MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. Padmaja Tushar Mishra	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60857/NMU0047234	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 10:41 am	**Report Date**	: 09-Mar-24 06:33 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	20 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.015	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	1-2	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		4-6	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.		

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Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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Bill No/ UMR No	: NMBC60857/NMU0047234	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 10:41 am	**Report Date**	: 09-Mar-24 01:59 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.33	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		12.7	12.0 - 15.0 g/dl	
PCV/HCT		37.6	40 - 50 % 36 - 46 %	
MCV		87	83 - 101 fl 83 - 101 fl	
MCH		29.5	27 - 32 pg	
MCHC		33.9	31.5 - 34.5 g/dl	
RDW(cv)		13.2	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	130	150 - 400 10^3/µL	
MPV		11.5	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.9	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	57	40 - 80 %	
LYMPHOCYTES		33	20 - 40 %	
MONOCYTES		04	02 - 10 %	
EOSINOPHILS		06	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Predominantly normocytic normochromic.		
WBC		Normal morphology.		
PLATELETS		Mildly reduced in smear. Macroplatelets and giant platelets are also seen.		
ESR	CITRATED BLOOD	40	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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Bill No/ UMR No	: NMBC60857/NMU0047234	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 10:41 am	**Report Date**	: 09-Mar-24 05:13 pm

TUBE AGGLUTINATI

Parameters	Specimen	Result

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. Padmaja Tushar Mishra	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60857/NMU0047234	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 10:41 am	**Report Date**	: 09-Mar-24 01:57 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.6	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		92	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		132.7	70 - 204 ng/dl	
T4		6.29	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.85	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.58	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		10	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.58	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		17.2	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		14	<= 33 U/L	Method : UV without P5P
SGOT (AST)		18	<= 32 U/L	
ALKALINE PHOSPHATASE (ALP)		60	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		4.9	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.7	2.5 - 3.5 g/dL	
A/G RATIO		1.81	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		11	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. Padmaja Tushar Mishra	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60857/NMU0047234	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 10:41 am	**Report Date**	: 09-Mar-24 05:02 pm

Specimen

BUN(BLOOD UREA NITROGEN)			
BUN (Blood Urea Nitrogen.)	10	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	182	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL	50	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL	123	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	12		
SERUM TRYGLYCERIDES	61	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO	3.64	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO	2.46		
SERUM URIC ACID	4.1	2.4 - 5.7 mg/dL	uricase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)			
HBA1C	5.5	< 5.7 Normal Prediabetic 5.7 TINIA - 6.4 & >/=6.5 Diabetic %	
MPG(Mean Plasma Glucose)	111	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)			
PLBS (POST LUNCH BLOOD GLUCOSE)	82	110 - 180 mg/dL	Hexokinase

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. Padmaja Tushar Mishra	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC60857/NMU0047234	**Referred By**	: Dr. DMO
Received Dt	: 09-Mar-24 01:18 pm	**Report Date**	: 11-Mar-24 08:44 am

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

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

Verified By : : 022633

Test results related only to the item tested.

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MEDICOVER HOSPITALS

Patient ID:	*NMU0047234*	*Patient Name:*	*Padmaja Tushar Mishra*
Age:	*35 Years*	*Sex:*	*F*
Accession Number:	*NMBC60857*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*09-Mar-2024*		

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 JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 10-Mar-2024 14:16:05

MEDICOVER HOSPITALS

Patient ID:	*NMU0047234*	*Patient Name:*	*Padmaja Tushar Mishra*
Age:	*35 Years*	*Sex:*	*F*
Accession Number:	*NMBC60857*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*09-Mar-2024*	*Study Time:*	*12:22:21*

USG ABDOMEN & PELVIS

The Liver is normal in size (15.5 cm) and shows grade I fatty change. 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 echotexture.

The spleen is normal size (9.0 cm). No focal lesion is seen.

Both kidneys are normal in size, shape and echotexture. They shows normal cortical echogenicity with maintained cortico-medullary distinction.
The Right Kidney measures 10.2 x 3.8 cm.
The Left Kidney measures 11.1 x 4.1 cm.
There is no evidence of a calculus, hydronephrosis, or hydroureter.

The Urinary bladder is adequately distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

The uterus is normal in size and echotexture. It measures 6.8 x 6.2 x 4.0 cm.
No focal lesion is seen. The Endometrial thickness is 13 mm.

Both ovaries are well visualized and appear normal in size and echotexture.
The Right ovary measures 2.5 x 2.2 cm
The Left ovary measures 2.3 x 1.5 cm
There is no evidence of any ovarian or adnexal mass lesion.

Visualised bowel loops are unremarkable.
There is no evidence of significant lymphadenopathy.
No ascitis is seen.

IMPRESSION:

- **Grade I fatty liver.**
- **No other significant abnormality detected**

DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

NMU0047234 PADMAJA MISHRA 3/9/2024 2:24:46 PM
35 Years Female

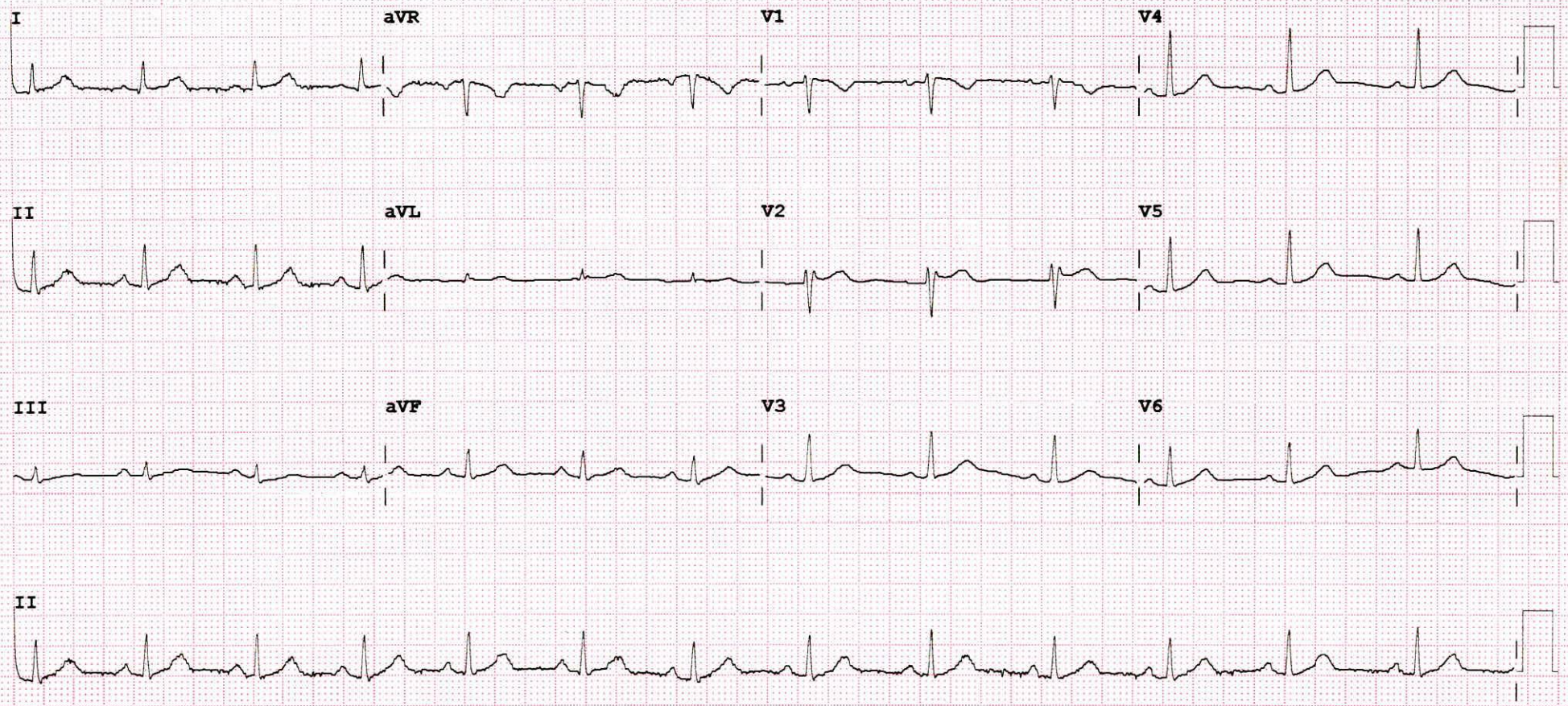
Rate 79 . Sinus rhythm.....normal P axis, V-rate 50- 99
. RSR' in V1 or V2, probably normal variant.....small R' only
PR 156
QRSD 88
QT 353
QTc 405

--AXIS--
P 70
QRS 45
T 44

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement Unconfirmed Diagnosis

NVR
RBB
2 am



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

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mrs. Padmaja Mishra**	**Date:-09/03/2024**
Age / Sex	: **35 Yrs /Female**	**UMR No. 0047234**
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 = 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 MR and TR. No PH.**
- **Normal LV and RV systolic function.**

DR. SAMEER VANKAR
MD DM CARDIOLOGY

M-MODE MEASURMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	5			Nil
TRICUSPID	20			Trivial
PULMONERY	4.4			Nil

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 09/03/24.
PATIENT NAME: Mrs. Padmaja Mishra AGE / SEX 51F
UMR NO : NAVI00.47234

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

			SPHERE	CYLINDER	AXIS	VA
MRx	O	D	-0.50	———	———	6/6 N6
	O	S	Plano	———	———	6/6 N6

HISTORY :

- NH/O systemic illness (DM, HTN). H/O long standing (Distance
- NH/O ocular surgical Allergies & surgeries.

OCULAR FINDINGS :

(BE) - Ant seg WNL

(Undilated) Disc < 0.2
0.2

ADVICE:

Yearly Eye Examination (BE)

DR. ANUSHREE VANKAR

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MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Padmaja Mishra DATE: 09/03/24

AGE : 35 Yrs/F SEX: Male/ Female

NMU: NMU00047234 DOCTOR'S NAME:

TEMP :	97.2 °f	**BP :**	110/80 mmHg
PULSE :	82 b/m	**HEIGHT :**	151 cm
RR :	20 b/m	**WEIGHT :**	53.3 kg
SPO2 :	98 %	**HGT:**	—

REMARK: