NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Mamtha	**Date**	08/03/25
Age	30 years	**Hospital ID**	UHJA24012969
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

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Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in 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 (12.8 cms)*, normal in shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (9.3 x 3.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.7 x 4.6 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 normal in size, measures 9.3 x 3.2 x 4.5 cms. Myometrial echoes are normal. Endometrium measures 7.2 mm.
Right ovary is normal in size and echopattern, measures 9.3 cc.
Left ovary is normal in size and echopattern, measures 6.9 cc.
Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

- **Mild splenomegaly.** *Suggested clinical and CBP correlation.*
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

Name: mrs. mamatha
8-Mar-2025 AM9:49:44
SCHILLER

lex: F
Birth date:
30 years

cm kg / mmHg

1100 Sinus rhythm
8102 Low QRS voltage in chest leads [QRS deflection < 1.0 mV in chest leads]
9120 ** atypical ECG **

edication:
ymptoms:
istory:

ent. rate	63	bpm
R int	128	ms
RS dur	70	ms
T/QTc(E) int	380/ 388	ms
/QRS/T axis	18/ 39/ 36	°
V5/SV1 amp	0.72/ 0.68	mV
V5+SV1 amp	1.40	mV

Unconfirmed Report
Reviewed by:

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

10 mm/mV

I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6

2350K 03-08 07-01 Dept. :

Exam: UNITED HOSPITAL

NABH

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Out Patient Record

Patient Name	**: Mrs.MAMTHA**	**UHID**	**: UHJA24012969**
Age / Sex	: 30 Years / Female	OP NO/Reg Dt	: 08-03-2025 08:51 AM
Spouse / Father Name	: .	Department	:
Address	: JAYANAAGAR , , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

HT: 164 cm
Wt: 68 kg
BP: 103 | 61 mm Hg
SPO2: 98 %
PR 61 bpm

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. MAMTHA	Order No	: 1000119912
UHID	: UHJA24012969	Registered On	: 08/03/2025 08:51:47 AM
Age/Sex	: 30/Years Female	Collected On	: 08/03/2025 09:32:29 AM
Ward / Bed No	:	Reported On	: 08/03/2025 01:54:18 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018270
Station	: At Hospital	Mobile No	: 9972085558
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	96	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	93	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	94	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.00	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.15	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.79	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)	218	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	103	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	38.3	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	159.10	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	20.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.69		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	4.15		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	179.70	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.8	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.75	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.94	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.18	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.76	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.7	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.39	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.31	g/dL	2.3-3.5

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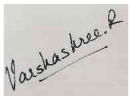
Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.33		2:1
SERUM SGOT (Method:IFCC without P5P)	20	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	12	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	51	U/L	44-107
GGT (Method:IFCC)	9	U/L	< 38



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)	12.16	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6000	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	61.87	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	31.17	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	0.89	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.73	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.34	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.60	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	80.7	fL	78-100
MCH (Method: Calculated)	26.4	pg	27-31
MCHC (Method: Calculated)	32.8	g/dL	31-37
RDW - CV (Method: Calculated)	15.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.17	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.18	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.6	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	3710	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	50	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1870	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	340	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	1-20

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

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

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	7.0		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)	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	Nil	/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
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