UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. NIVEDITHA PUNJA	Order No	: 1000120045
UHID	: UHJA24013007	Registered On	: 09/03/2025 08:07:39 AM
Age/Sex	: 40/Years Female	Collected On	: 09/03/2025 08:18:16 AM
Ward / Bed No	:	Reported On	: 09/03/2025 12:59:18 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018327
Station	: At Hospital	Mobile No	: 9741542946
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)	88	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.2	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	103	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.21	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.19	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.36	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)	189	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	63	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	41.9	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	134.50	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	12.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.51		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.21		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	147.10	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.1	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.36	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.08	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.28	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.28	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.92	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.47		2:1
SERUM SGOT (Method:IFCC without P5P)	25	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	17	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	73	U/L	46-122
GGT (Method:IFCC)	15	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	17.6	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.73	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	10.95		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)	12.86	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	39.2	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5520	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	53.18	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.92	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.47	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.04	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.39	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.58	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	85.5	fL	78-100
MCH (Method: Calculated)	28.1	pg	27-31
MCHC (Method: Calculated)	32.8	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.03	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)	8.38	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.8	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	2940	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	190	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	2040	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	330	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	28	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	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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	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
Sridhar Kandukuri

---End of Report---

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

DEPARTMENT OF RADIODIAGNOSIS

Name	Niveditha Punja	**Date**	09/03/25
Age	40 years	**Hospital ID**	UHJA24013007
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.

There is a simple cyst measuring at 1 o'clock position in right breast.

No focal solid lesions seen.

Multiple prominent ducts noted in retroareolar region measuring about 4 mm each in maximum diameter in both breasts. No obvious solid component visualized within the ducts. No obvious macro-calcification.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **Simple cyst in right breast.**
- **Multiple prominent ducts in retroareolar region of both breasts (right > left).**

Dr. Varun
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.NIVEDITHA PUNJA**	**UHID**	**: UHJA24013007**
Age / Sex	: 40 Years / Female	OP NO/Reg Dt	: 09-03-2025 08:07 AM
Spouse / Father Name	: .	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 - 166 cm
Wt - 67.3 kg
Bp - 97/60 mmHg.
SpO2 - 99 %
PR - 67/min.

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME:	Mrs. NIVEDITHA PUNJA	DATE:	09/03/25
AGE :	40 Years Sex: FEMALE	UHID :	24013007
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 : 3.7 (3.5-5.5)	MV EV : 103	AV : 53.8	MR : NORMAL
LA : 3.3 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 115		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 67.4		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ---	AV : ---	TR : TRIVIAL TR, PASP-25mmHg
TAPSE: 2.2 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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 :

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

DEPARTMENT OF RADIODIAGNOSIS

Name	Niveditha Punja	**Date**	09/03/25
Age	40 years	**Hospital ID**	UHJA24013007
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

NABH

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DEPARTMENT OF RADIODIAGNOSIS

Name	Niveditha Punja	**Date**	09/03/25
Age	40 years	**Hospital ID**	UHJA24013007
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 contracted. No obvious calculi are seen in the visualized portion of the lumen. Suggested review scan if any gallbladder pathology is suspected.

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 (10.3 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.8 x 4.8 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 6.5 x 4.5 x 5.5 cms. Myometrial echoes are normal. ***Endometrium measures 12.8 mm.***
Right ovary is normal in size and echopattern.
Left ovary is normal in size and echopattern.
Both adnexa: Normal. No mass is seen.

There is no ascites.

IMPRESSION:

- **No definite sonological abnormality detected.**

Dr. Varun
Consultant Radiologist

ID: 24013007
Name: mr nivedithaa
Sex: F
Birth date:
40 years
cm kg / mmHg
Medication:
Symptoms:
History:

9-Mar-2025 AM9:11:27

1100 Sinus rhythm
2210 Short PR interval [PR int. < 120 ms]
8102 Low QRS voltage in chest leads [QRS deflection < 1.0 mV in chest leads]
9150 ** abnormal ECG **

Vent. rate	63	bpm
PR int	110	ms
QRS dur	78	ms
QT/QTc(E) int	374/ 382	ms
P/QRS/T axis	0/ 52/ 32	°
RV5/SV1 amp	0.74/ 0.50	mV
RV5+SV1 amp	1.24	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