MEDICOVER HOSPITALS

MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Sachin Patil DATE: 29/3/24

AGE : 33yrs SEX: Male / Female

NMU: NMU000 49395 DOCTOR'S NAME: Health - Package

TEMP :	97.6 °f	**BP :**	124/83 mmHg
PULSE :	85 b/m	**HEIGHT :**	167 cm
RR :	20 b/m	**WEIGHT :**	57.5 kg
SPO2 :	100 % RA	**HGT:**	—

REMARK:

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NAVI MUMBAI

Sahin Patil.

S/B: Dr. Mandira Kamble

O/E:- Caries - 7/

Stain+ Calculus+

Advice:- Oral prophylaxis.

Restoration - 7/

MSKamble

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

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 29/03/24

PATIENT NAME: Mr Sachin Patil AGE / SEX: 33/M

UMR NO: NMU0049395.

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-1.25	-0.50	10°	6/6, N6
	O (L)	S	-1.25	-0.50	180	6/6, N6

HISTORY :

— H/O Using spectacle since 8 yrs — NO H/O Ocular trauma Allergies & surgeries.
— NO H/O systemic illness (DM, HTN, thyroid)

OCULAR FINDINGS :

(BE) - Ant seg WNL.

(undilated) Disc (BE) - 0.1, small discs

ADVICE:

Refresh Tears 1dd gtt 1 7 7 x 1 month.
Fundoscopy (BE)

AS
CDR. ANUSHREE VANKAR

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SACHIN PATIL	**Age /Gender**	: 33 Y(s)/Male
Bill No/ UMR No	: NMBC64135/NMU0049395	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:00 am	**Report Date**	: 29-Mar-24 06:23 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	1.020	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	OCCASIONAL	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		NIL	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.		

*** End Of Report ***

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Patient Name	: Mr. SACHIN PATIL	**Age /Gender**	: 33 Y(s)/Male
Bill No/ UMR No	: NMBC64135/NMU0049395	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:00 am	**Report Date**	: 29-Mar-24 06:23 pm

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. SACHIN PATIL	**Age /Gender**	: 33 Y(s)/Male
Bill No/ UMR No	: NMBC64135/NMU0049395	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:00 am	**Report Date**	: 29-Mar-24 03:14 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.87	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		9.1	13.0 - 17.0 g/dl	
PCV/HCT		32.8	40 - 50 %	
			36 - 46 %	
MCV		56	83 - 101 fl	
			83 - 101 fl	
MCH		15.6	27 - 32 pg	
MCHC		27.8	31.5 - 34.5 g/dL	
RDW(cv)		19.7	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	370	150 - 400 10^3/µL	
MPV		9.1	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.4	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	60	40 - 80 %	
LYMPHOCYTES		29	20 - 40 %	
MONOCYTES		09	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Moderate anisopoikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes, tear drop cells and some target cells.		
WBC		Normal morphology.		
PLATELETS		Adequate in smear.		
ADVISED		Haemoglobin electrophoresis/ HPLC assay.		
ESR	CITRATED BLOOD	13	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SACHIN PATIL	**Age /Gender**	: 33 Y(s)/Male
Bill No/ UMR No	: NMBC64135/NMU0049395	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:00 am	**Report Date**	: 29-Mar-24 03:05 pm

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. SACHIN PATIL	**Age /Gender**	: 33 Y(s)/Male
Bill No/ UMR No	: NMBC64135/NMU0049395	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:00 am	**Report Date**	: 29-Mar-24 02:08 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM CREATININE				
CREATININE		0.78	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		12	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.78	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		15.38	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)		28	<= 41 U/L	Method : UV without P5P
SGOT (AST)		29	<= 40 U/L	
ALKALINE PHOSPHATASE (ALP)		85	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		4.7	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.3	2.5 - 3.5 g/dL	
A/G RATIO		1.42	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		25	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		12	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		168	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		43	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. SACHIN PATIL	**Age /Gender**	: 33 Y(s)/Male
Bill No/ UMR No	: NMBC64135/NMU0049395	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:00 am	**Report Date**	: 29-Mar-24 02:59 pm

Parameters	Specimen	Result	Biological Reference In	Method
LDL CHOLESTEROL		115	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		21		
SERUM TRYGLYCERIDES		106	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	
CHO/HDL RATIO		3.91	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.67		
SERUM URIC ACID		4.8	3.4 - 7.0 mg/dL	uricase
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		96	Normal Range : 70 - 99 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		137.0	70 - 204 ng/dL	Method : ECLIA
T4		8.76	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		0.596	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		78	110 - 180 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.1	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		128	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SACHIN PATIL	**Age /Gender**	: 33 Y(s)/Male
Bill No/ UMR No	: NMBC64135/NMU0049395	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:00 am	**Report Date**	: 30-Mar-24 09:42 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 026979

Test results related only to the item tested.

