



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. NIDHI CHANDNANI	Age / Gender : 34 Y(s)/Female
Bill No/ UMR No : NMBC60790/NMU0047173	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:31 am	Report Date : 09-Mar-24 06:58 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	30 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.01	1.000 - 1.030	Dipstick
PH		6.0	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.
BLOOD		NEGATIVE	NEGATIVE	Dipstick/Microscopy
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	1-2	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		2-3	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
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		





MEDICOVER
HOSPITALS

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Received Dt : 09-Mar-24 08:31 am	Report Date : 09-Mar-24 06:58 pm

Parameters

Specimen

Result

Biological Reference In Method

*** End Of Report ***





DEPARTMENT OF LABORATORY

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Patient Name : Mrs. NIDHI CHANDNANI	Age / Gender : 34 Y(s)/Female
Bill No/ UMR No : NMBC60790/NMU0047173	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:31 am	Report Date : 09-Mar-24 12:47 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	4.50	3.8 - 4.8 10 ⁶ /μL	
HEMOGLOBIN		12.1	12.0 - 15.0 g/dl	
PCV/HCT		37.3	40 - 50 % 36 - 46 %	
MCV		83	83 - 101 fl 83 - 101 fl	
MCH		26.8	27 - 32 pg	
MCHC		32.3	31.5 - 34.5 g/dL	
RDW(cv)		14.0	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	409	150 - 400 10 ³ /μL	
MPV		7.9	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	9.1	4.0 - 11.0 10 ³ /μl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	50	40 - 80 %	
LYMPHOCYTES		38	20 - 40 %	
MONOCYTES		08	02 - 10 %	
EOSINOPHILS		04	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	35	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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HOSPITALS

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Bill No/ UMR No : NMBC60790/NMU0047173	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:31 am	Report Date : 09-Mar-24 05:14 pm

Parameters

Specimen Result

TUBE AGGLUTINATI





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. NIDHI CHANDNANI	Age /Gender : 34 Y(s)/Female
Bill No/ UMR No : NMBC60790/NMU0047173	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:31 am	Report Date : 09-Mar-24 12:42 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
SERUM ELECTROLYTES				
SERUM SODIUM		139	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.1	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		108	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM CREATININE				
CREATININE		0.62	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		12.9	7.0 - 21.0 mg/dL	Calculated
LFT(LIVER FUNCTION TEST)				
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	<= 33 U/L	Method : UV without P5P
SGOT (AST)		21	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		76	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)		16	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		7.5	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				





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Bill No/ UMR No : NMBC60790/NMU0047173	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:31 am	Report Date : 09-Mar-24 12:42 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
TOTAL CHOLESTEROL		241	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		34	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		178	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		56		
SERUM TRYGLYCERIDES		281	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		7.09	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		5.24		
SERUM URIC ACID		3.9	2.4 - 5.7 mg/dL	uricase
T3,T4 AND TSH				
T3		107.3	70 - 204 ng/dL	Method : ECLIA
T4		6.42	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.06	0.270 - 4.20 uIU/mL	Method : ECLIA
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.5	< 5.7 Normal Prediabetic 5.7 - 6.4 & >=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		140	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)		144	110 - 180 mg/dL	Hexokinase

*** End Of Report ***

THIS IS A MODIFIED REPORT





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. NIDHI CHANDNANI	Age / Gender : 34 Y(s)/Female
Bill No/ UMR No : NMBC60790/NMU0047173	Referred By : Dr. DMO
Received Dt : 09-Mar-24 11:44 am	Report Date : 11-Mar-24 08:30 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
Head, Laboratory Services

Verified By : : 022633

Test results related only to the item tested.

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Page 7 of 7



Patient ID:	NMU0047173	Patient Name:	NIDHI CHANDNANI
Age:	34 Years	Sex:	F
Accession Number:	NMBC60790	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	09-Mar-2024	Study Time:	09:04:16

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.

RIGHT OVARY: 3.2 x 2.0 cm, LEFT OVARY: 3.1 x 1.5 cm.

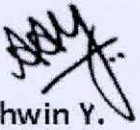
Visualised bowel loops appear normal. There is no free fluid seen.

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)

Patient ID:	NMU0047173	Patient Name:	NIDHI CHANDNANI
Age:	34 Years	Sex:	F
Accession Number:	NMBC60790	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	09-Mar-2024	Study Time:	09:02:15

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 14:32:49

Rate 82 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 132
QRSD 86
QT 388
QTc 453

