



**DEPARTMENT OF LABORATORY**

**NAVI MUMBAI**

**Patient Name** : Mr. PARAKH KISHORE  
**Age / Gender** : 31 Y(s)/Male  
**Bill No/ UMR No** : NMBC60815/NMU0047201  
**Referred By** : Dr. DMO  
**Received Dt** : 09-Mar-24 09:44 am  
**Report Date** : 09-Mar-24 06:26 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
<b>CUE(COMPLETE URINE EXAMINATION)</b>				
<b><u>PHYSICAL EXAMINATION</u></b>				
<b>VOLUME</b>	Urine	20 ML		
<b>COLOUR</b>		PALE YELLOW	PALE YELLOW	
<b>APPEARANCE</b>		SLIGHTLY HAZY	CLEAR	
<b>DEPOSIT</b>		ABSENT	ABSENT	
<b><u>CHEMICAL EXAMINATION</u></b>				
<b>SPECIFIC GRAVITY</b>	Urine	1.015	1.000 - 1.030	Dipstick
<b>PH</b>		6.0	5.0 - 8.0	Dipstick
<b>PROTEIN</b>		NEGATIVE	NEGATIVE	Dipstick/Heat coagulation test
<b>GLUCOSE</b>		ABSENT	ABSENT	Dipstick/Benedict's test
<b>UROBILINOGEN</b>		NORMAL	NORMAL	Dipstick
<b>KETONE</b>		NEGATIVE	NEGATIVE	Dipstick/Rothera's Nitroprusside test.
<b>BILIRUBIN</b>		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
<b>BILE SALT</b>		NEGATIVE	NEGATIVE	Hay's sulphur powder test
<b>BILE PIGMENT</b>		NEGATIVE	NEGATIVE	Fouchet test
<b>NITRITE</b>		NEGATIVE	NEGATIVE	Dipstick
<b>LEUCOCYTE ESTERASE</b>		NEGATIVE	NEGATIVE	
<b><u>MICROSCOPIC EXAMINATION</u></b>				
<b>PUS CELLS</b>	Urine	1-2	0 - 5 /hpf	MICROSCOPIC EXAMINATION
<b>RBC</b>		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
<b>EPITHELIAL CELLS</b>		0-1	0 - 5 /hpf	MICROSCOPIC EXAMINATION
<b>CRYSTALS</b>		NIL	NIL	MICROSCOPIC EXAMINATION
<b>CASTS</b>		NIL	NIL	MICROSCOPIC EXAMINATION
<b>BACTERIA</b>		ABSENT		MICROSCOPIC EXAMINATION
<b>YEAST</b>		ABSENT		MICROSCOPIC EXAMINATION
<b>AMORPHOUS DEPOSITS</b>		ABSENT		MICROSCOPIC EXAMINATION
<b>MUCUS THREAD</b>		PRESENT		MICROSCOPIC EXAMINATION
<b>NOTE</b>		Microscopic examination of urine is carried out on centrifuged urinary sediment.		





**MEDICOVER**  
HOSPITALS

**DEPARTMENT OF LABORATORY**

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<b>Bill No/ UMR No</b> : NMBC60815/NMU0047201	<b>Referred By</b> : Dr. DMO	
<b>Received Dt</b> : 09-Mar-24 09:44 am	<b>Report Date</b> : 09-Mar-24 06:26 pm	

Parameters                      Specimen    Result                      Biological Reference In Method  
\*\*\* End Of Report \*\*\*







**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mr. PARAKH KISHORE	<b>Age / Gender</b> : 31 Y(s)/Male	<b>NAVI MUMBAI</b>
<b>Bill No/ UMR No</b> : NMBC60815/NMU0047201	<b>Referred By</b> : Dr. DMO	
<b>Received Dt</b> : 09-Mar-24 09:44 am	<b>Report Date</b> : 09-Mar-24 01:13 pm	

