

DEPARTMENT OF LABORATORY MEDICINE

| | | | |
|---------------|----------------------------|---------------|--------------------------|
| Patient Name | : Mr. SANTOSH KUMAR BEHERA | Order No | : 1000120084 |
| UHID | : UHJ A24013017 | Registered On | : 09/03/2025 08:37:50 AM |
| Age/Sex | : 45/Years Male | Collected On | : 09/03/2025 09:03:14 AM |
| Ward / Bed No | : | Reported On | : 09/03/2025 01:27:28 PM |
| Reference | : Dr. Ashmitha Padma | Bill No | : OPBJ A240018337 |
| Station | : At Hospital | Mobile No | : 8136086782 |
| Payer Name | : Mediwheel | Report Status | : Final Report |

| Test Name | Result | Unit | Bio. Ref. Interval |
|---|--------|--------|--|
| <u>BIOCHEMISTRY</u> | | | |
| FASTING GLUCOSE (Method: Hexokinase) | 149 | mg/dL | ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes |
| POST PRANDIAL GLUCOSE (Method: Hexokinase) | 316 | mg/dL | 70-140 |
| GLYCOSYLATED HAEMOGLOBIN (HBA1C) | | | Sample: Whole blood (EDTA) |
| HBA1C (Method: HPLC) | 9.1 | % | ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes |
| Estimated Average Glucose (eAG) (Method: Calculated) | 214 | mg/dL | |
| THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH) | | | Sample: Serum |
| TOTAL T3 (Method: CLIA) | 1.59 | ng/mL | 0.87-1.78 |
| TOTAL T4 (Method: CLIA) | 10.22 | ng/dL | 5.1-14.1 |
| THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive) | 3.95 | μIU/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) | 143 | mg/dL | < 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High |
| HDL CHOLESTEROL (Method: ENZYMATIC METHOD) | 35.4 | mg/dL | < 40 - Low ≥ 60 - High |

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| LDL CHOLESTEROL (Method: Calculated) | 123.00 | mg/dL | <100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high |
| VLDL CHOLESTEROL (Method: Calculated) | 28.60 | mg/dL | < 30 |
| TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated) | 5.28 | | Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 |
| LDL/HDL CHOLESTEROL RATIO (Method: Calculated) | 3.47 | | < 2.5 Optimal |
| NON HDL CHOLESTEROL (Method: Calculated) | 151.60 | mg/dL | < 130 |
| URIC ACID (Method:Uricase - POD(Enzymatic)) | 4.1 | mg/dL | 3.5-7.2 |
| 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) | 1.01 | mg/dL | 0.9-1.3 |
| BUN/CRE-RATIO (Method: Calculated) | 12.87 | | 12~20 : 1 |
| LIVER FUNCTION TEST | | | Sample: Serum |
| TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization) | 0.81 | mg/dL | 0.3-1.2 |
| DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization) | 0.22 | mg/dL | 0.0-0.2 |
| INDIRECT BILIRUBIN (Method: Calculated) | 0.59 | mg/dL | 0.2-1.0 |
| TOTAL PROTEIN (Method:BIURET) | 7.3 | g/dL | 6.6-8.3 |

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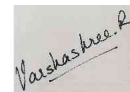
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| ALBUMIN (Method:BCG) | 4.29 | g/dL | 3.5-5.2 |
| GLOBULIN (Method: Calculated) | 3.01 | g/dL | 2.3-3.5 |
| AG RATIO (Method: Calculated) | 1.43 | | 2:1 |
| SERUM SGOT (Method:IFCC without P5P) | 33 | U/L | < 50 |
| SERUM SGPT (Method:IFCC without P5P) | 45 | U/L | < 50 |
| ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer) | 114 | U/L | 50-116 |
| GGT (Method:IFCC) | 37 | U/L | < 55 |
| PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA) | 0.21 | ng/mL | < 4.0 |

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

| | | | |
|---|------|-------|-------|
| UREA (Method:Urease GLDH - Kinetic) | 28.1 | mg/dL | 17-43 |
|---|------|-------|-------|



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)

| | | | |
|--|-------|-------------|------------|
| HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method) | 12.97 | g/dL | 13.5-17.5 |
| PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated) | 39.3 | % | 42-52 |
| TOTAL WBC COUNT (TLC) (Method:Coulter Principle) | 5570 | Cells/Cum | 4000-11000 |
| DIFFERENTIAL COUNT | | | |
| NEUTROPHILS (Method:Optical/Impedance) | 59.62 | % | 40-75 |
| LYMPHOCYTES (Method:Optical/Impedance) | 28.60 | % | 20-45 |
| EOSINOPHILS (Method:Optical/Impedance) | 4.01 | % | 0-6 |
| MONOCYTES (Method:Optical/Impedance) | 7.39 | % | 2-10 |
| BASOPHILS (Method:Optical/Impedance) | 0.38 | % | 0-2 |
| RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle) | 4.94 | million/cum | 4.5-5.9 |
| MCV (Method:Derived from RBC Histogram) | 79.5 | fL | 78-100 |
| MCH (Method: Calculated) | 26.3 | pg | 27-31 |
| MCHC (Method: Calculated) | 33.0 | g/dL | 31-37 |
| RDW - CV (Method: Calculated) | 14.7 | % | 11.5-14.5 |
| PLATELET COUNT (Method:Electrical Impedance) | 2.24 | Lakhs/Cum | 1.5-4.5 |


