MEDICOVER HOSPITALS

NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. NINAD NANDKUMAR HOMBALKAR	**Age /Gender**	: 35 Y(s)/Male
Bill No/ UMR No	: NMBC64159/NMU0049411	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 11:01 am	**Report Date**	: 29-Mar-24 06:07 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		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.020	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		NIL	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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Received Dt	: 29-Mar-24 11:01 am	**Report Date**	: 29-Mar-24 06:07 pm

Parameters	**Specimen**	**Result**	**Biological Reference In**	**Method**

*** End Of Report ***

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Bill No/ UMR No	: NMBC64159/NMU0049411	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 11:01 am	**Report Date**	: 29-Mar-24 02:15 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	EDTA Blood	4.91	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		14.4	13.0 - 17.0 g/dl	
PCV/HCT		42.5	40 - 50 %	
MCV		86.6	83 - 101 fl	
MCH		29.3	27 - 32 pg	
MCHC		33.8	31.5 - 34.5 g/dL	
RDW(cv)		13.2	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	EDTA Blood	325	150 - 400 10^3/µL	
MPV		9.4	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	8.5	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	65	40 - 80 %	
LYMPHOCYTES		26	20 - 40 %	
MONOCYTES		04	02 - 10 %	
EOSINOPHILS		05	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	25	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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Patient Name	: Mr. NINAD NANDKUMAR HOMBALKAR	**Age /Gender**	: 35Y(s)/Male
Bill No/ UMR No	: NMBC64159/NMU0049411	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 11:02 am	**Report Date**	: 29-Mar-24 02:12 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		95	Normal Range : 70 - 99 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		134.6	70 - 204 ng/dL	Method : ECLIA
T4		8.57	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.96	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		1.08	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		1.08	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		9.2	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		1.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.4	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.9	<= 1.0 mg/dL	
SGPT (ALT)		29	<= 41 U/L	Method : UV without P5P
SGOT (AST)		23	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		61	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		4.4	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.0	2.5 - 3.5 g/dL	
A/G RATIO		1.47	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		18	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

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Bill No/ UMR No	: NMBC64159/NMU0049411	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 11:01 am	**Report Date**	: 29-Mar-24 05:15 pm

Parameters	**Specimen**	**Result**	**Biological Reference In**	**Method**
LIPID PROFILE				
TOTAL CHOLESTEROL		161	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		32	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
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		20		
SERUM TRYGLYCERIDES		98	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		5.03	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.59		
SERUM URIC ACID		7.5	3.4 - 7.0 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		98	110 - 180 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.5	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		140	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. NINAD NANDKUMAR HOMBALKAR	**Age /Gender**	: 35Y(s)/Male
Bill No/ UMR No	: NMBC64159/NMU0049411	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 11:02 am	**Report Date**	: 30-Mar-24 09:41 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 026979

Test results related only to the item tested.

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HOSPITALS

Patient ID:	NMU0049411	Patient Name:	NINAD NANDKUMAR HOMBALKAR
Age:	35 Years	Sex:	M
Accession Number:	NMBC64159	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	29-Mar-2024	Study Time:	12:03:57

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

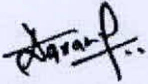
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

No significant abnormality is seen.



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 29-Mar-2024 15:33:46

MEDICOVER
HOSPITALS

Patient ID:	NMU0049411	Patient Name:	NINAD NANDKUMAR HOMBALKAR
Age:	35 Years	Sex:	M
Accession Number:	NMBC64159	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	29-Mar-2024	Study Time:	11:29:25

USG WHOLE ABDOMEN

LIVER is normal in size, normal in shape and shows bright 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.

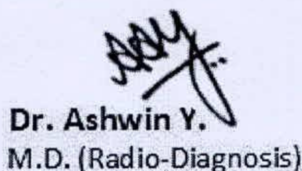
Visualised bowel loops appear normal. There is no free fluid seen.

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

IMPRESSION –

- **Grade I fatty liver.**
- **No other 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.