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>COMPLETE BLOOD COUNT</b>				
<b>RBC</b>				
R B C COUNT	Blood	4.62	4.5 - 5.5 $10^6/\mu\text{L}$	
HEMOGLOBIN		14.2	13.0 - 17.0 g/dl	
PCV/HCT		40.4	40 - 50 %	
			36 - 46 %	
MCV		87	83 - 101 fl	
			83 - 101 fl	
MCH		30.8	27 - 32 pg	
MCHC		35.3	31.5 - 34.5 g/dL	
RDW(cv)		12.3	11.6 - 14.0 %	
<b>PLATELETS</b>				
PLATELET COUNT	Blood	279	150 - 400 $10^3/\mu\text{L}$	
MPV		9.6	7.5 - 11.5 fl	
<b>WBC</b>				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.6	4.0 - 11.0 $10^3/\mu\text{L}$	
<b>DIFFERENTIAL COUNT</b>				
NEUTROPHILS	Blood	56	40 - 80 %	
LYMPHOCYTES		33	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		04	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	26	0 - 10 mm/1st hour	WESTERGREN'S METHOD

\*\*\* End Of Report \*\*\*





**DEPARTMENT OF LABORATORY**

NAVI MUMBAI

<b>Patient Name</b> : Mr. PARAKH KISHORE	<b>Age / Gender</b> : 31 Y(s)/Male
<b>Bill No/ UMR No</b> : NMBC60815/NMU0047201	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 09-Mar-24 09:44 am	<b>Report Date</b> : 09-Mar-24 12:53 pm

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)</b>				
FASTING BLOOD GLUCOSE		89	Normal Range ; 70 - 99 mg/dL	Hexokinase
<b>SERUM CREATININE</b>				
CREATININE		1.13	0.8 - 1.3 mg/dl	Method : jaffe
<b>BUN / CREATININE RATIO</b>				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		1.13	0.8 - 1.3 mg/dl	
BUN / CREATININE RATIO		7.96	10 - 20	
<b>LFT(LIVER FUNCTION TEST)</b>				
TOTAL BILIRUBIN		0.6	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.4	<= 1.0 mg/dL	
SGPT (ALT)		22	<= 41 U/L	Method : UV without P5P
SGOT (AST)		18	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		82	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		5.0	3.5 - 5.2 g/dL	Method : Bromocresol Green (BCG)
GLOBULINS		2.7	2.5 - 3.5 g/dL	
A/G RATIO		1.85	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		14	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
<b>BUN(BLOOD UREA NITROGEN)</b>				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
<b>TOTAL PROTEIN</b>				
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
<b>LIPID PROFILE</b>				
TOTAL CHOLESTEROL		188	Desirable : < 200 mg/dL Borderline High : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric







**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mr. PARAKH KISHORE	<b>Age / Gender</b> : 31 Y(s)/Male	<b>NAVI MUMBAI</b>
<b>Bill No/ UMR No</b> : NMBC60815/NMU0047201	<b>Referred By</b> : Dr. DMO	
<b>Received Dt</b> : 09-Mar-24 09:44 am	<b>Report Date</b> : 09-Mar-24 01:55 pm	

Parameters	Specimen	Result	Biological Reference	In Method
HDL CHOLESTEROL		41	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		119	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		39		
SERUM TRYGLYCERIDES		194	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.59	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.9		
SERUM URIC ACID		6.9	3.4 - 7.0 mg/dL	uricase
<b>T3,T4 AND TSH</b>				
T3		109.7	70 - 204 ng/dL	Method : ECLIA
T4		8.34	5.1 - 14.1 ug/dL	Method : ECLIA
TSH (THYROID STIMULATING HORMONE)		1.14	0.270 - 4.20 uIU/ml	Method : ECLIA
<b>HBA1C (GLYCOSYLATED HAEMOGLOBIN)</b>				
HBA1C		5.6	< 5.7 Normal Prediabetic 5.7 - 6.4 & > / = 6.5 Diabetic %	TINIA
MPG (Mean Plasma Glucose)		114	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
<b>PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)</b>				
PLBS (POST LUNCH BLOOD GLUCOSE)		118	110 - 180 mg/dL	Hexokinase

\*\*\* End Of Report \*\*\*





# MEDICOVER HOSPITALS

## DEPARTMENT OF LABORATORY

NAVI MUMBAI

**Patient Name** : Mr. PARAKH KISHORE  
**Bill No/ UMR No** : NMBC60815/NMU0047201  
**Received Dt** : 09-Mar-24 01:41 pm

**Age / Gender** : 31 Y(s)/Male  
**Referred By** : Dr. DMO  
**Report Date** : 11-Mar-24 08:34 am

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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Lab Incharge

  
**Dr. VISHAL MEHROTRA, MD Pathology**  
Consultant Pathology Services

Verified By : : 022633

Test results related only to the item tested.

