MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs santosh . vasila   DATE: 29/3/24

AGE : 38yrs   SEX: Male/ Female

NMU: NMU000 49385   DOCTOR'S NAME: Health - Package

TEMP :	97·6 °f	BP :	125/93 mmHg
PULSE :	70 b/m	HEIGHT :	168 cm
RR :	20 b/m	WEIGHT :	80·6 kg
SPO2 :	98 % RA	HGT:	—

REMARK:

Santosh.

S/B: Dr. Mandira Kamble

O/E: Stain+ Calculus++

Advice: Oral prophylaxis.

Mkamble

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 santosh sisila. AGE / SEX: 35/m

UMR NO : NMMU0049385.

	RE	LE
VA (DISTANCE)	6/9p.	6/6p.
VA(NEAR)	N6	N6.
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-1.00.	———	———	6/6, N6
	O (L).	S	-0.50	———	———	6/6, N6

HISTORY :

- H/O spectacle use ~ 10 yrs. - No H/O ocular trauma, Allergies & surgeries.
- No H/O. systemic illness (DM, H-N, thyroid).

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc < 0.3 / 0.2

ADVICE:

Refresh Tears e/d qid 1777 X 1month

(DR. ANUSHREE VANKAR)

MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SANTOSH KUMAR SISTLA	**Age /Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC64121/NMU0049385	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 09:39 am	**Report Date**	: 29-Mar-24 06:41 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	20ML		
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	OCCASIONAL	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		NIL	0 - 5 /hpf	
CRYSTALS		0-1	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

Patient Name	: Mr. SANTOSH KUMAR SISTLA	**Age /Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC64121/NMU0049385	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 09:39 am	**Report Date**	: 29-Mar-24 06:41 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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MEDICOVER
HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SANTOSH KUMAR SISTLA	**Age /Gender**	: 35Y(s)/Male
Bill No/ UMR No	: NMBC64121/NMU0049385	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 09:39 am	**Report Date**	: 29-Mar-24 12:50 pm

FINAL REPORT

Parameter	**Specimen**	**Result Values**	**Biological Reference**	**Method**
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	5.47	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		16.2	13.0 - 17.0 g/dl	
PCV/HCT		47.9	40 - 50 % 36 - 46 %	
MCV		88	83 - 101 fl 83 - 101 fl	
MCH		29.6	27 - 32 pg	
MCHC		33.8	31.5 - 34.5 g/dL	
RDW(cv)		13.2	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	317	150 - 400 10^3/µL	
MPV		9.1	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	8.2	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	51	40 - 80 %	
LYMPHOCYTES		40	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	07	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. SANTOSH KUMAR SISTLA	**Age /Gender**	: 35Y(s)/Male
Bill No/ UMR No	: NMBC64121/NMU0049385	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 09:40 am	**Report Date**	: 29-Mar-24 01:58 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		89	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.85	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.85	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		11.7	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.7	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.5	<= 1.0 mg/dL	
SGPT (ALT)		17	<= 41 U/L	Method : UV without P5P
SGOT (AST)		15	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		54	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
SERUM ALBUMIN		4.7	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.7	2.5 - 3.5 g/dL	
A/G RATIO		1.74	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		23	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - 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		162	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric

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MEDICOVER
HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SANTOSH KUMAR SISTLA	**Age /Gender**	: 35Y(s)/Male
Bill No/ UMR No	: NMBC64121/NMU0049385	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 09:39 am	**Report Date**	: 29-Mar-24 04:57 pm

Parameters	Specimen	Result	Biological Reference In	Method
HDL CHOLESTEROL		40	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		105	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		28		
SERUM TRYGLYCERIDES		138	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.05	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.63		
SERUM URIC ACID		6.1	3.4 - 7.0 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		154	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
T3,T4 AND TSH				
T3		126.8	70 - 204 ng/dL	Method : ECLIA
T4		9.97	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.55	0.270 - 4.20 uIU/mL	
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.0	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		125	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. SANTOSH KUMAR SISTLA	**Age /Gender**	: 35Y(s)/Male
Bill No/ UMR No	: NMBC64121/NMU0049385	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 09:39 am	**Report Date**	: 30-Mar-24 11:08 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 022315

Test results related only to the item tested.