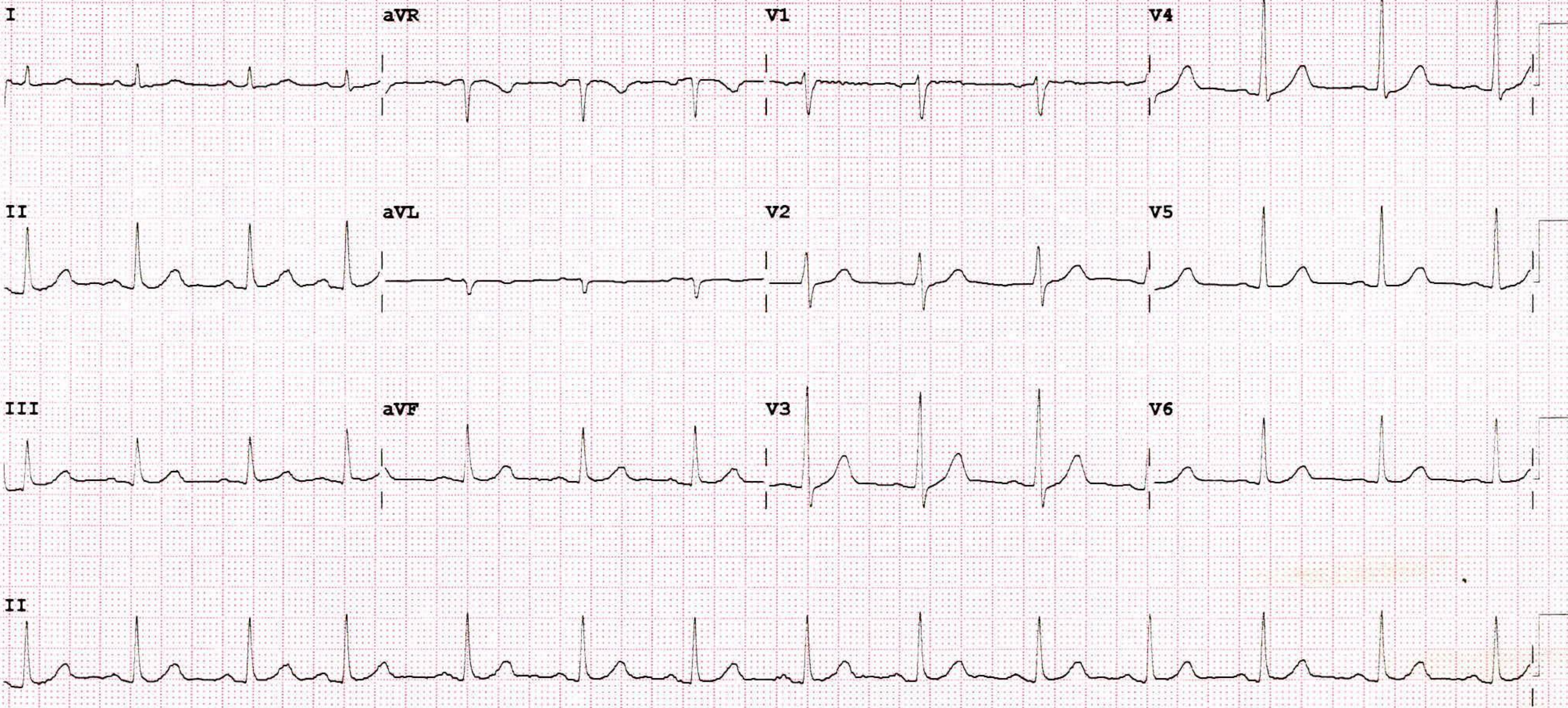


Dr. Ashwin Y.
M.D. (Radio-Diagnosis)

HC 49409 NINAD HOMMBALKAR 3/29/2024 1:54:41 PM
35 Years Male

Rate	81	. Sinus rhythm....................................normal P axis, V-rate 50- 99
		. Atrial premature complex........................SV complex w/ short R-R interval
PR	175	. ST elev, probable normal early repol pattern................ST elevation, age<55
QRSD	87	
QT	368	
QTc	428	
--AXIS--		
P	55	
QRS	78	- OTHERWISE NORMAL ECG -
T	70	

12 Lead; Standard Placement 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?

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name : **Mr. Ninad Hombalkar**	**Date:-29/03/2024**
Age / Sex : **35 Yrs / male**	**UMR No. 0049411**
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. 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	N			Nil
PULMONERY	4.4			Nil

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

NAVI MUMBAI

DATE: 29/03/24

PATIENT NAME: Mr. Ninad Hombalkar AGE / SEX : 35/m

UMR NO : NMU 00 49411

	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, Nc
	O	S	plano	———		6/6, Nc

HISTORY :

H/o HT on Rx :- 4 years.
No H/o DM / Thyroid.
No H/o spectacle use
No H/o Ocular Trauma (BE).

OCULAR FINDINGS :

(BE) – Ant seg WNL

(undilated) Disc < 0·3 / 0·3, Tilted.

ADVICE:

Refresh Tears e/d qid 1777 X 1 month.
Fundoscopy (BE)

Dr. ANUSHREE VANKAR

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