MEDICOVER HOSPITALS

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Rohan Sadashiv Suryagandh DATE: 29/3/24

AGE : 38yrs SEX: Male / Female

NMU: NMU000 49406 DOCTOR'S NAME: Health-Package

TEMP :	97.6 °f	BP :	130/81 mmHg
PULSE :	92 b/m	HEIGHT :	170 cm
RR :	20 b/m	WEIGHT :	81.8 kg
SPO2 :	100 % RA	HGT:	—

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 29/03/24

PATIENT NAME: Mr Rohan Suryagandh AGE / SEX : 38/m

UMR NO : NMMU0049406.

	RE	LE
VA (DISTANCE)	6/12p	6/12
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	-1.00	—		6/6, Nc
	O (L)	S.	-0.75	-0.50	80°	6/6, Nc

HISTORY :

- No H/O systemic illness (DM, HTN, thyroid) No H/O spectacle
- No H/O ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

. Ant seg </ BRwnc, dryness (+)

. Om - BRfull

ADVICE:

(1) e/d Zivifresh 1-1x (2) Day CBT (+)
(+) glass c CARC/ Blueblocks

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. ROHAN SADASHIV SURYAGANDH	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC64155/NMU0049406	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:39 am	**Report Date**	: 29-Mar-24 06:01 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	6-8	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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Patient Name	: Mr. ROHAN SADASHIV SURYAGANDH	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC64155/NMU0049406	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:39 am	**Report Date**	: 29-Mar-24 06:01 pm

Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. ROHAN SADASHIV SURYAGANDH	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC64155/NMU0049406	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:44 am	**Report Date**	: 29-Mar-24 03:12 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	7.46	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		15.2	13.0 - 17.0 g/dl	
PCV/HCT		47.6	40 - 50 % 36 - 46 %	
MCV		64	83 - 101 fl 83 - 101 fl	
MCH		20.4	27 - 32 pg	
MCHC		31.9	31.5 - 34.5 g/dL	
RDW(cv)		16.1	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	225	150 - 400 10^3/µL	
MPV		9.5	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.3	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	38	40 - 80 %	
LYMPHOCYTES		50	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		06	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisocytosis moderate poikilocytosis. 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	05	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. ROHAN SADASHIV SURYAGANDH	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC64155/NMU0049406	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:44 am	**Report Date**	: 29-Mar-24 03:08 pm

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. ROHAN SADASHIV SURYAGANDH	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC64155/NMU0049406	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:44 am	**Report Date**	: 29-Mar-24 02:14 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		134	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.81	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		13	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.81	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		16.0	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)		23	<= 41 U/L	Method : UV without P5P
SGOT (AST)		22	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		76	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		4.9	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.1	2.5 - 3.5 g/dL	
A/G RATIO		1.58	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		32	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		13	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		220	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. ROHAN SADASHIV SURYAGANDH	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC64155/NMU0049406	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:44 am	**Report Date**	: 29-Mar-24 05:14 pm

Parameters	Specimen	Result	Biological Reference In	Method
HDL CHOLESTEROL		45	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		145	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		59		
SERUM TRYGLYCERIDES		294	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.89	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.22		
SERUM URIC ACID		6.4	3.4 - 7.0 mg/dL	uricase
T3,T4 AND TSH				
T3		89.74	70 - 204 ng/dL	Method : ECLIA
T4		5.09	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.37	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		206	110 - 180 mg/dL	Hexokinase
URINE SUGAR		(+)		Dipstick
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		7.6	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		171	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. ROHAN SADASHIV SURYAGANDH	**Age /Gender**	: 38 Y(s)/Male
Bill No/ UMR No	: NMBC64155/NMU0049406	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:44 am	**Report Date**	: 30-Mar-24 09:41 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 026979

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MEDICOVER HOSPITALS

Patient ID:	*NMU0049406*	*Patient Name:*	*ROHAN SADASHIV SURYAGANDH*
Age:	*38 Years*	*Sex:*	*M*
Accession Number:	*NMBC64155*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*29-Mar-2024*	*Study Time:*	*11:16:26*

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)

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Rohan.

S/B :- Dr. Mandira kamble

O/E :- Stain+ Calculus++.

