UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SUNITHA KRISHNAMURTHY	Order No	: 1000120029
UHID	: UHJA24013003	Registered On	: 09/03/2025 07:52:25 AM
Age/Sex	: 51/Years Female	Collected On	: 09/03/2025 08:01:58 AM
Ward / Bed No	:	Reported On	: 09/03/2025 12:48:20 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018323
Station	: At Hospital	Mobile No	: 9980741711
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	174	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	265	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	8.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	192	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.58	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	14.13	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.32	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	187	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	124	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	39.1	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	123.10	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	24.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.78		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.15		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	147.90	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.9	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.51	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.41	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.7	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.12	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.58	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.15		2:1
SERUM SGOT (Method:IFCC without P5P)	17	U/L	< 35

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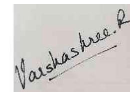
SERUM SGPT (Method:IFCC without P5P)	21	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	121	U/L	46-122
GGT (Method:IFCC)	17	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	28.2	mg/dL	17-43

BUN/CREATININE RATIO

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.54	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	24.07		12¯20 : 1



Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC) — Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	10.51	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	33.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7410	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.10	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	23.29	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.62	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.59	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.40	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.49	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	73.4	fL	78-100
MCH (Method: Calculated)	23.4	pg	27-31
MCHC (Method: Calculated)	31.8	g/dL	31-37
RDW - CV (Method: Calculated)	16.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.93	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.83	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	26.6	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4820	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	420	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1730	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	410	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	30	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	54	mm/hour	1-30

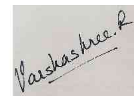
BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
ABO Group (Method:Agglutination Method)	B
Rh Factor (Method:Agglutination Method)	Positive

Interpretation Notes

Note: Both forward and reverse grouping performed



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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.030		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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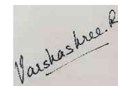
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	0-2	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Present (2+)		



Verified By
Sridhar Kandukuri

---End of Report---

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

NABH

No.1

Out Patient Record

Patient Name	: **Mrs.SUNITHA KRISHNAMURTHY**	**UHID**	: **UHJA24013003**
Age / Sex	: 51 Years / Female	OP NO/Reg Dt	: 09-03-2025 07:52 AM
Spouse / Father Name	: S L KRISHNAMURTHY	Department	:
Address	: jayanagar , , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

HT - 152 cm
Wt - 87.0 kg
SpO_2 - 98 %
PR - 95 b/m
BP - 150/83 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH

No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sunitha Krishnamurthy	Date	09/03/25
Age	51 years	Hospital ID	UHJA24013003
Sex	Female	Ref.	Health check

FINDINGS:

ULTRASOUND ABDOMEN AND PELVIS

Liver is normal in size and ***shows mildly increased echopattern.*** No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in size, course and caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (12.0 x 4.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (12.0 x 5.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is mildly distended.

Pelvic structures could not be visualized due to mildly distended urinary bladder.

There is no ascites.

IMPRESSION: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Fatty infiltration of liver (Grade II).**
- **No other definite sonological abnormality detected.**

Dr. Varun
Consultant Radiologist

NABH

No.1

Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sunitha Krishnamurthy	Date	09/03/25
Age	51 years	Hospital ID	UHJA24013003
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Varun
Consultant Radiologist

ID:24013003 Name:Mrs.Sunitha 9-Mar-2025 AM8:53:48

lex:F Birth date: / 51 years

cm kg mmHg

ledication:

lymptoms:

listory:

lent. rate	91	bpm
R int	128	ms
RS dur	78	ms
T/QTc(E) int	312/ 360	ms
/QRS/T axis	58/ 40/ 237	°
V5/SV1 amp	0.95/ 1.32	mV
V5+SV1 amp	2.27	mV

1100 Sinus rhythm

4012 Moderate ST depression [0.05+ mV ST depression (II, V5)]

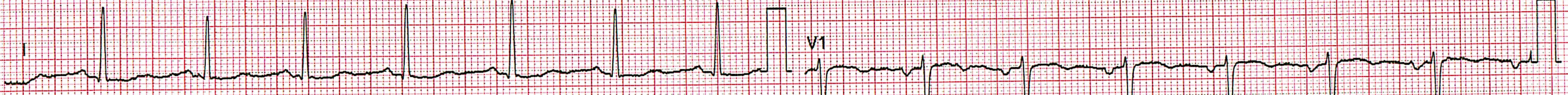
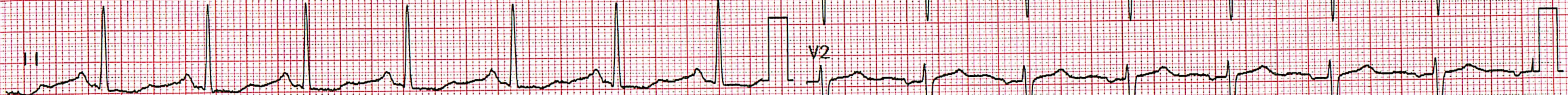
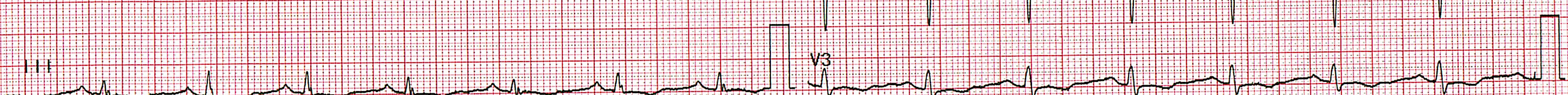
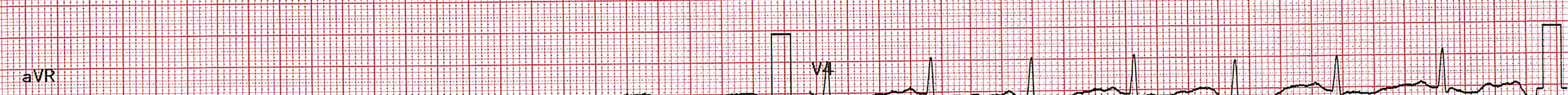
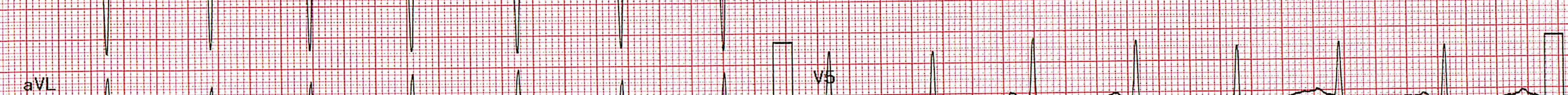
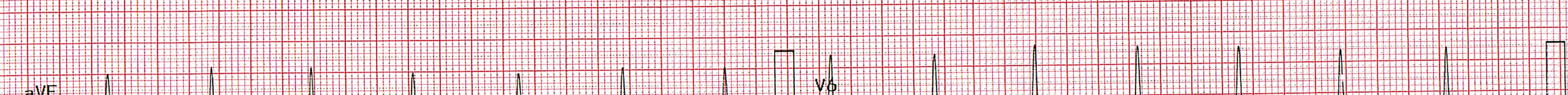
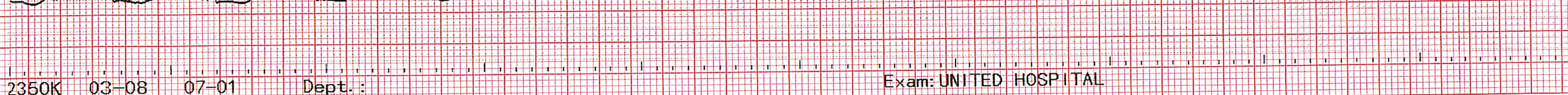
4664 Twave abnormality, possible inferior ischemia [negative T (II, aVF)]

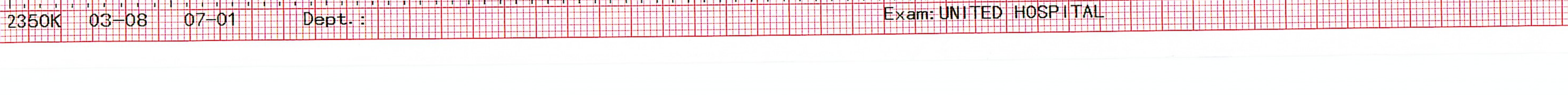
9150 ** abnormal ECG **

Unconfirmed Report

Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 35 Hz 10 mm/mV



2350K 03-08 07-01 Dept.: Exam:UNITED HOSPITAL

NABH No.1

PATIENT NAME:	Mrs. SUNITHA KRISHNAMURTHY	DATE:	09/03/25
AGE :	51 Years Sex: MALE	UHID :	24013003
REF BY :	CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

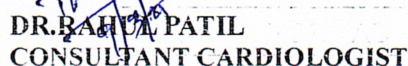
(c.m)	(c.m)	(cm/sec)		
AO : 2.8 (2.5-3.7)	LVIDD : 5.1 (3.5-5.5)	MV EV : 85.9	AV : 101	MR : TRIVIAL MR
LA : 3.3 (1.9-4.0)	LVIDS : 3.0 (2.4-4.2)	AV : 140		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 105		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ---	AV : ---	TR : TRIVIAL TR, PASP-30mmHg
TAPSE: 2.0 (>1.6)	LVPWD : 0.8 (0.6-1.1)	Diastolic Function : GRADE I LVDD		
	LVPWS : 1.0 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis:	NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	:NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

TACHYCARDIA OBSERVED DURING THE STUDY (HR – 105 bpm)
NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE I LV DIASTOLIC DYSFUNCTION
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION



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