ID:24007776
Name:MRS ISSAC

9-Nov-2024 AM8:32:11

ex:F Birth date: 57 years

cm kg / mmHg

edication:
ymptoms:
istory:

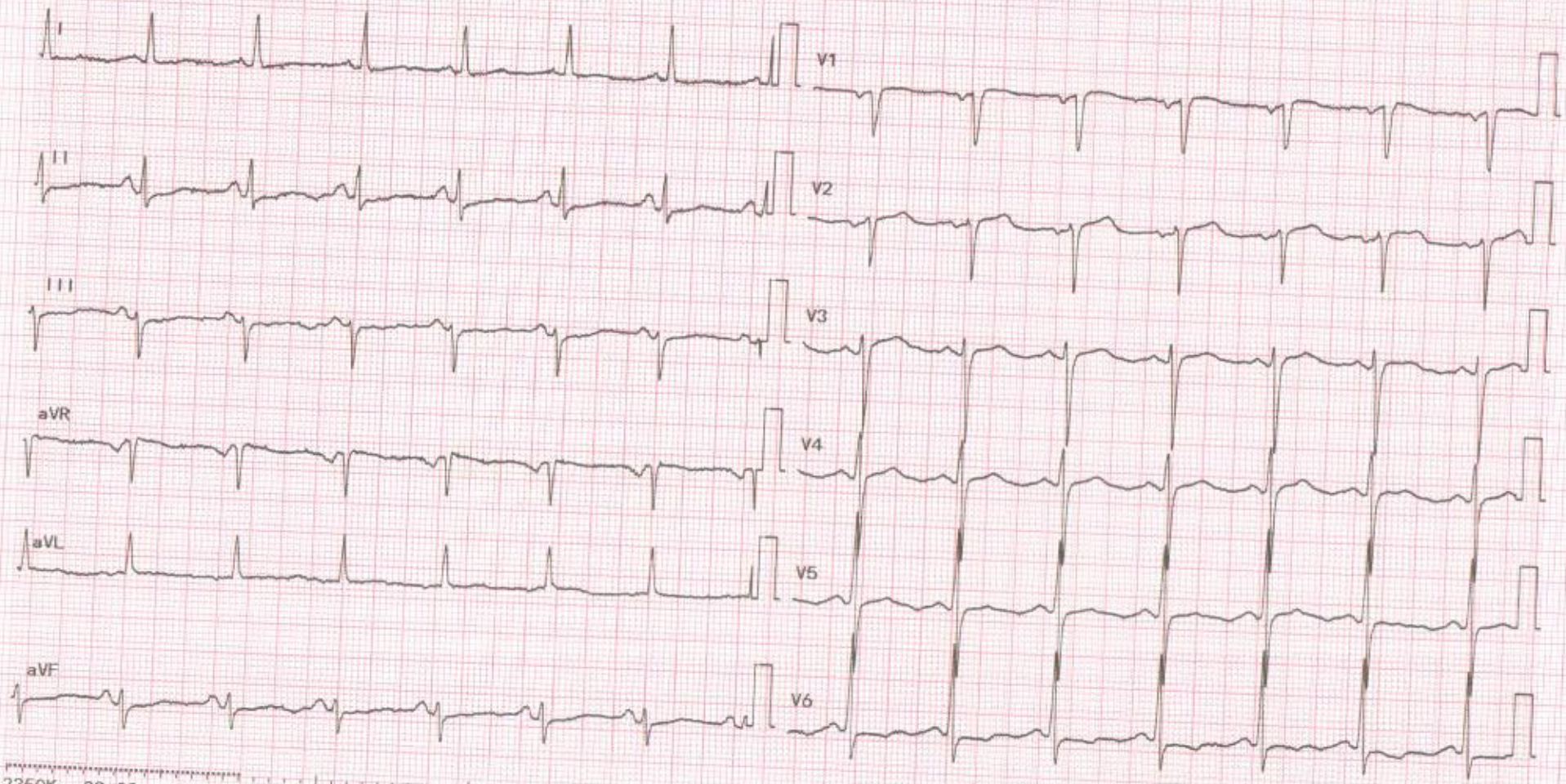
ent. rate	88	bpm
R int	142	ms
RS dur	84	ms
T/QTc(E) int	372/ 418	ms
/QRS/T axis	64/ -8/ 90	°
V5/SV1 amp	1.47/ 0.85	mV
V5+SV1 amp	2.32	mV

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (I, II, aVL, 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. ISSAC SOPHIA ELIZA**	**Date :**	**09/11/24**
Age :	**57 years GENDER: FEMALE**	**Patient ID :**	**24007776**
Ref by :	**CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 3.5 (3.5-5.5)	MV EV : 0.5	AV : 0.8	MR : TRIVIAL MR
LA : 3.4 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 1.4		AR : TRIVIAL AR
RA : 2.0 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 0.8		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ------	AV : ------	TR : TRIVIAL TR, PASP-25mmHg
TAPSE: 1.7 (>1.6)	LVPWD 0.8 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.9 (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	: MITRAL VALVE PROLAPSE
Aortic Valve	:NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

MITRAL VALVE PROLAPSE
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

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Issac Sophia Eliza	**Date**	09/11/24
Age	57 years	**Hospital ID**	UHJA24007776
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size ***and shows mild diffuse coarse 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 mildly enlarged in size (12 cms)***, normal in shape, contour and echopattern. No evidence of mass or focal lesions. ***Small splenunclus is seen near the hilum.***

Right Kidney is normal in size (10.6 x 4.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis. ***There are few simple cortical cysts, largest measures 1.6 x 1.2 cms in the interpole region.***

Left Kidney is normal in size (10.4 x 4.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis. ***There are few simple cortical cysts, largest measures 1.6 x 1.5 cms in the lowerpole region.***

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

Urinary Bladder is distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is surgically absent.
Both ovaries could not be visualized.

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

IMPRESSION:

- **Mild splenomegaly.** *Suggested clinical, CBC and peripheral smear correlation.*
- **Mild diffuse coarse hepatic parenchyma - of concern for early changes of chronic hepatic parenchymal disease.** *Suggested clinical, LFT and liver elastography correlation.*
- **Bilateral renal simple cortical cysts. Bosniak 1 - Benign**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Issac Sophia Eliza	**Date**	09/11/24
Age	57 years	**Hospital ID**	UHJA24007776
Sex	Female	**Ref.**	Health check

BILATERAL SONOMAMMOGRAPHY

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **No significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

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DEPARTMENT OF RADIODIAGNOSIS

Name	Issac Sophia Eliza	**Date**	09/11/24
Age	57 years	**Hospital ID**	UHJA24007776
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. *Aortic arch calcifications are seen.*

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs.ISSAC SOPHIA ELIZA	UHID	: UHJA24007776
Age / Sex	: 57 Years / Female	OP NO/Reg Dt	: 09-11-2024 07:49 AM
Spouse / Father Name	: EDWARD	Department	:
Address	: , , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

~~Wt~~ - 62.3kg
~~Ht~~ - 152cm
BP - 160/90
PR - 90b/m
SpO2 - 99.1

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. ISSAC SOPHIA ELIZA	Order No	: 1000102672
UHID	: UHJA24007776	Registered On	: 09/11/2024 07:49:48 AM
Age/Sex	: 57/Years Female	Collected On	: 09/11/2024 07:57:20 AM
Ward / Bed No	:	Reported On	: 09/11/2024 11:36:04 AM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240010502
Station	: Corp	Mobile No	: 6366112895
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	**275**	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	**260**	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	**13.0**	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	**326**	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)	11.39	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.19	µIU/mL	0.38-5.33
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	**205**	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	**256**	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	44.7	mg/dL	< 40 - Low ≥ 60 - High

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	**109.10**	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	**51.20**	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	**4.59**		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.44		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	**160.30**	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.0	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.80	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.13	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.67	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.17	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.03	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.38		2:1
SERUM SGOT (Method:IFCC without P5P)	22	U/L	< 35

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	**37**	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	**142**	U/L	46-122
GGT (Method:IFCC)	**98**	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	28.8	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.66	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	19.6		12–20 : 1

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

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)	13.12	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	40.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	**3870**	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	53.92	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	34.70	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.16	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.77	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.45	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.91	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.2	fL	78-100
MCH (Method: Calculated)	**26.7**	pg	27-31
MCHC (Method: Calculated)	32.5	g/dL	31-37
RDW - CV (Method: Calculated)	**14.7**	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.70	Lakhs/Cum	1.5-4.5

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	9.42	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.2	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	2090	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	120	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1340	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	300	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-30

BLOOD GROUPING & RH TYPING Sample: Whole blood (EDTA)

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	1.020		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Present (2.0%)		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)	Absent		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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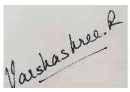
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	0-2	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Present (2.0%)		
URINE SUGAR (POST PRANDIAL)	Present (2.0%)		

Verified By
G Mahesh kumar

---End of Report---



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