Advice :- oral prophylaxis.

mskamble

Dr Mandira Sushil Kamble
MDS In Conservative Dentistry And Endodontics
Reg. No. A-43262

MEDICOVER
HOSPITALS

Patient ID:	*NMU0049406*	*Patient Name:*	*ROHAN SADASHIV SURYAGANDH*
Age:	*38 Years*	*Sex:*	*M*
Accession Number:	*NMBC64155*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*29-Mar-2024*	*Study Time:*	*11:22:45*

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)

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: Mr. Rohan Suryagandh	Date:-29/03/2024
Age / Sex	: 38 Yrs / male	UMR No. 0049406
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 = 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 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			Nil
AORTIC	7			Nil
TRICUSPID	20			Trivial
PULMONERY	4.4			Nil

HC 49406 ROHAN SURYAGANDH 3/29/2024 1:26:52 PM
38 Years Male

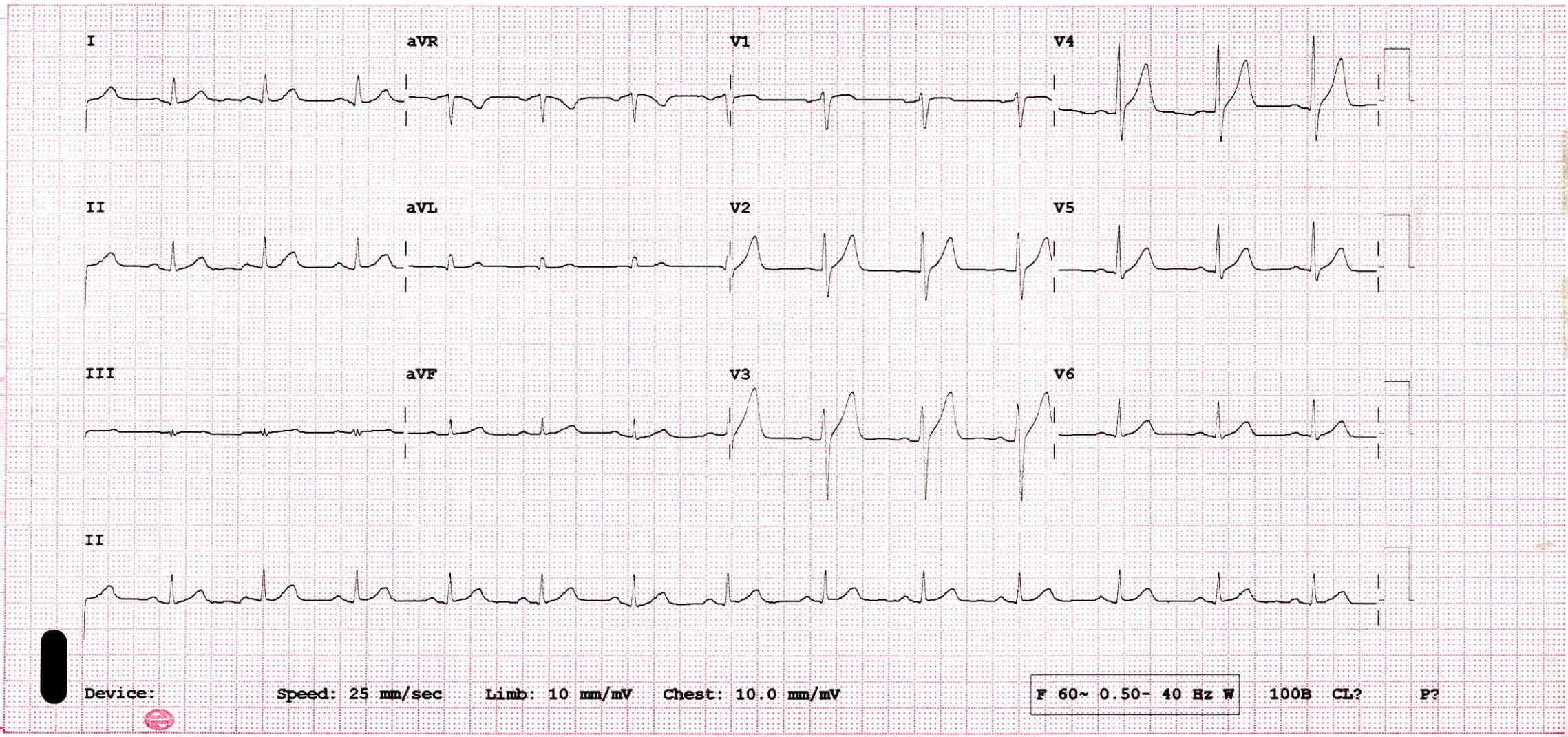
Rate	82	. Sinus rhythm	normal P axis, V-rate 50- 99
		. Abnormal R-wave progression, early transition	QRS area>0 in V2
PR	148	. ST elevation, consider anterior injury	ST >0.15mV, V1-V5
QRSD	95		
QT	348		
QTc	407		

--AXIS--
P 42
QRS 27
T 43

- ABNORMAL ECG -

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?