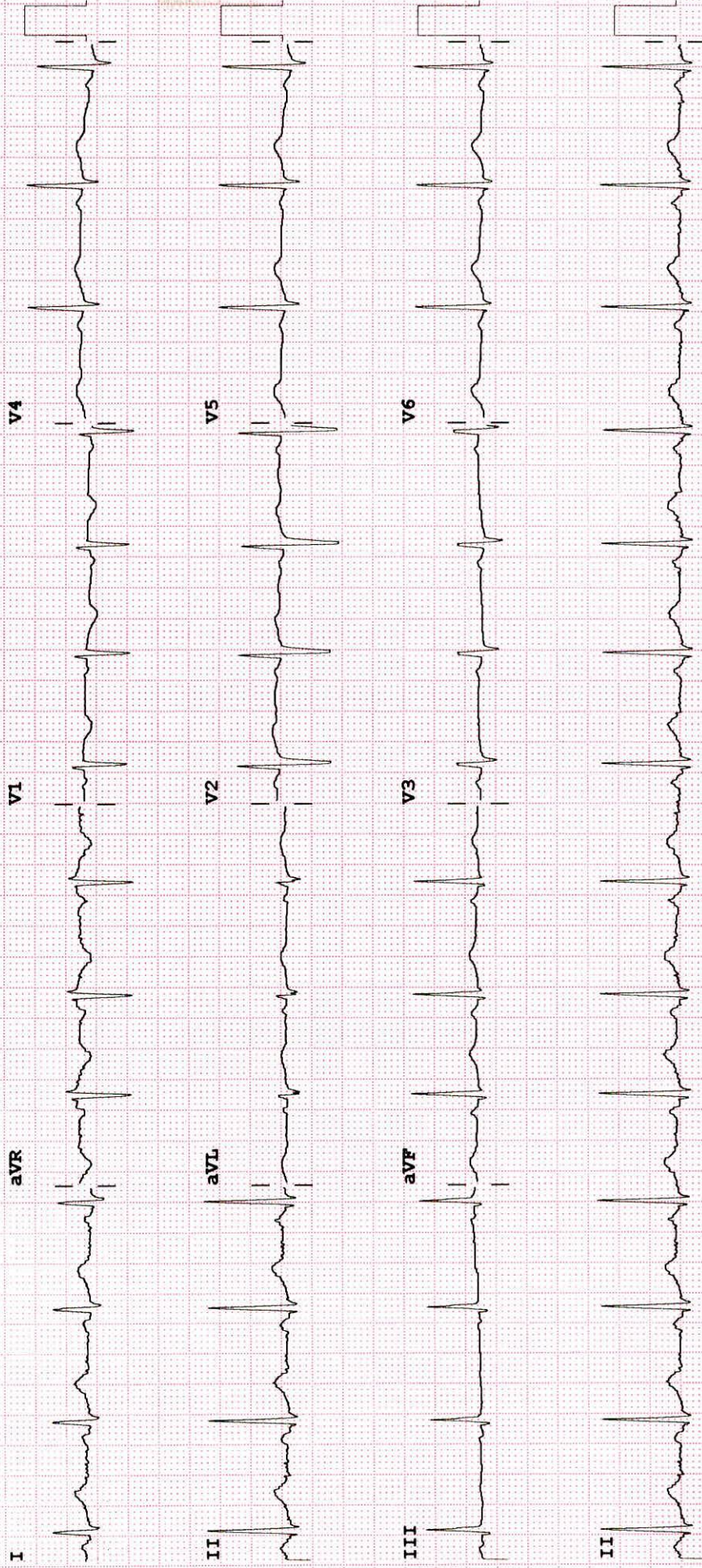
--AXIS--
P 36
QRS 59
T 28

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis

NIR
GML
↳



Device:

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

100B CL

P?

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : Mrs. Nidhi Chandani

Date:-09/03/2024

Age / Sex : 34 Yrs /Female

UMR No. 0047173

Referred By : Health check up

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I 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:

- Grade I left ventricle diastolic dysfunction.
- No RWMA.
- Trivial MR and 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	19	mm
LVID(s)	32	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	09	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



Mrs. Midhi Chandnani
34/F

No H/O DM/HTN/BALDA.

No DOE chest pain



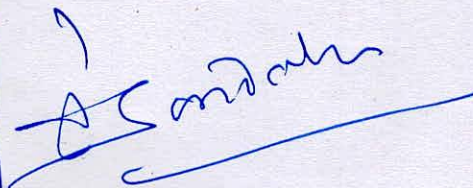
MEDICOVER
HOSPITALS

NAVI MUMBAI
913124

RL - BS - vesi.

Ch. SIC (N)

CMS - NAD



DR. ADITYA VINOD SONDANKAR
MBBS DNB MEDICINE
MASTERCLASS IN DIABETES
PGDCED
REG MMC 2009083017





MEDICOVER
HOSPITALS

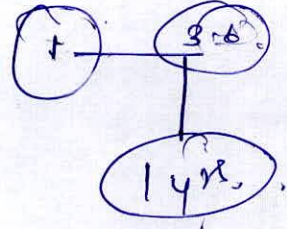
NAVI MUMBAI

Nidhi

O/E: pericoronitis \bar{c} $\frac{+}{8}$

Calculus +++

Adv: complete Oral
prophylaxis,



Sayali Mandekar

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





DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 09/03/24

PATIENT NAME: Mrs Nidhi Chandani

AGE / SEX : 34 / F. NAVI MUMBAI

UMR NO : NM00047173.

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

		SPHERE	CYLINDER	AXIS	VA
MRx	O D	plano	_____		6/6, NG.
	O S	plano	_____		6/6, NG.

HISTORY :

- NH/O Ocular trauma, Allergies. H/O LASIK done (August 2017) (CBE)
- NH/O systemic illness (DM, HTN, Thyroid).

OCULAR FINDINGS :

(BE) Ant seg WNL
 (undilated) Disc < 0.2
 0.2

ADVICE:

Refresh Tears 4x a day 1777 X 1 month

AS
 (DR. ANUSHREE VANWAR)



MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Nidhi Chandinani DATE: 9/3/24

AGE : 34 yrs

SEX: Male/ Female

NMU: NMU000 47171

DOCTOR'S NAME:

Health package

TEMP :	<u>98</u>	° f	BP :	<u>120/70</u>	mmHg
PULSE :	<u>89</u>	b/m	HEIGHT :	<u>147</u>	cm
RR :	<u>22</u>	b/m	WEIGHT :	<u>62.6</u>	kg
SPO2 :	<u>98</u>	% R.A	HGT:	<u>-</u>	

REMARK: