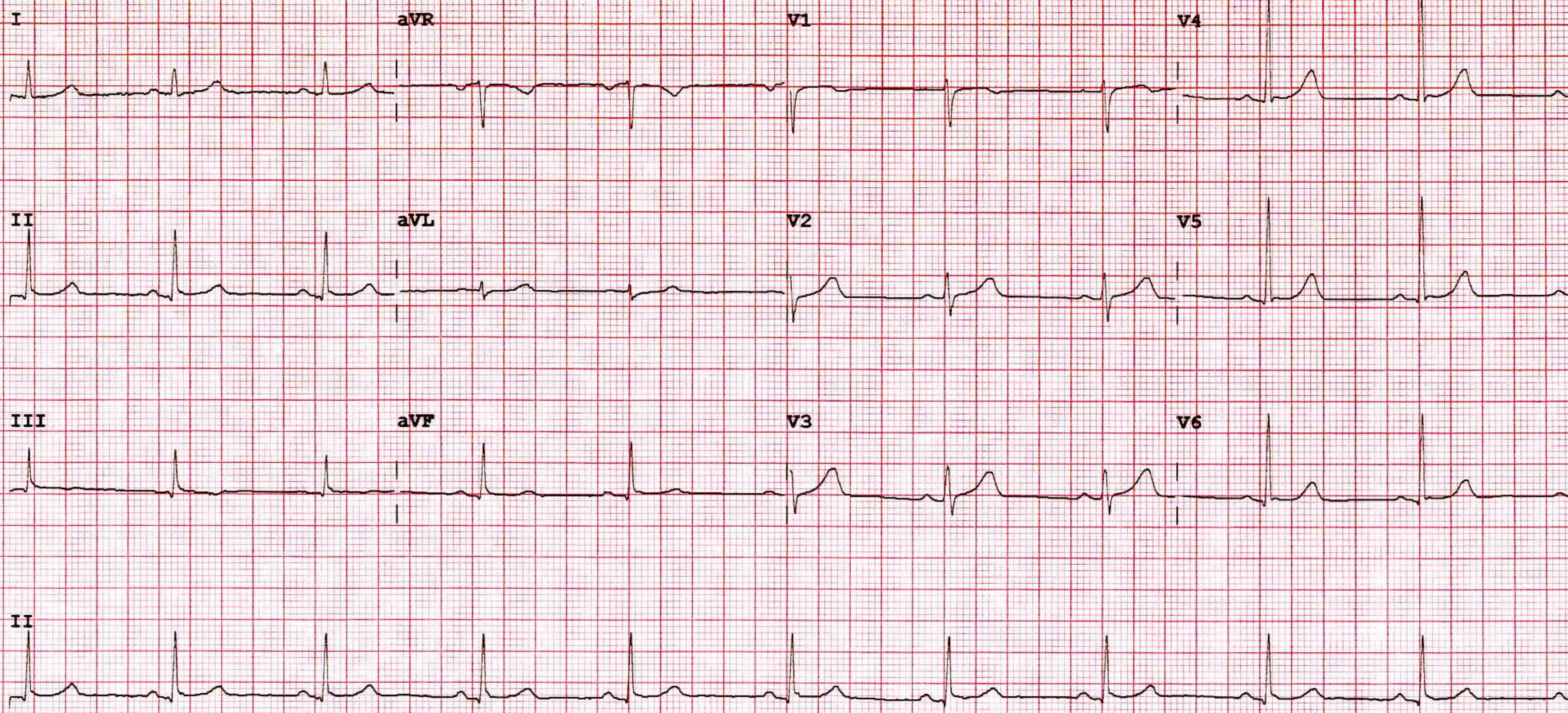
--AXIS--

P	43
QRS	60
T	28

- 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?