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| MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram) | 6.40 | fl | 7-11 |
| PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated) | 17.8 | fl | 9-19 |
| ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated) | 3320 | Cells/Cum | 1500-7500 |
| ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated) | 220 | Cells/Cum | 40-440 |
| ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated) | 1590 | Cells/Cum | 1000-4000 |
| ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated) | 410 | Cells/Cum | 200-1000 |
| ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated) | 20 | Cells/Cum | 20-100 |
| ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method) | 30 | mm/hour | 1-15 |
| 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

PHYSICAL EXAMINATION

| | | | |
|------------------|-------------|----|-------------|
| VOLUME | 25 | mL | |
| COLOUR | Pale Yellow | | |
| APPEARANCE | Clear | | |
| PH | 7.0 | | 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) | 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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| EPITHELIAL CELLS | 0-2 | /HPF | 0-5 |
| PUS CELLS | 0-2 | /HPF | 0-5 |
| RBCs | Nil | /HPF | 0-2 |
| CASTS | Nil | /LPF | |
| CRYSTALS | Nil | | |
| OTHERS | Nil | | |
| URINE SUGAR, FASTING (Method:GOD-POD) | Absent | | |
| URINE SUGAR (POST PRANDIAL) | Present (4+) | | |

Verified By
Sridhar Kandukuri

---End of Report---



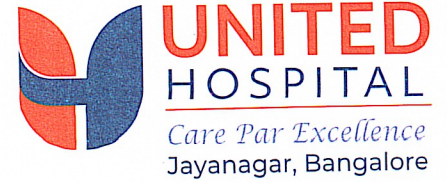
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KMC No : 103567



NABH



No.1



Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIO DIAGNOSIS

| | | | |
|------|-----------------------|-------------|--------------|
| Name | Santhosh Kumar Behera | Date | 09/03/25 |
| Age | 45 years | Hospital ID | UHJA24013017 |
| Sex | Male | Ref. | Health check |

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and *shows 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 focal lesion.

Right Kidney is normal in size (10.9 x 4.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.7 x 5.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus 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.

Prostate is normal in echopattern and size, measures ~ 20 cc.

No ascites.

IMPRESSION:

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

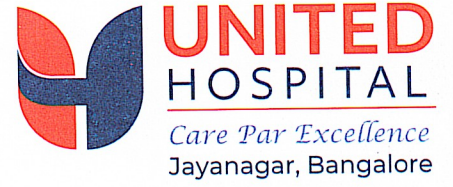
Dr. Varun
Consultant Radiologist



NABH



No.1



Out Patient Record

Patient Name : Mr.SANTOSH KUMAR BEHERA UHID : UHJA24013017
Age / Sex : 45 Years / Male OP NO/Reg Dt : 09-03-2025 08:37 AM
Spouse / Father Name : . Department :
Address : . , Bengaluru Urban, Karnataka, INDIA, Referred By :
Consultant : Dr.Ashmitha Padma MBBS, MD
(GENERAL MEDICINE), PGDCC,FEM
KMC No. : 02M1087

Complaints / Findings / Observations :

