

NMD0050316
37 Years

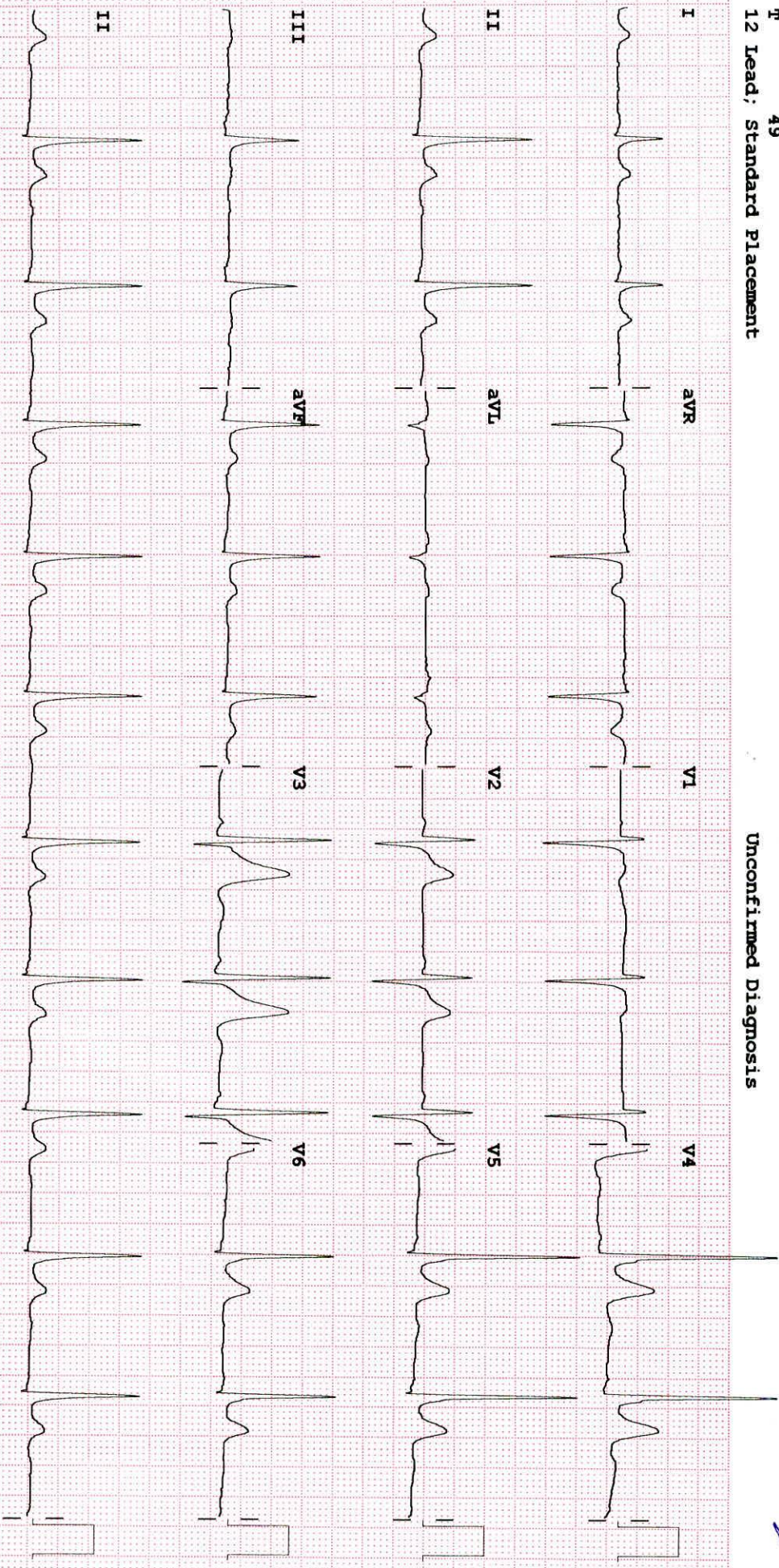
ANIL ~~DEWAR~~ BHUIR
Male

4/8/2024 8:36:49 AM

Rate 65 . Sinus rhythm.....normal P axis, V-rate 50-99
PR 142 . Abnormal R-wave progression, early transition.....QRS area>0 in V2
QRSD 88 . Left ventricular hypertrophy.....multiple voltage criteria
QT 356 . ST elevation suggests acute pericarditis.....ST >0.10mV, ant/lat/inf
QTc 371 . Baseline wander in lead(s) V6

