

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. RAVISHANKAR ITTA	Order No	: 1000120034
UHID	: UHJ A24013004	Registered On	: 09/03/2025 07:54:27 AM
Age/Sex	: 42/Years Male	Collected On	: 09/03/2025 08:05:44 AM
Ward / Bed No	:	Reported On	: 09/03/2025 12:52:31 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJ A240018324
Station	: At Hospital	Mobile No	: 9381460097
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	298	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	376	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	10.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	252	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)	11.15	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	4.69	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	233	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	239	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	32.4	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	152.80	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	47.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	7.19		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	4.72		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	200.60	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.8	mg/dL	3.5-7.2
BUN/CREATININE RATIO			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.85	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	15.29		12~20 : 1
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.69	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.14	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.55	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3

Sample: Serum

Sample: Serum

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ALBUMIN (Method:BCG)	4.44	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.96	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.50		2:1
SERUM SGOT (Method:IFCC without P5P)	31	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	69	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	113	U/L	50-116
GGT (Method:IFCC)	42	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.42	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)	28.3	mg/dL	17-43
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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)	15.31	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	46.3	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7360	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	61.92	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	25.22	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.10	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.40	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.36	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.25	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	88.2	fL	78-100
MCH (Method: Calculated)	29.2	pg	27-31
MCHC (Method: Calculated)	33.1	g/dL	31-37
RDW - CV (Method: Calculated)	13.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.25	Lakhs/Cum	1.5-4.5

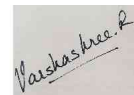
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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.63	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.6	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4560	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	300	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1860	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	620	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	30	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	24	mm/hour	1-15
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

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.025		1.005-1.030

CHEMICAL EXAMINATION

PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Present (3+)		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)	Present (3+)		
URINE SUGAR (POST PRANDIAL)	Present (4+)		

Verified By
Sridhar Kandukuri

---End of Report---



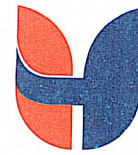
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KMC No : 103567



NABH



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIO DIAGNOSIS

Name	Ravi Shankar Itta	Date	09/03/25
Age	42 years	Hospital ID	UHJA24013004
Sex	Male	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 is partially distended. 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 focal lesion.

Right Kidney is normal in size (10.5 x 4.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.1 x 5.3 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 ~ 14.4 cc.

No ascites.

IMPRESSION:

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

Dr. Varun
Consultant Radiologist



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Ravi Shankar Itta	Date	09/03/25
Age	42 years	Hospital ID	UHJA24013004
Sex	Male	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

9-Mar-2025 AM10:47.23

SCHILLER

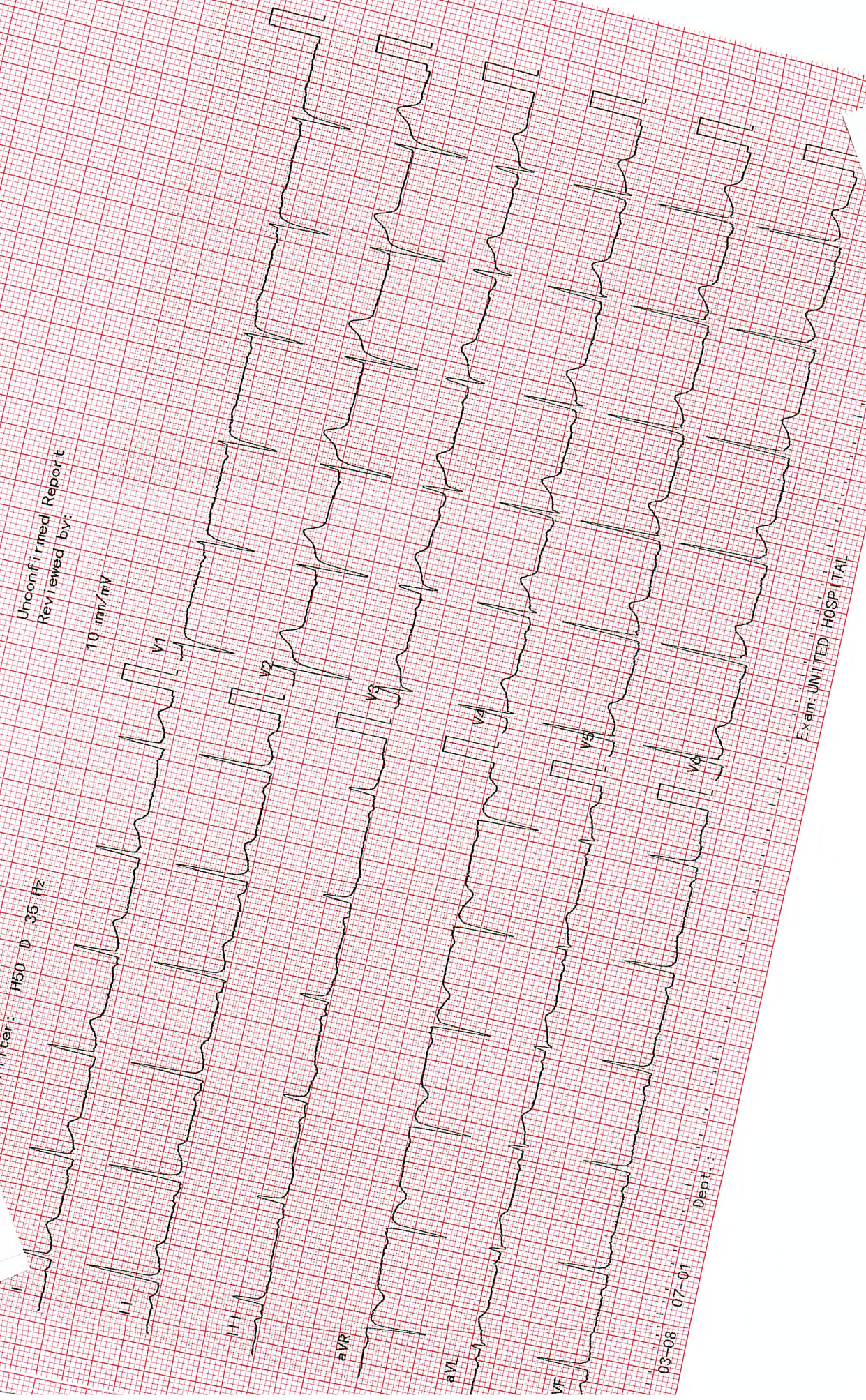
7100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (II, III, aVF)]
9130 xx borderline ECG xx

Unconfirmed Report
Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

1.07 mV
2.73 mV



03-08 07-01 Dept.:

Exam: UNITED HOSPITAL



NABH



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mr.RAVI SHANKAR ITTA

UHID : UHJA24013004

Age / Sex : 42 Years / Male

OP NO/Reg Dt : 09-03-2025 07:54 AM

Spouse / Father Name : RADHAMMA CHITTEPUREDDY

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 - 153 cm

wt - 74.1 kg

Spo2 - 98%

PR - 79 /min

Bp - $\frac{115}{72}$ 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

PATIENT NAME:	Mr. RAVI SHANKAR ITTA	DATE:	09/03/25
AGE :	42 Years Sex: MALE	UHID :	24013004
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 : 4.2 (3.5-5.5)	MV EV : 89.2	AV : 69.8	MR : NORMAL
LA : 3.4 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 117		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 78.1		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ---	AV : ---	TR : NORMAL
TAPSE: 2.0 (>1.6)	LVPWD : 0.8 (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

(Signature)
DR. RAHUL PATIL
 CONSULTANT CARDIOLOGIST