Ht- 165cm

Wt- 87.1kg

SpO2 - 98%

PR - 92/mnts

Bp - 116/88mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

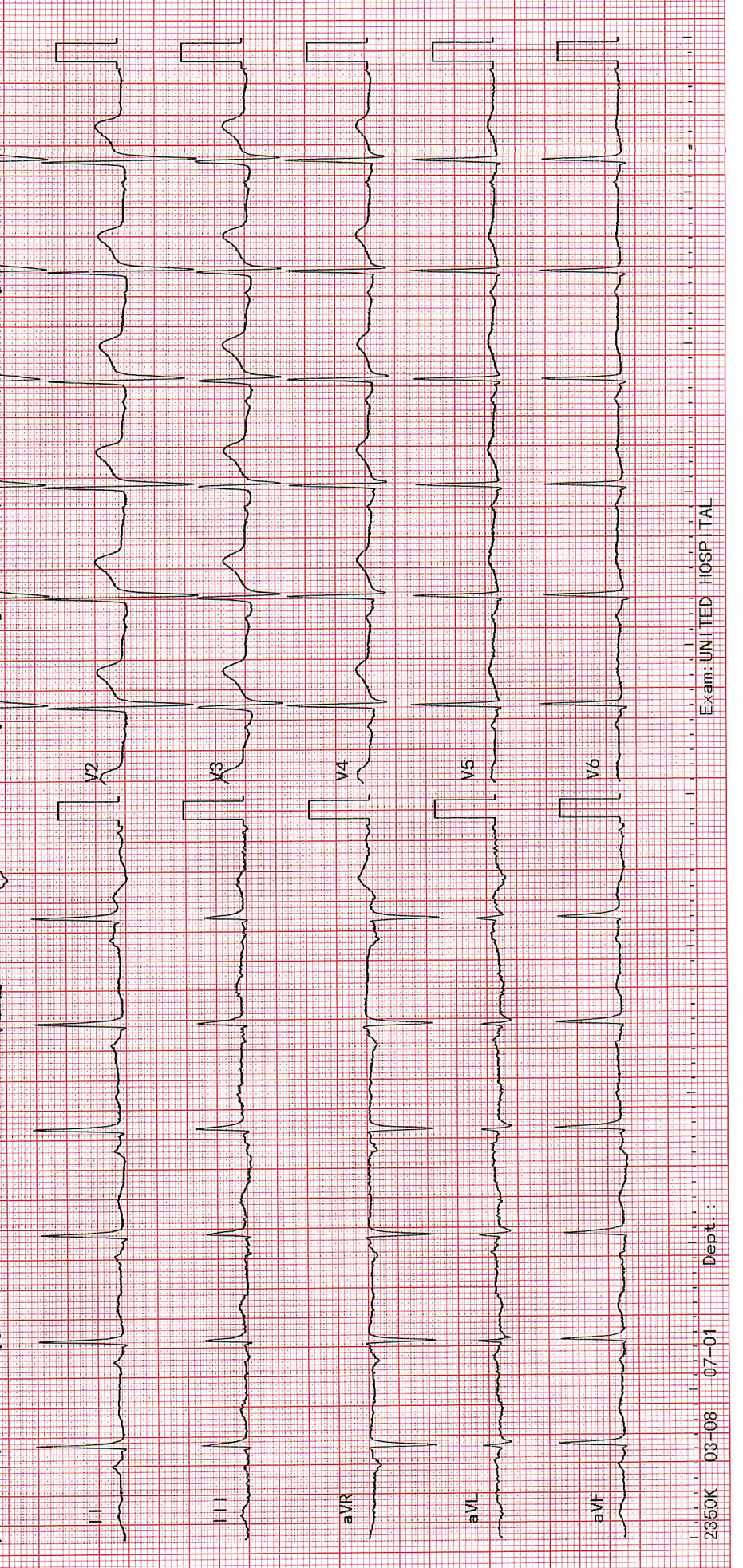
Follow Up Advice :

Signature of the Doctor

Name: Mr. SanthoshKumar
 Birth date: / /
 Sex: M
 Weight: kg
 Height: mmHg
 Indication: /
 Symptoms: /
 History: /
 Heart rate: 84 bpm
 R int: 150 ms
 RS dur: 88 ms
 T/QTc(E) int: 364/404 ms
 I/QRS/T axis: 40/60/108 °
 V5/SV1 amp: 1.52/0.97 mV
 V5+SV1 amp: 2.50 mV

1100 Sinus rhythm
 4068 Nonspecific Twave abnormality [flat T or negative T (I, II, aVF, V5, V6)]
 9130 **borderline ECG**

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





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No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

| | | | |
|----------------------|---------------------------------|------------------|------------------------|
| PATIENT NAME: | Mr. SANTOSH KUMAR BEHERA | DATE: | 09/03/25 |
| AGE : | 45 Years | Sex: MALE | UHID : 24013017 |
| REF BY : | CMO | OP/IP : | HEALTH CHECK |

2D- ECHOCARDIOGRAPHY

M - MODE AND DOPPLER MEASUREMENTS

| (c.m) | (c.m) | (cm/sec) | |
|--------------------|-----------------------|-------------------------|------------------------------|
| AO : 3.2 (2.5-3.7) | LVIDD : 4.1 (3.5-5.5) | MV EV : 93.6 | AV : 77.6 |
| LA : 3.5 (1.9-4.0) | LVIDS : 2.8 (2.4-4.2) | AV : 122 | MR : TRIVIAL MR |
| RA : 2.5 (<4.4) | IVSD : 1.2 (0.6-1.1) | PV : 85.9 | AR : NORMAL |
| RV : 1.5 (<3.5) | IVSS : 1.3 (0.9-1.2) | TV EV : --- | PR : NORMAL |
| TAPSE: 2.0 (>1.6) | LVPWD : 1.2 (0.6-1.1) | Diastolic Function : NO | TR : TRIVIAL TR, PASP-28mmHg |
| | LVPWS : 1.3 (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 |

IMPRESSION :

CONCENTRIC LV HYPERTROPHY
 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



DEPARTMENT OF RADIODIAGNOSIS

| | | | |
|-------------|-----------------------|--------------------|--------------|
| Name | Santhosh Kumar Behera | Date | 09/03/25 |
| Age | 45 years | Hospital ID | UHJA24013017 |
| Sex | Male | Ref. | Health check |

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Hazy opacity is noted in the lower zone of left lung field. Adjacent cardiac border is obscured.

Rest of the bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- Hazy opacity in the lower zone of left lung field. Adjacent cardiac border is obscured.
- No other radiographic abnormality.


Dr. Varun
Consultant Radiologist