UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. THILAKA S	Order No	: 1000119923
UHID	: UHJA24012972	Registered On	: 08/03/2025 09:00:30 AM
Age/Sex	: 42/Years Female	Collected On	: 08/03/2025 09:41:27 AM
Ward / Bed No	:	Reported On	: 08/03/2025 01:03:46 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018273
Station	: At Hospital	Mobile No	: 9594096660
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	103	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	132	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	114	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.94	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.21	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.57	ı IU/mL	0.34 - 5.60 ı IU/mL (Non Pregnant) 0.3 - 4.5 ı IU/mL (I trimester) 0.5 - 5.2 ı IU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	242	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	92	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.2	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	176.40	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	18.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.13		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.74		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	194.80	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.9	mg/dL	2.6-6.0
CREATININE (Method:Modified Jaffe, Kinetic)	0.65	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.17	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.23	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.94	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.5	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.21	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.29	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.28		2:1

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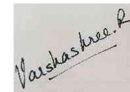
SERUM SGOT (Method:IFCC without P5P)	12	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	8	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	59	U/L	46-122
GGT (Method:IFCC)	6	U/L	< 38



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

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NABH CERTIFIED

DEPARTMENT OF LABORATORY MEDICINE

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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)	12.03	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.8	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	10160	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	66.24	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	24.82	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.13	%	0-6
MONOCYTES (Method:Optical/Impedance)	4.60	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.21	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.58	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.6	fL	78-100
MCH (Method: Calculated)	26.3	pg	27-31
MCHC (Method: Calculated)	31.8	g/dL	31-37
RDW - CV (Method: Calculated)	17.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	4.14	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)	6.70	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.6	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	6730	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	420	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	2520	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	470	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	40	mm/hour	1-20

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
ABO Group (Method:Agglutination Method)	O
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	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.005		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)	Present (+)		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

DEPARTMENT OF LABORATORY MEDICINE

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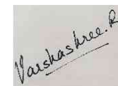
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	4-6	/HPF	0-5
PUS CELLS	6-8	/HPF	0-5
RBCs	0-2	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		



Verified By
Dr Varsha Shree R

---End of Report---

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

NABH

No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Thilaka S	**Date**	08/03/25
Age	42 years	**Hospital ID**	UHJA24012972
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

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 ***shows few polyps, largest measures 3.5 mm.*** There is no 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 (9.6 x 3.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.2 x 4.2 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 normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and ***mildly bulky in size, measures 10.5 x 6.0 x 4.6 cms.*** Endometrium measures 10.7 mm. ***There is a small subserosal fundic fibroid measuring 1.7 x 1.0 cms.***
Right ovary is normal in size and echopattern, measures 8.2 cc.
Adnexa: ***There is a large thin walled anechoic cyst measuring 8.1 x 6.8 x 5.0 cms in the left adnexa. Left ovary could not be separately visualized.***

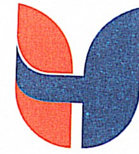
There is no ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **Large left adnexal cyst - likely left ovarian cyst.** *Suggested CA 125 correlation and followup scan after 3 months.*
- **Mild bulky uterus with a small fibroid.**
- **Few small gall bladder polyps.**
- **Mild fatty infiltration of liver (Grade I).**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1



UNITED HOSPITAL
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Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.THILAKA S**	**UHID**	**: UHJA24012972**
Age / Sex	: 42 Years / Female	OP NO/Reg Dt	: 08-03-2025 09:00 AM
Spouse / Father Name	: .	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

Ht: 157 cm
Wt: 66.8 kg
SpO_2: 98 %
PR: 86 bpm
Bp: 140/90 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	Thilaka S	Date	08/03/25
Age	42 years	Hospital ID	UHJA24012972
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. Elluru Santosh Kumar
Consultant Radiologist

SCHILLER

ID: 24012972 Part No.2.157017M CE 0123 R.BE

8-Mar-2025 AM10:36:06

Name: Mrs. Thilaka

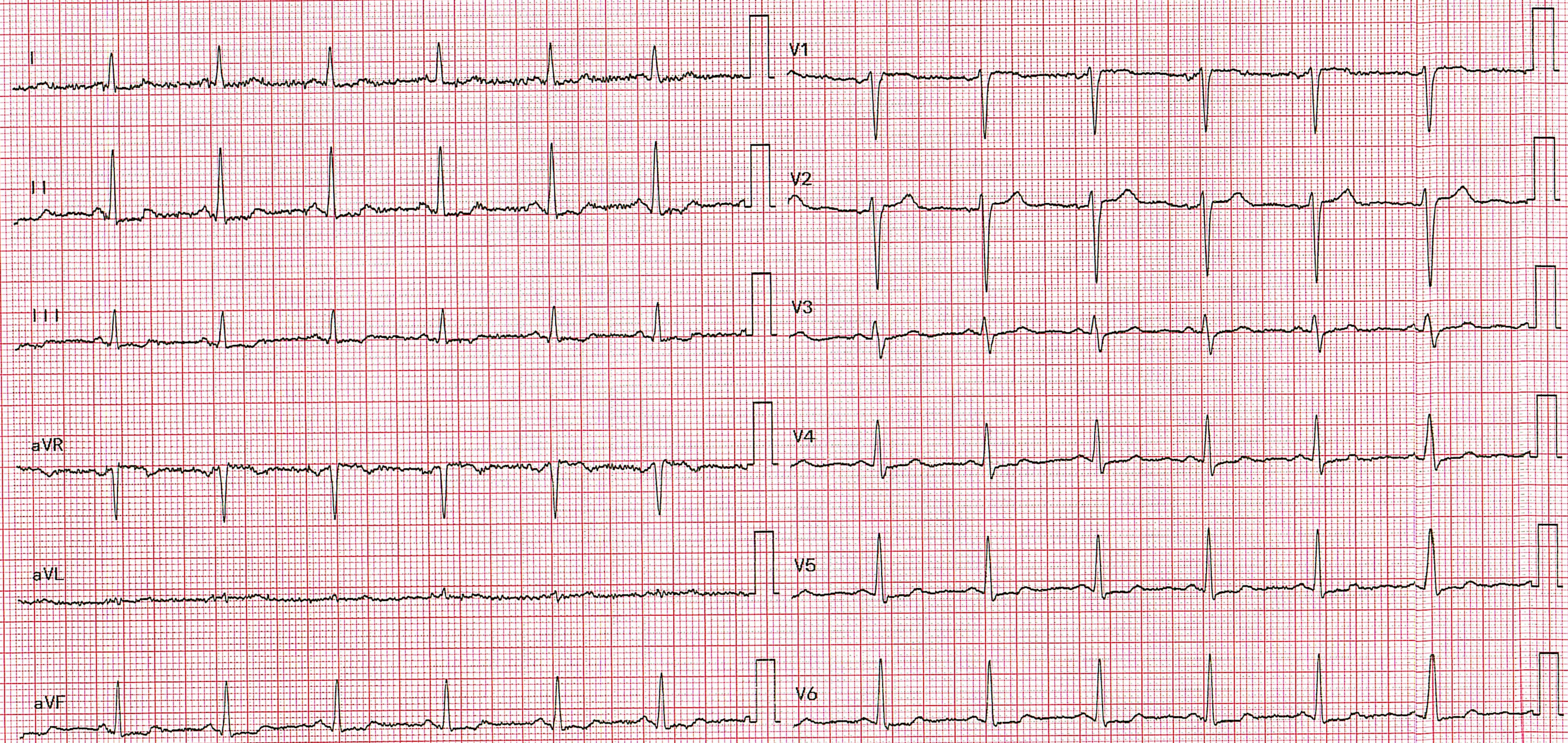
lex: F	Birth date:		42 years
cm	kg	/	mmHg
ledication:			
ymptoms:			
listory:			
lent. rate	84	bpm	
R int	122	ms	
RS dur	92	ms	
T/QTc(E) int	332/ 373	ms	
/QRS/T axis	60/ 51/ 43	°	
V5/SV1 amp	1.05/ 1.03	mV	
V5+SV1 amp	2.08	mV	

1100 Sinus rhythm
4011 Minimal ST depression [0.025+ mV ST depression (II, aVF, V5, V6)]
4048 Nonspecific ST & Twave abnormality [ST abnormality (II, aVF, V5, V6), flat T or negative T (II, aVF, V5, V6)]
0102 ARTIFACT PRESENT
9130 ** borderline 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

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME :	Mrs. THILAKA S	DATE :	08/03/25
AGE :	42 years GENDER: FEMALE	PATIENT ID :	24012972
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 : 4.0 (3.5-5.5)	MV EV : 105	AV : 85.9	MR : NORMAL
LA : 3.5 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 110		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 84.4		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ------	AV : ----	TR : NORMAL
TAPSE: 2.0 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: CONCENTRIC LVH
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 AND COLLAPSING

IMPRESSION :

NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST