MEDICOVER HOSPITALS

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MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Pranchi vttam Gurav DATE: 29/3/24

AGE : 40yrs SEX: Male/Female

NMU: NMU000 49407 DOCTOR'S NAME:

TEMP :	97.6 °f	BP :	110/76 mmHg
PULSE :	69 b/m	HEIGHT :	150.3 cm
RR :	20 b/m	WEIGHT :	49.1 kg
SPO2 :	100 %	HGT:	—

REMARK:

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 29/03/24

PATIENT NAME: Mrs Preethi gurav AGE / SEX: 40/F

UMR NO: NMMU049407.

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	+ −	0.50	170°	6/6
	O (L)	S	+	0.50	20°	6/6

HISTORY :

- H/O Using spectacle currently use occasionally.
- NO H/O Systemic Illness (DM, HTN). NO H/O ocular trauma, Allergies.

OCULAR FINDINGS :

(BE) – Ant seg WNL

(undilated) Disc < 0.2
0.3

ADVICE:

Refresh Tears eld qid 1777 x 1 months

AS
CDR. ANUSHREE VANKAR

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Prachi.

S/B:- Dr. mandira kamble -

O/E:- Caries - $\frac{}{8|8}$.

Dep caries - $\frac{}{|7}$

Grossly decayed - $\frac{|8}{6|}$

Stain & calculus ++

Advice:- oral prophylaxis.

Surgical extraction - $\frac{|8}{6|}$

Restoration - $\frac{}{8|8}$

RCT - $\frac{}{|7}$?

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

mskamble

MEDICOVER HOSPITALS

Patient ID:	*NMU0049407*	*Patient Name:*	*PRACHI UTTAM GURAV*
Age:	*40 Years*	*Sex:*	*F*
Accession Number:	*NMBC64150*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*29-Mar-2024*	*Study Time:*	*11:56:42*

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 15:33:56

MEDICOVER HOSPITALS

Patient ID:	*NMU0049407*	*Patient Name:*	*PRACHI UTTAM GURAV*
Age:	*40 Years*	*Sex:*	*F*
Accession Number:	*NMBC64150*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*29-Mar-2024*	*Study Time:*	*10:56:51*

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 anteverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures – 6.0 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.**

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

MEDICOVER HOSPITALS

Patient ID:	*NMU0049407*	*Patient Name:*	*PRACHI GURAV 40YRS/F*
Age:		*Sex:*	*F*
Accession Number:		*Modality:*	*CR*
Referring Physician:		*Study:*	*BREAST*
Study Date:	*29-Mar-2024*		

X-RAY MAMMOGRAPHY

INDICATION: Routine screening.

MAMMOGRAPHY

Bilateral mammograms were obtained in the oblique mediolateral and craniocaudad projections.
The film markers are placed on the axillary / lateral part of the breast.
Both breasts display scattered areas of fibroglandular density, which limits the mammographic evaluation (ACR category b).
There is no focal spiculated mass lesion seen.
There are no clusters of microcalcification, distortion of the lobular architecture or nipple retraction.
Skin and subcutaneous tissues are normal.

IMPRESSION :-

No significant abnormality is seen.
BIRADS Category I (Negative)
Suggest a routine screening mammography after one year.
*(**BIRADS CATEGORY :** BIRADS O - Requires additional evaluation, I - Negative, II - Benign findings, III - Probably benign findings, IV - Suspicious abnormality, V - Highly suggestive of malignancy, VI - Known biopsy proven malignancy.)*

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 29-Mar-2024 18:06:55

MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PRACHI UTTAM GURAV	**Age /Gender**	: 40 Y(s)/Female
Bill No/ UMR No	: NMBC64150/NMU0049407	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:27 am	**Report Date**	: 29-Mar-24 05:58 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	1.020	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	3-4	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
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PRACHI UTTAM GURAV	**Age /Gender**	: 40 Y(s)/Female
Bill No/ UMR No	: NMBC64150/NMU0049407	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:27 am	**Report Date**	: 29-Mar-24 05:58 pm

Parameters	Specimen	Result	Biological Reference In	Method

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PRACHI UTTAM GURAV	**Age /Gender**	: 40 Y(s)/Female
Bill No/ UMR No	: NMBC64150/NMU0049407	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:27 am	**Report Date**	: 29-Mar-24 03:07 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	25	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	EDTA Blood	4.38	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		13.1	12.0 - 15.0 g/dl	
PCV/HCT		39.2	40 - 50 %	
MCV		89.6	83 - 101 fl	
MCH		29.9	27 - 32 pg	
MCHC		33.3	31.5 - 34.5 g/dL	
RDW(cv)		13.4	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	EDTA Blood	385	150 - 400 10^3/µL	
MPV		9.2	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	4.74	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	63	40 - 80 %	
LYMPHOCYTES		33	20 - 40 %	
MONOCYTES		03	02 - 10 %	
EOSINOPHILS		01	00 - 06 %	
BASOPHILS		00	00 - 01 %	

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PRACHI UTTAM GURAV	**Age /Gender**	: 40 Y(s)/Female
Bill No/ UMR No	: NMBC64150/NMU0049407	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:27 am	**Report Date**	: 29-Mar-24 02:11 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM	Serum	141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.5	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		104	98 - 107 mmol/L	ISE INDIRECT
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		88	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.55	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		0.55	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		14.5	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)		23	<= 33 U/L	Method : UV without P5P
SGOT (AST)		25	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		88	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.2	2.5 - 3.5 g/dL	
A/G RATIO		1.41	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		18	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PRACHI UTTAM GURAV	**Age /Gender**	: 40 Y(s)/Female
Bill No/ UMR No	: NMBC64150/NMU0049407	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:27 am	**Report Date**	: 29-Mar-24 05:03 pm

Parameters	Specimen	Result	Biological Reference In	Method
LIPID PROFILE				
TOTAL CHOLESTEROL		225	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		61	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		154	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		15		
SERUM TRYGLYCERIDES		76	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.69	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.52		
SERUM URIC ACID		4.4	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		114.9	70 - 204 ng/dL	Method : ECLIA
T4		5.90	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.27	0.270 - 4.20 uIU/mL	
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		96	110 - 180 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.9	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		123	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. PRACHI UTTAM GURAV	**Age /Gender**	: 40 Y(s)/Female
Bill No/ UMR No	: NMBC64150/NMU0049407	**Referred By**	: Dr. DMO
Received Dt	: 29-Mar-24 10:27 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

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2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: **Mrs. Prachi Gurav**	**Date:-29/03/2024**
Age / Sex	: **41 Yrs / Female**	**UMR No. 0049407**
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 = 22 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	22			Trivial
PULMONERY	4.4			Nil

HC 49407 PRACHI GURAV 3/29/2024 12:36:31 PM
40 Years Female

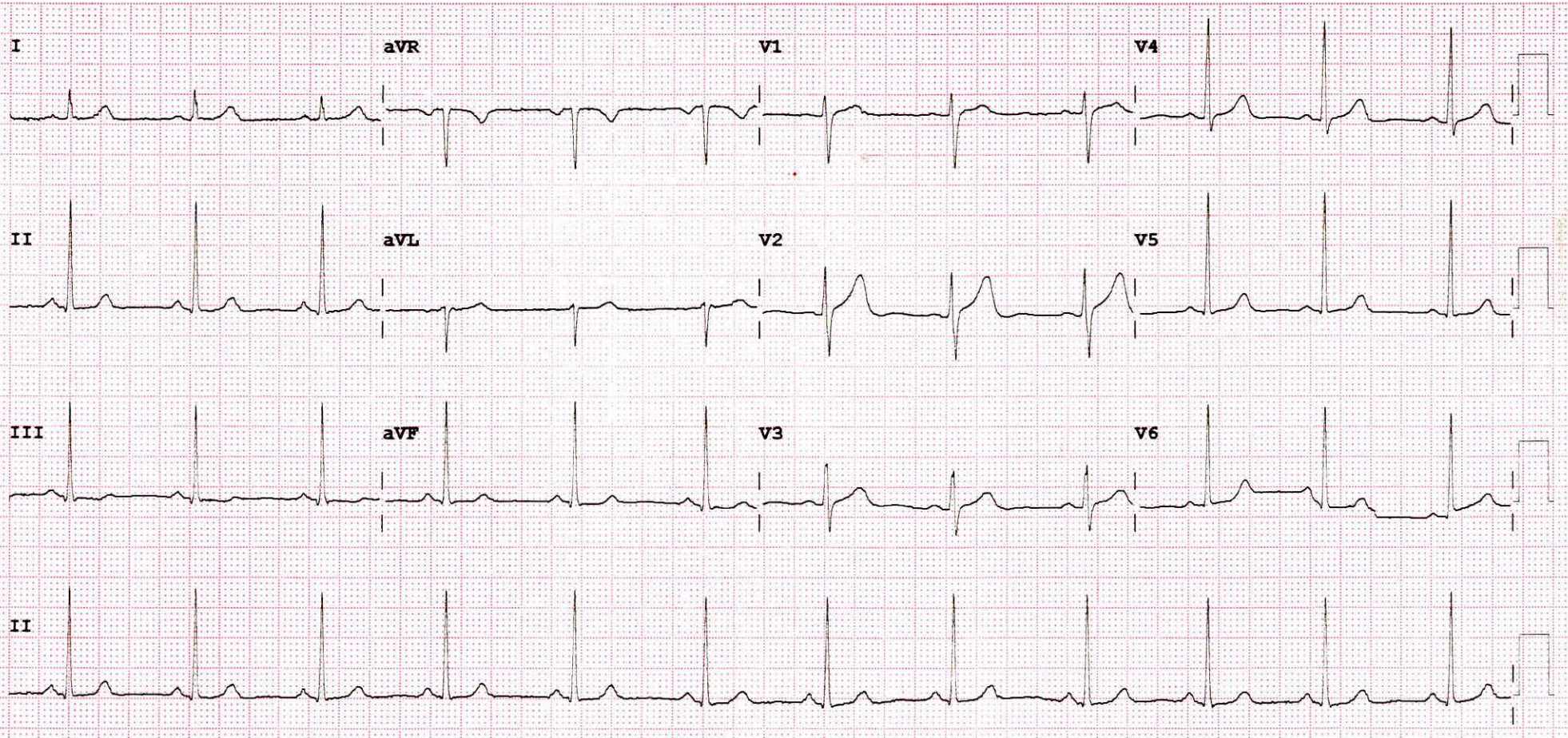
Rate 72 . Sinus rhythm.....normal P axis, V-rate 50- 99
. ST elev, probable normal early repol pattern.....ST elevation, age<55

PR 138
QRSD 87
QT 356
QTc 390

--AXIS--
P 80
QRS 72
T 19

- 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?