No part of the report can be reproduced without written permission of the laboratory.





<b>Patient ID:</b>	<b>NMU0047201</b>	<b>Patient Name:</b>	<b>PARAKH KISHORE</b>
<b>Age:</b>	<b>31 Years</b>	<b>Sex:</b>	<b>M</b>
<b>Accession Number:</b>	<b>NMBC60815</b>	<b>Modality:</b>	<b>US</b>
<b>Referring Physician:</b>	<b>DR.DMO</b>	<b>Study:</b>	<b>USG ABDOMEN WHOLE</b>
<b>Study Date:</b>	<b>09-Mar-2024</b>	<b>Study Time:</b>	<b>10:23:23</b>

### USG WHOLE ABDOMEN

LIVER is normal in size (14.5 cm), normal in shape with bright 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 (11.7 cm) 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. It ms 18 gms.

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 –

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

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE. THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CORRELATION BEFORE ANY APPLICATION.



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

<i>Patient ID:</i>	<i>NMU0047201</i>	<i>Patient Name:</i>	<i>PARAKH KISHORE</i>
<i>Age:</i>	<i>31 Years</i>	<i>Sex:</i>	<i>M</i>
<i>Accession Number:</i>	<i>NMBC60815</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>09-Mar-2024</i>	<i>Study Time:</i>	<i>09:53:57</i>

**X RAY CHEST PA VIEW**

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

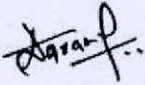
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

**Impression:**

- **No significant abnormality is seen.**



DR. ANUPKUMAR AGRAWAL  
Consultant & HOD Radiology  
MBBS, MD

Date: 09-Mar-2024 14:39:18



NMU0047201  
31 Years

PARAKH KISHORE  
Male

3/9/2024 12:49:19 PM

Rate 74 . Sinus rhythm.....normal P axis, V-rate 50- 99  
. ST elev, probable normal early repol pattern.....ST elevation, age<55  
PR 135 . Baseline wander in lead(s) V2  
QRSD 89  
QT 366  
QTc 406

