

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Manisho Patil

DATE: 29/3/24

AGE : 32yrs

SEX: Male/Female

NMU: NMU000 49394

DOCTOR'S NAME:

Health - Package

TEMP :	<u>96.8</u>	° f	BP :	<u>96/71</u>	mmHg
PULSE :	<u>91</u>	b/m	HEIGHT :	<u>160</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>71.2</u>	kg
SPO2 :	<u>98 %</u>	<u>RA</u>	HGT:	<u>—</u>	

REMARK:



DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 29/03/24

PATIENT NAME: Mrs. Manisha Patil

AGE / SEX:

NAVI MUMBAI

UMR NO: NMMU 0049394

33/F

	RE	LE
VA (DISTANCE)	6/6	6/6
VA (NEAR)	NG (CB)	NG (CB)
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O D (R)		plano	_____		6/6, NC
	O S (L)		plano	_____		6/6, NC

HISTORY :

No h/o HT / DM / Thyroid

No h/o spectacle use

No h/o ocular Trauma (BE)

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc \leftarrow 0.3
0.3

ADVICE:

Refresh Tears eld qid 1777 X 1 month

Dr
CDR. ANUSHREE VANWAR





MEDICOVER
HOSPITALS

NAVI MUMBAI

Manisha Patil -

8/B :- Dr. Mandira Kamble

O/E :- Stain⁺ Calculus⁺

Advice :- Oral prophylaxis.

M Kamble

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





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. MANISHA SACHIN PATIL	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : NMBC64137/NMU0049394	Referred By : Dr. DMO
Received Dt : 29-Mar-24 10:05 am	Report Date : 29-Mar-24 06:35 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	30ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
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 sulphur powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
<u>MICROSCOPIC EXAMINATION</u>				
PUS CELLS	Urine	8-10	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		3-4	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
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.		





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. MANISHA SACHIN PATIL	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : NMBC64137/NMU0049394	Referred By : Dr. DMO
Received Dt : 29-Mar-24 10:05 am	Report Date : 29-Mar-24 06:35 pm

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

*** End Of Report ***





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. MANISHA SACHIN PATIL	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : NMBC64137/NMU0049394	Referred By : Dr. DMO
Received Dt : 29-Mar-24 10:05 am	Report Date : 29-Mar-24 03:16 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.59	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		11.3	12.0 - 15.0 g/dl	
PCV/HCT		35.4	40 - 50 % 36 - 46 %	
MCV		77	83 - 101 fl 83 - 101 fl	
MCH		24.6	27 - 32 pg	
MCHC		31.8	31.5 - 34.5 g/dL	
RDW(cv)		15.2	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	308	150 - 400 $10^3/\mu\text{L}$	
MPV		7.7	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.8	4.0 - 11.0 $10^3/\mu\text{l}$	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	54	40 - 80 %	
LYMPHOCYTES		38	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC			Mild anisopoikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes and some target cells.	
WBC			Normal morphology.	
PLATELETS			Adequate in smear.	
ADVISED			Serum iron studies.	
ESR	CITRATED BLOOD	35	0 - 20 mm/1st hour	WESTERGREN'S METHOD

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. MANISHA SACHIN PATIL	Age / Gender : 33 Y(s)/Female
Bill No/ UMR No : NMBC64137/NMU0049394	Referred By : Dr. DMO
Received Dt : 29-Mar-24 10:05 am	Report Date : 29-Mar-24 03:06 pm

Parameters

Specimen

Result

Biological Reference In Method





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. MANISHA SACHIN PATIL	Age /Gender : 33 Y(s)/Female
Bill No/ UMR No : NMBC64137/NMU0049394	Referred By : Dr. DMO
Received Dt : 29-Mar-24 10:05 am	Report Date : 29-Mar-24 02:11 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
SERUM CREATININE				
CREATININE		0.57	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.57	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		14.0	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		15	<= 33 U/L	Method : UV without P5P
SGOT (AST)		16	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		80	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.6	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.2	3.5 - 5.2 g/dL	Method : Bromocresol Green (BCG)
GLOBULINS		3.4	2.5 - 3.5 g/dL	
A/G RATIO		1.24	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		17	6 - 42 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		7.6	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		172	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		45	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. MANISHA SACHIN PATIL	Age /Gender : 33 Y(s)/Female
Bill No/ UMR No : NMBC64137/NMU0049394	Referred By : Dr. DMO
Received Dt : 29-Mar-24 10:05 am	Report Date : 29-Mar-24 02:59 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
LDL CHOLESTEROL		109	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		27		
SERUM TRYGLYCERIDES		136	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.82	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.42		
SERUM URIC ACID		4.6	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		125.8	70 - 204 ng/dL	Method : ECLIA
T4		9.00	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.91	0.270 - 4.20 uIU/mL	Method : ECLIA
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		84	Normal Range : 70 - 99 mg/dL	Hexokinase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		99	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.7	< 5.7 Normal Prediabetic 5.7 - 6.4 & >=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		117	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. MANISHA SACHIN PATIL	Age /Gender : 33 Y(s)/Female
Bill No/ UMR No : NMBC64137/NMU0049394	Referred By : Dr. DMO
Received Dt : 29-Mar-24 10:05 am	Report Date : 30-Mar-24 09:42 am

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

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Consultant Hematology Services

Verified By : : 022443

Test results related only to the item tested.

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Patient ID:	NMU0049394	Patient Name:	MANISHA SACHIN PATIL
Age:	33 Years	Sex:	F
Accession Number:	NMBC64137	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	29-Mar-2024	Study Time:	11:08:43

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, normal in shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal 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. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal.

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

UTERUS is retroverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures – 5- 6 mm.

Both ovaries are normal in size, shape and position.

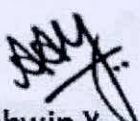
Visualised bowel loops appear normal. There is no free fluid seen.

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 REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



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

<i>Patient ID:</i>	<i>NMU0049394</i>	<i>Patient Name:</i>	<i>MANISHA SACHIN PATIL</i>
<i>Age:</i>	<i>33 Years</i>	<i>Sex:</i>	<i>F</i>
<i>Accession Number:</i>	<i>NMBC64137</i>	<i>Modality:</i>	<i>DX</i>
<i>Referring Physician:</i>	<i>DR.DMO</i>	<i>Study:</i>	<i>CHEST</i>
<i>Study Date:</i>	<i>29-Mar-2024</i>	<i>Study Time:</i>	<i>10:58:38</i>

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)

MANISHA PATIL
Female

HC 49394
33 Years

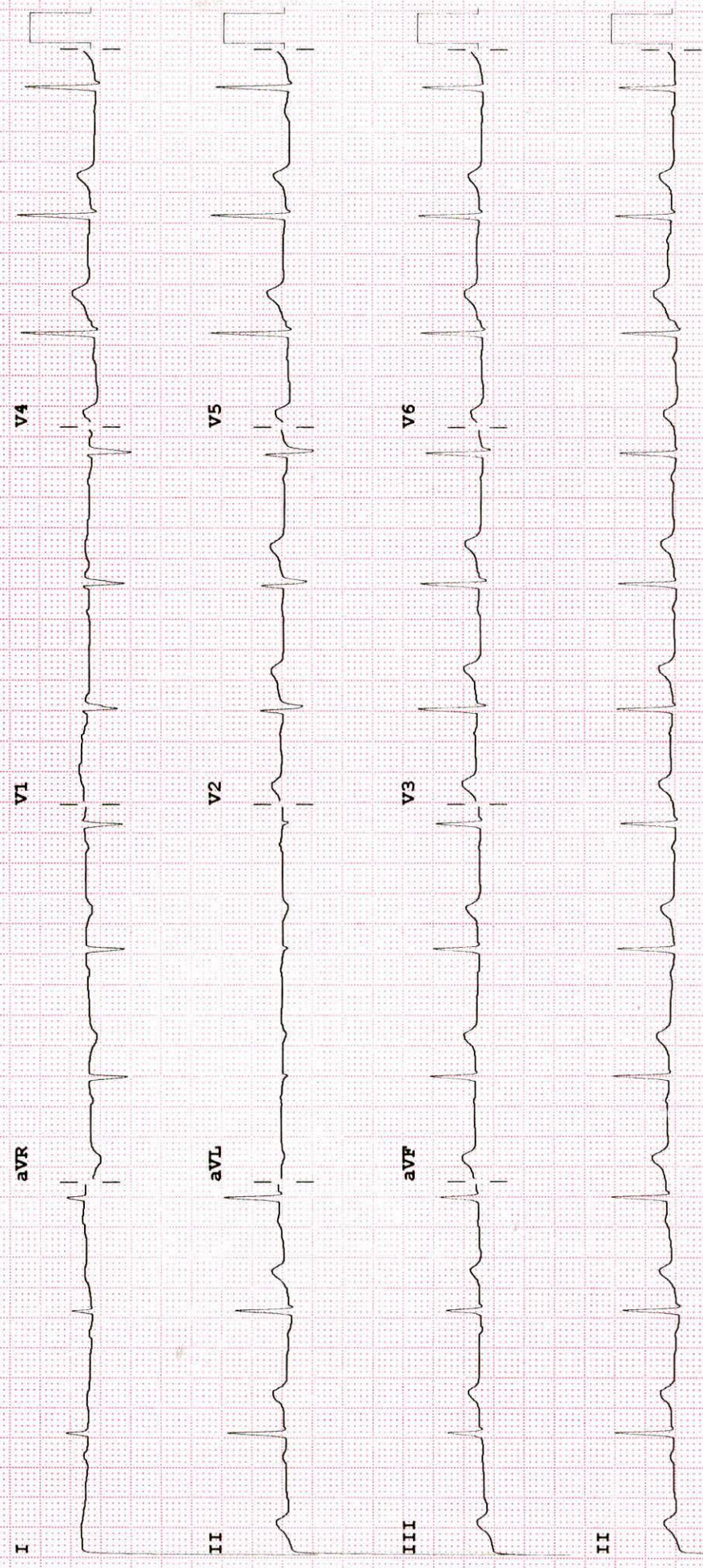
V12
20B13
3

Rate 74 . Sinus rhythm.....normal P axis, V-rate 50- 99
PR 176 . Nonspecific T abnormalities, lateral leads.....T <-0.10mV, I aVL V5 V6
QRS 81 . Baseline wander in lead(s) I, II, III, aVR, aVL
QT 391
QTc 434

--AXIS--
P 6
QRS 69
T 76
12 Lead; Standard Placement

Unconfirmed Diagnosis

- ABNORMAL ECG -





MEDICOVER
HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name : Mrs. Manisha Patil

Date:-29/03/2024

Age / Sex : 33 Yrs / Female

UMR No. 0049392

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.
- Mild mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 24 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.
- Mild MR. Trivial 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	28	mm
AO CUSP SEP	17	mm
LVID(s)	31	mm
LVID(d)	44	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Mild
AORTIC	7			Nil
TRICUSPID	24			Trivial
PULMONERY	4.4			Nil