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2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: **Mr. Santosh Kumar**	**Date:-29/03/2024**
Age / Sex	: **37 Yrs / male**	**UMR No. 0049385**
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.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
  PASP = 25 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 TR. No PH.**
- **Normal LV and RV systolic function.**

DR. SAMEER VANKAR
MD DM CARDIOLOGY

M-MODE MEASURMENTS:

LA	34	mm
AO root	29	mm
AO CUSP SEP	17	mm
LVID(s)	31	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	7			Nil
TRICUSPID	35			Trivial
PULMONERY	4.4			Nil

NMU0049385 SANTOSH SISTLA 3/29/2024 10:48:22 AM
35 Years Male

Rate 76 . Sinus rhythm..normal P axis, V-rate 50- 99

PR	124
QRSD	90
QT	381
QTc	429

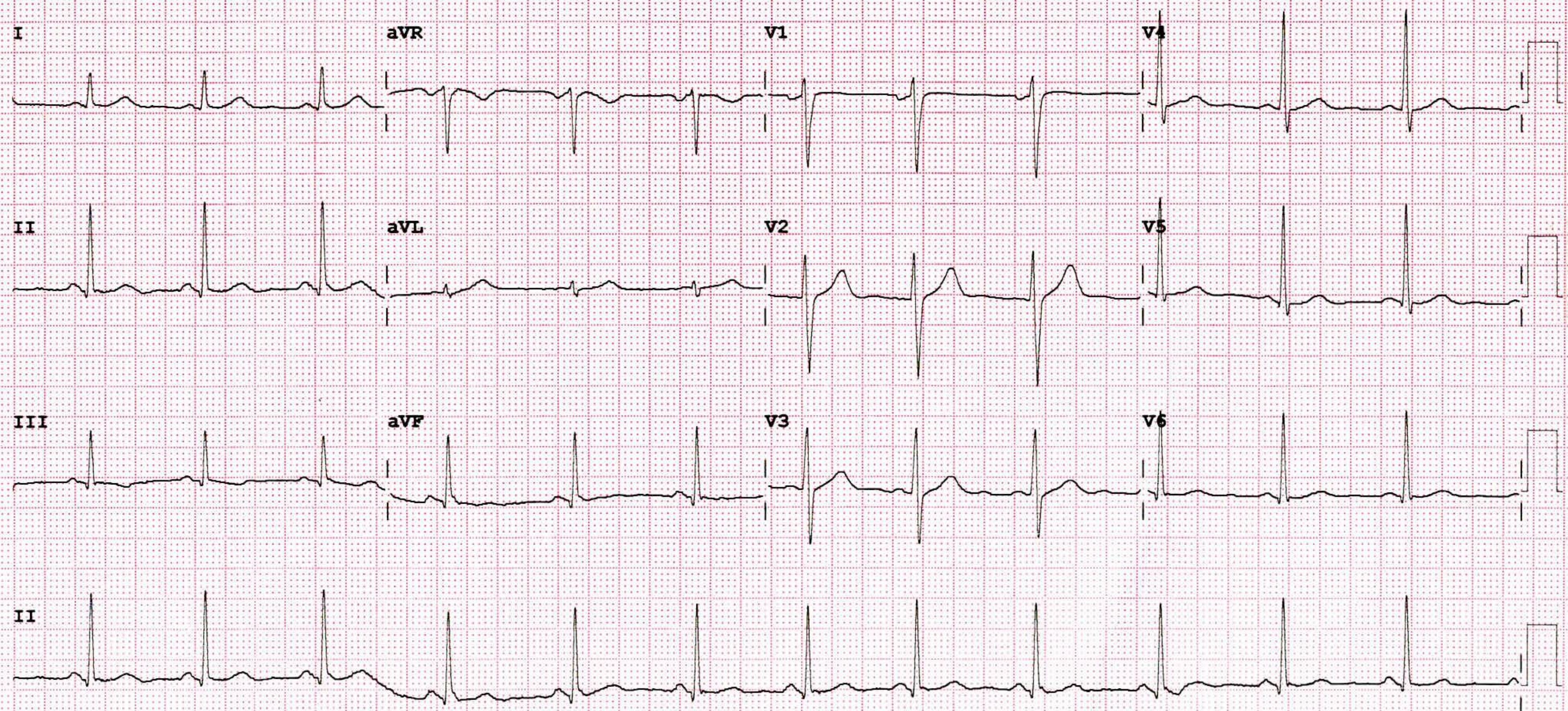
--AXIS--

P	61
QRS	61
T	13

- 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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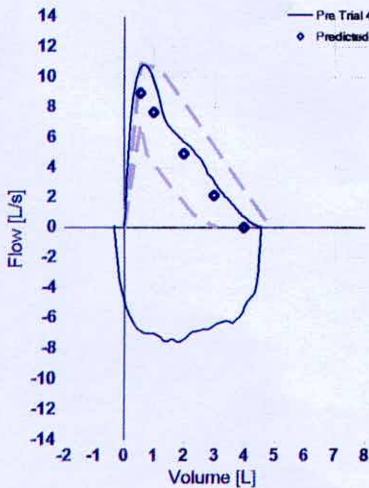
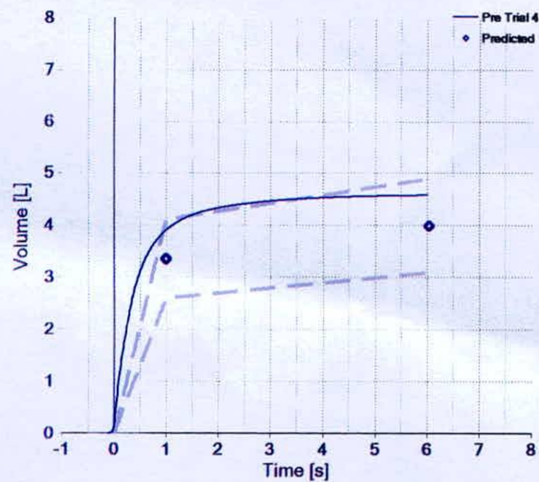
Patient Information		**Test Information**	
Name	SISTLA, SANTOSH KUMAR	Test Date	29-03-2024 11:51:49
ID	NMU0049385	Test Type	FVL (ex/in)
Age	35 (28-06-1988)	Post Time	
Height	168 cm	Interpretation	GOLD(2008)/Hardie
Weight	80 kg BMI 28.3	Predicted	ERS (ECCS/EGKS), 1993 * 0.90
Gender	Male		
Ethnicity	Asian	Referred by	HC

Your FEV1 / Predicted: 116%





Test Result

Parameter	Pred	Pre Best	%Pred
FVC [L]	3.98	4.57	115
FEV1 [L]	3.35	3.89	116
FEV1/FVC [%]	80.9	85.1	105
FEF25-75 [L/s]	4.45	4.20	94
PEF [L/s]	8.96	10.83	121
FET [s]	-	6.0	-
FIVC [L]	3.98	4.90	123
PIF [L/s]	-	7.63	-
FEF25 [L/s]	7.69	8.55	111
FEF50 [L/s]	4.93	5.10	103
FEF75 [L/s]	2.13	1.92	90

COMMENTS: WITHIN NORMAL LIMITS, CORRELATE CLINICALLY..

DR. SHAHID PATEL
MBBS,MD (Pulmonary Medicine)

MEDICOVER
HOSPITALS

Patient ID:	NMU0049385	Patient Name:	SANTOSH KUMAR SISILA
Age:	35 Years	Sex:	M
Accession Number:	NMBC64121	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	29-Mar-2024	Study Time:	09:40:34

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.

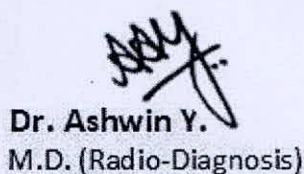
Visualised bowel loops appear normal. There is no free fluid seen.

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

IMPRESSION –

- **No significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQURE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



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

MEDICOVER
HOSPITALS

Patient ID:	NMU0049385	Patient Name:	SANTOSH KUMAR SISILA
Age:	35 Years	Sex:	M
Accession Number:	NMBC64121	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	29-Mar-2024		

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

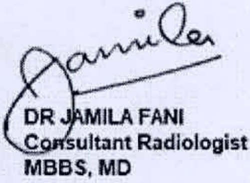
Both hilar shadows are normal in position and density.

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: 29-Mar-2024 18:32:21