--AXIS--
P -18
QRS 70
T 49

12 Lead; Standard Placement
Unconfirmed Diagnosis
- ABNORMAL ECG -



Handwritten notes:
P-R-T
V1-V6
ST
T
V6
V5
V4
V3
V2
V1
aVR
aVL
aVF
III
II
I

Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV P 60 ~ 0.50 - 40 Hz W 100B CL P2

Patient ID:	NMU0050316	Patient Name:	ANIL SUDAM BHOIR
Age:	37 Years	Sex:	M
Accession Number:	NMBC65536	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	08-Apr-2024	Study Time:	08:21:04

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. SUYOG SANGALE
MBBS DMRE
CONSULTANT RADIOLOGIST

Patient ID:	NMU0050316	Patient Name:	ANIL SUDAM BHOIR
Age:	37 Years	Sex:	M
Accession Number:	NMBC65536	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	08-Apr-2024	Study Time:	09:36:34

ULTRASOUND EXAMINATION OF ABDOMEN & PELVIS

The Liver is normal in size (13.7 cm) and shows mild increase in parenchymal reflectivity. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. 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.

The spleen is normal size. It measures 9.3 cm in long axis. No focal lesion is seen.

Both kidneys are normal in position and size. They show normal cortical reflectivity and cortico-medullary distinction.

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 Prostate gland is normal in size.
It has smooth outlines and normal reflectivity.

IMPRESSION:

- Grade I fatty liver.
- No other significant abnormality is seen.



DR. SUYOG SANGALE
MBBS DMRE
CONSULTANT RADIOLOGIST



DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 8/4/24

PATIENT NAME: Mr. Anil Bhoir

AGE / SEX: NAVI MUMBAI

UMR NO: NMU 0050316

37/m

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

		SPHERE	CYLINDER	AXIS	VA	
MRx	O D	-0.75	_____		6/6	N6
	O S	-0.75	-0.25	10°	6/6	N6

HISTORY :

No h/o HT/Dm/Thyroid

No h/o ocular Trauma

No h/o spectacle use.

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc 0.4, deep cup, ? Thin superior rim
0.4, slightly deep cup

ADVICE:

Refresh Tears / Zivifresh e/d qid 1777X / month

AS
DR. ANUSHREE VANWANI





MEDICOVER
HOSPITALS

NAVI MUMBAI

Anil.

S/B:- Dr. Mandira Kamble

O/E:- Grossly decayed \bar{c} $\frac{6}{6}$

Caries \bar{c} $\frac{7}{76}$

Stain calculus \bar{c}

Advice:- Surgical extraction \bar{c} $\frac{6}{6}$

Restoration \bar{c} $\frac{7}{76}$

Oral prophylaxis

MfKamble

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





MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs ANIL SUDAM BHOIR

DATE: 08/04/24

AGE : 37y15

SEX: Male/ Female

NMU: NMU00050314

DOCTOR'S NAME:

HEALTH - PACKAGE

TEMP :	<u>96</u>	^o f	BP :	<u>130 / 90</u>	mmHg
PULSE :	<u>85</u>	b/m	HEIGHT :	<u>165</u>	cm
RR :	<u>18</u>	b/m	WEIGHT :	<u>59.3</u>	kg
SPO2 :	<u>100</u>	%	HGT:	<u>—</u>	

REMARK:

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name : Mr. Anil Bhoir

Date:-08/04/2024

Age / Sex : 37 Yrs / Male

UMR No. 0050316

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 = 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 MR & TR. No PH.
- Normal LV and RV systolic function.



DR. SAMEER VANKAR
MD DM CARDIOLOGY



MEDICOVER
HOSPITALS

NAVI MUMBAI

M-MODE MEASUREMENTS:

LA	34	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	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	5.1			Nil
TRICUSPID	25			Trivial
PULMONERY	4.1			Nil





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. ANIL SUDAM BHOIR	Age /Gender : 37 Y(s)/Male
Bill No/ UMR No : NMBC65536/NMU0050316	Referred By : Dr. DMO
Received Dt : 08-Apr-24 08:16 am	Report Date : 08-Apr-24 04:38 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
CUE(COMPLETE URINE EXAMINATION)				
<u>PHYSICAL EXAMINATION</u>				
VOLUME	Urine	25 ml		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
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 sulphur powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
<u>MICROSCOPIC EXAMINATION</u>				
PUS CELLS	Urine	2-3	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		1-2	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		
AMORPHOUS DEPOSITS		ABSENT		
MUCUS THREAD		ABSENT		

NOTE Microscopic examination of urine is carried out on centrifuged urinary sediment.

*** End Of Report ***





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. ANIL SUDAM BHOIR

Age / Gender : 37 Y(s)/Male

Bill No/ UMR No : NMBC65536/NMU0050316

Referred By : Dr. DMO

Received Dt : 08-Apr-24 08:16 am

Report Date : 08-Apr-24 04:38 pm

Parameters

Specimen

Result

Biological Reference In Method





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. ANIL SUDAM BHOIR	Age / Gender : 37 Y(s)/Male
Bill No/ UMR No : NMBC65536/NMU0050316	Referred By : Dr. DMO
Received Dt : 08-Apr-24 08:16 am	Report Date : 08-Apr-24 11:08 am

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
ESR	CITRATED BLOOD	06	0 - 10 mm/1st hour	WESTERGREN'S METHOD

COMPLETE BLOOD COUNT

RBC

Parameter	Specimen	Result	Biological Reference Intervals
R B C COUNT	EDTA Blood	4.88	4.5 - 5.5 $10^6/\mu\text{L}$
HEMOGLOBIN		14.0	13.0 - 17.0 g/dl
PCV/HCT		41.9	40 - 50 %
MCV		86.0	83 - 101 fl
MCH		28.8	27 - 32 pg
MCHC		33.5	31.5 - 34.5 g/dL
RDW(cv)		13.4	11.6 - 14.0 %

PLATELETS

PLATELET COUNT	EDTA Blood	194	150 - 400 $10^3/\mu\text{L}$
MPV		9.0	7.5 - 11.5 fl

WBC

TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	7.23	4.0 - 11.0 $10^3/\mu\text{l}$
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DIFFERENTIAL COUNT

NEUTROPHILS	EDTA Blood	64	40 - 80 %
LYMPHOCYTES		29	20 - 40 %
MONOCYTES		03	02 - 10 %
EOSINOPHILS		04	00 - 06 %
BASOPHILS		00	00 - 01 %

*** End Of Report ***





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. ANIL SUDAM BHOIR	Age /Gender : 37 Y(s)/Male
Bill No/ UMR No : NMBC65536/NMU0050316	Referred By : Dr. DMO
Received Dt : 08-Apr-24 08:16 am	Report Date : 08-Apr-24 11:08 am

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C	Whole Blood	5.3	< 5.7 Normal Prediabetic 5.7 - 6.4 & \geq 6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		105	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
SERUM CREATININE				
CREATININE		0.88	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.88	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		9.0	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	\leq 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	\leq 1.0 mg/dL	
SGPT (ALT)		21	\leq 41 U/L	Method : UV without P5P
SGOT (AST)		17	\leq 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		7.5	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.6	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.59	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		20	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.5	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. ANIL SUDAM BHOIR	Age / Gender : 37 Y(s)/Male
Bill No/ UMR No : NMBC65536/NMU0050316	Referred By : Dr. DMO
Received Dt : 08-Apr-24 08:16 am	Report Date : 08-Apr-24 12:57 pm

Parameters	Specimen	Result	Biological Reference In	Method
TOTAL CHOLESTEROL		197	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		27	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		94	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
SERUM TRYGLYCERIDES		418	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		7.3	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.48		
NOTE		VLDL Cholesterol could not be calculated, as the value of triglycerides obtained is more than 400 mg/dL.		
SERUM URIC ACID		4.8	3.4 - 7.0 mg/dL	uricase
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		80	Normal Range : 70 - 99 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		97.80	70 - 204 ng/dL	Method : ECLIA
T4		6.46	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.31	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		108	110 - 180 mg/dL	Hexokinase
URINE SUGAR		Absent		Dipstick

*** End Of Report ***





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mr. ANIL SUDAM BHOIR	Age / Gender : 37 Y(s)/Male
Bill No/ UMR No : NMBC65536/NMU0050316	Referred By : Dr. DMO
Received Dt : 08-Apr-24 11:26 am	Report Date : 10-Apr-24 08:27 am

Parameter **Specimen** **Result Values** **Biological Reference** **Method**

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head of Laboratory Services

Verified By : : 026979

Test results related only to the item tested.

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