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MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: **Mr. Sachin Patil**	**Date:-29/03/2024**
Age / Sex	: **33 Yrs / Male**	**UMR No. 0049395**
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.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 20 mm Hg.
- 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 and TR. No PH.**
- **Normal LV and RV systolic function.**

DR. SAMEER VANKAR
MD DM CARDIOLOGY

M-MODE MEASURMENTS:

LA	35	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	31	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	20			Trivial
PULMONERY	4.4			Nil

HC 49395
33 Years

SACHIN PATIL
Male

3/29/2024 12:33:23 PM

Rate	70
PR	137
QRSD	80
QT	348
QTc	376

. Sinus arrhythmia.....V-rate 57- 80, variation>10%
. Baseline wander in lead(s) V3

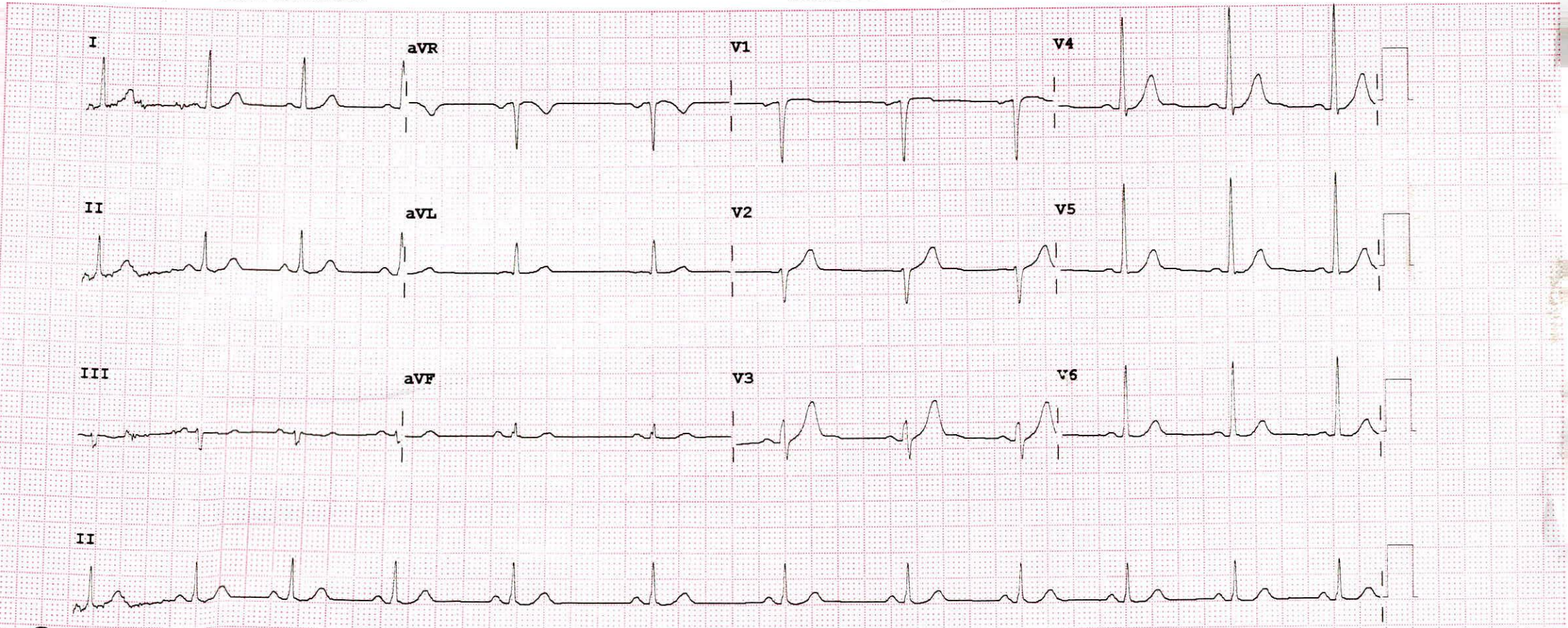
--AXIS--

P	49
QRS	17
T	23

12 Lead; Standard Placement

- OTHERWISE NORMAL ECG -

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

Patient ID:	*NMU0049395*	*Patient Name:*	*SACHIN PATIL*
Age:	*33 Years*	*Sex:*	*M*
Accession Number:	*NMBC64135*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*29-Mar-2024*	*Study Time:*	*10:50:27*

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. Ashwin Y.
M.D. (Radio-Diagnosis)

MEDICOVER
HOSPITALS

Patient ID:	*NMU0049395*	*Patient Name:*	*SACHIN PATIL*
Age:	*33 Years*	*Sex:*	*M*
Accession Number:	*NMBC64135*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*29-Mar-2024*	*Study Time:*	*10:52:05*

USG WHOLE ABDOMEN

LIVER is normal in size, normal in shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal flow. No evidence of intra-hepatic biliary duct dilatation.

Gall Bladder appears partially distended with normal wall thickness. There is no obvious calculus or pericholecystic collection or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

SPLEEN is normal in size and echotexture. No focal lesion seen. SV is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

Urinary Bladder is adequately distended; no e/o wall thickening or mass or calculi seen.
Post-void residue is not significant.

PROSTATE is normal in size, shape & echotexture.

Visualised bowel loops appear normal. There is no free fluid seen.

NB:- This scan does not rule out all pathologies related to bowel and appendix.

IMPRESSION –

- **No significant abnormality detected.**

Dr. Ashwin Y.
M.D. (Radio-Diagnosis)