PHILIPS REORDER # M2483A

MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Sonali Kalpesh Patil DATE: 23/3/24

SEX: Male/ Female (circled)

AGE : 32 yrs

DOCTOR'S NAME: Health Package

NMU: NMU000 48864

TEMP :	97.6 °f	BP :	108/80 mmHg
PULSE :	66 b/m	HEIGHT :	156 cm
RR :	20 b/m	WEIGHT :	63 kg
SPO2 :	98 % RA	HGT:	—

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 23/03/24
PATIENT NAME: Mrs. Sonali patil. AGE / SEX: 34/F.
UMR NO: NMMU0048864

	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 DM, HTN, thyroid.
No H/O ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

(BE) – Ant seg WNL

Undilated Disc C $^{0.2}_{0.4}$

ADVICE:

Yearly Eye Examination

(Dr. ANUSHREE VANKAR)

MEDICOVER
HOSPITALS

NAVI MUMBAI

Sonali Patil.

S/B :- Dr. Mandira Kamble.

O/E :- Caries c̄ 76 | 67 / 6. | 67

Stain⁺ Calculus⁺⁺

Advice :- Oral prophylaxis.

Restoration c̄ 76 | 67 / 6 | 67

MSKamble

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

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MEDICOVER
HOSPITALS

Patient ID:	NMU0048864	Patient Name:	PATIL SONALI KALPESH
Age:	34 Years	Sex:	F
Accession Number:	NMBC63356	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 8.8 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 10.2 x 3.3 cm.
The Left Kidney measures 10.6 x 4.4 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 7.9 x 4.2 x 3.1 cm.
The uterine myometrial echotexture is homogeneous. No focal lesion is seen.

The Endometrial thickness is 6.7 mm.

Both ovaries are bulky and show multiple tiny peripherally arranged follicles with central echogenic stroma suggestive of polycystic ovaries.
The Right ovary measures 3.8 x 3.3 x 1.9 cm (Volume – 13.1 cc).
The Left ovary measures 3.2 x 2.9 x 2.2 cm (Volume – 11.5 cc).

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

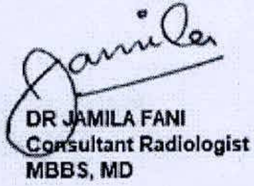
No evidence of any fluid collection in the pelvis.

MEDICOVER
HOSPITALS

Patient ID:	NMU0048864	Patient Name:	PATIL SONALI KALPESH
Age:	34 Years	Sex:	F
Accession Number:	NMBC63356	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	23-Mar-2024		

IMPRESSION:

- **Bilateral polycystic ovaries.**
- **No other significant abnormality is seen.**



DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 23-Mar-2024 17:49:05

MEDICOVER
HOSPITALS

Patient ID:	NMU0048862	Patient Name:	SONALI PATIL 32 Y
Age:		Sex:	F
Accession Number:		Modality:	US
Referring Physician:		Study:	
Study Date:	23-Mar-2024		

ULTRASOUND EXAMINATION OF THE BREAST

Real -Time Sonography of both the Breasts was done with a high resolution linear transducer.

Normal glandular breast parenchyma is seen in both breasts.

There is no evidence of any solid or cystic mass lesion noted.

There is no evidence of any ductal dilatation seen in the retro-areolar region.

Small reactive lymph nodes with maintained fatty hilum are seen in both axilla.

A 12 x 3 mm sized simple lobulated cyst is seen in dermis of left axilla likely benign in etiology.

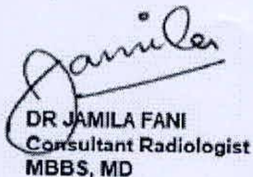
IMPRESSION:

- **Small cyst in left axilla.**
- **No other significant abnormality is seen.**

BIRADS Category II (Benign findings)

Suggest a routine screening sonomammography after one year.

*(**BIRADS CATEGORY :** BIRADS O - Requires additional evaluation, I - Negative, II - Benign findings, III - Probably benign findings, IV - Suspicious abnormality, V-Highly suggestive of malignancy, VI – Known biopsy proven malignancy.)*



DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 25-Mar-2024 15:54:08

Patient ID:	NMU0048864	Patient Name:	PATIL SONALI KALPESH
Age:	34 Years	Sex:	F
Accession Number:	NMBC63356	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.

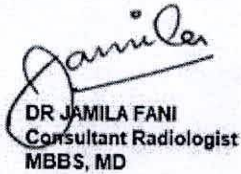
Both hilar shadows are normal in position and density.

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 17:18:27