*NR*  
*uu*  
*lc*

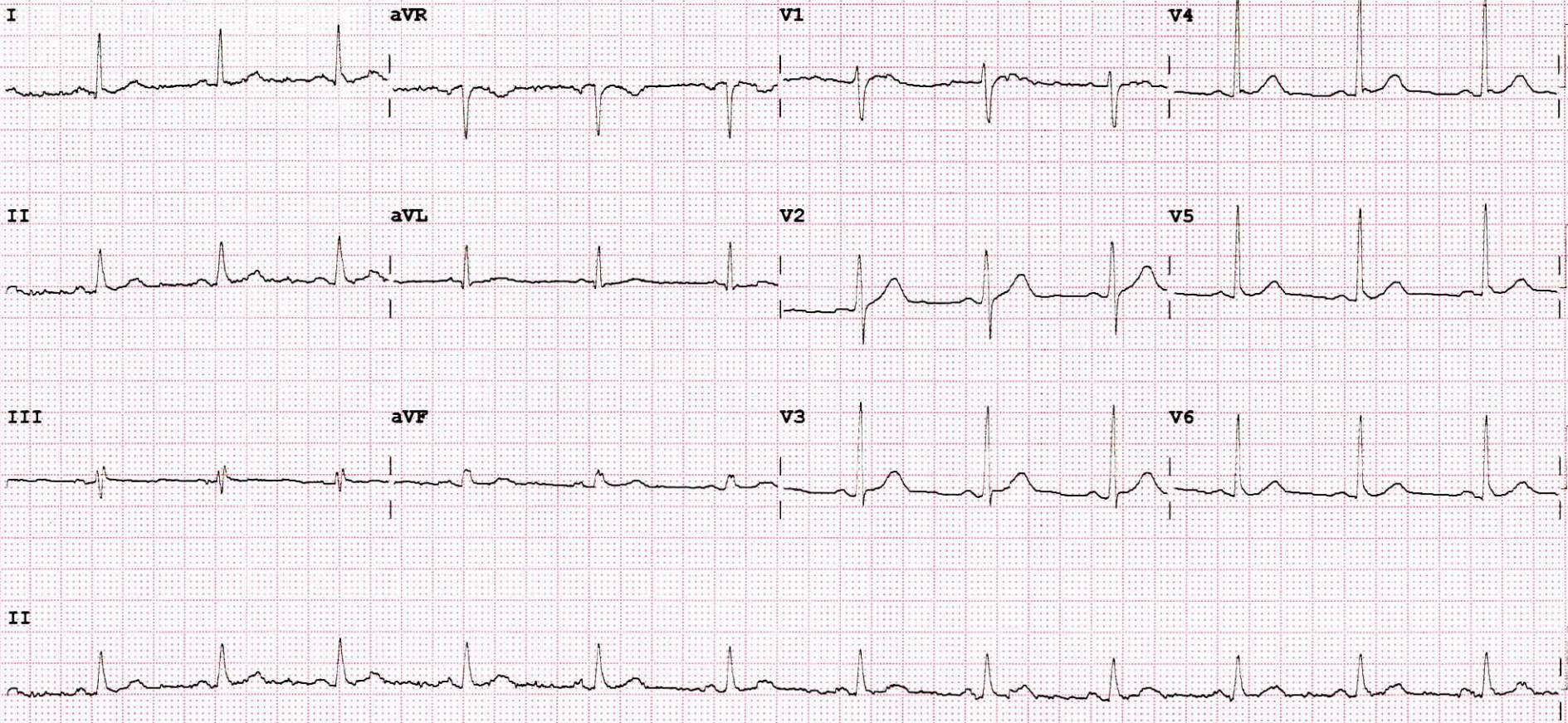
--AXIS--

P 39  
QRS 34  
T 32

- 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?



**MEDICAL HEALTH CHECK- UP ASSESMENT FORM**

NAME : Mr / Mrs Pavakh Kishore

DATE: 09/03/24

AGE : 31 yrs 1m

SEX: Female / Male

NMU: NMU00047201

DOCTOR'S NAME:

TEMP :	<u>97.1</u>	° f	BP :	<u>130/70</u>	mmHg
PULSE :	<u>80</u>	b/m	HEIGHT :	<u>172</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>95.5</u>	kg
SPO2 :	<u>97</u>	%	HGT:	<u>—</u>	

REMARK:





# DEPARTMENT OF OPHTHALMOLOGY

# MEDICOVER HOSPITALS

DATE: 09/03/21

PATIENT NAME: Mrs Parvathi Kishore

AGE / SEX : 31/m NAVI MUMBAI

UMR NO : N0000047201

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

		SPHERE	CYLINDER	AXIS	VA
MRx	O D	Plano	_____		6/6, N6
	O S	Plano	_____		6/6, N6

### HISTORY :

NH/O systemic illness (DM, HTN, Thyroid) NH/O spectacle use  
 NH/O Ocular trauma Allergis & surgeries.

### OCULAR FINDINGS :

(B) - Ant seg WNL  
 (unilateral) Disc  $\leq 0.5$   
 $0.4$

### ADVICE:

Refresh Tears e/d q/d 1777 X 1month

AS  
 C.P.R. ANUSHREE VANKAR





**MEDICOVER**  
HOSPITALS

NAVI MUMBAI

Parakh

O/E: Spacing - lower anteriors

Stains +++

Calculus +++

Adv: Complete oral prophylaxis.

**Dr. Sayali Vasant Mandekar**  
**MDS In Conservative Dentistry**  
**And Endodontics**  
**Reg. No. A-32634.**

