



NABH



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Anand T	Date	08/03/25
Age	31 years	Hospital ID	UHJA24012964
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 surgically absent.

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 (10.4 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.2 x 5.4 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 ~ 10.8 cc. *There is a small cyst measuring 1.3 x 0.8 cms in the prostatic parenchyma.*

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

IMPRESSION: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Postcholecystectomy status.**
- **Mild fatty infiltration of liver (Grade I).**

Dr. Elluru Santosh Kumar
Consultant Radiologist



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DEPARTMENT OF RADIO DIAGNOSIS

Name	Anand T	Date	08/03/25
Age	31 years	Hospital ID	UHJA24012964
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. Elluru Santosh Kumar
Consultant Radiologist

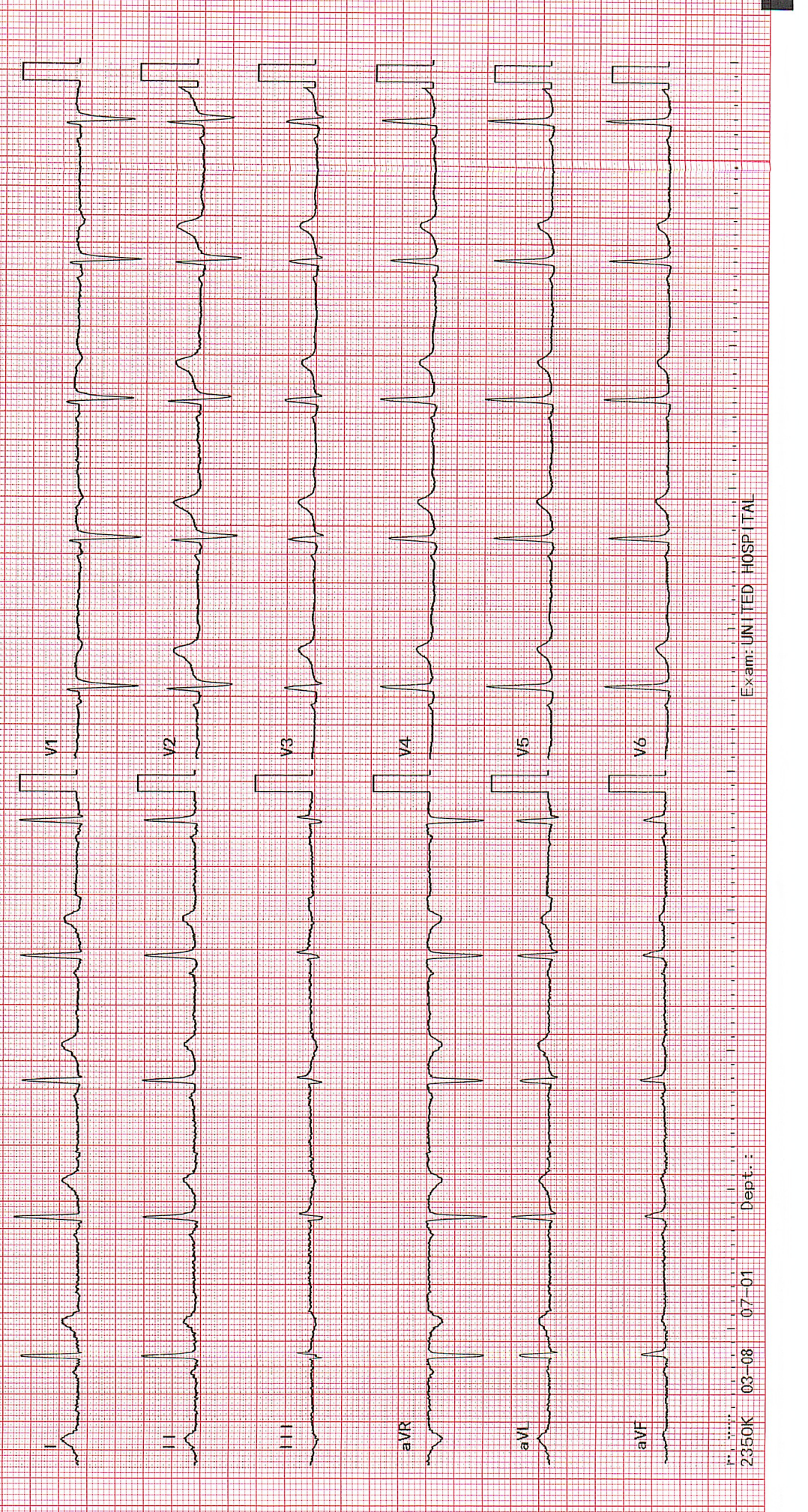
Name: mr. anand t
 Birth date: /
 Weight: kg
 Height: mmHg

1100 Sinus rhythm
 0102 ARTIFACT PRESENT
 9110 ** normal ECG **

31 years

Unconfirmed Report
 Reviewed by:

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

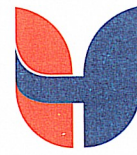




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Jayanagar, Bangalore

Out Patient Record

Patient Name : Mr.ANAND T

UHID : UHJA24012964

Age / Sex : 31 Years / Male

OP NO/Reg Dt : 08-03-2025 08:40 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: 168 cm

WT: 86.6 kg

BP: 144/84 mmHg

Investigations:

SpO₂: 98 %

PR: 77 bpm

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor



NABH



No.1

PATIENT NAME :	Mr. ANAND T	DATE :	07/03/25
AGE :	31 years GENDER: MALE	PATIENT ID :	24012964
REF BY :	CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY**M – MODE AND DOPPLER MEASUREMENTS**

(c.m)	(c.m)	(cm/sec)			
AO : 2.5 (2.5-3.7)	LVIDD : 3.7 (3.5-5.5)	MV EV :92.6	AV : 75.7	MR :	NORMAL
LA : 2.9 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 141		AR :	NORMAL
RA : 2.5 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 103		PR :	NORMAL
RV : 1.5 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : -----	AV : ----	TR :	TRIVIAL TR, PASP-25mmHg
TAPSE: 2.0 (>1.6)	LVPWD :0.9 (0.6-1.1)	Diastolic Function :NO LVDD			
	LVPWS : 1.0 (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 AND COLLAPSING

IMPRESSION :**BRADYCARDIA OBSERVED DURING THE STUDY (HR – 58 bpm)**

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 LABORATORY MEDICINE

Patient Name : Mr. ANAND T	Order No : 1000119888
UHID : UHJ A24012964	Registered On : 08/03/2025 08:40:27 AM
Age/Sex : 31/Years Male	Collected On : 08/03/2025 09:15:03 AM
Ward / Bed No :	Reported On : 08/03/2025 12:54:00 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJ A240018262
Station : At Hospital	Mobile No : 7411300262
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	102	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	97	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	108	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.35	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	11.87	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	1.39	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	225	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	69	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	50.2	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	161.00	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	13.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.48		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)	174.80	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.8	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.83	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.49	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.39	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.8	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.57	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.23	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.41		2:1

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	36	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	45	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	91	U/L	50-116
GGT (Method:IFCC)	46	U/L	< 55



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)	14.22	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.2	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7340	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	62.64	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	23.82	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	6.15	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.07	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.32	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.18	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	83.4	fL	78-100
MCH (Method: Calculated)	27.5	pg	27-31
MCHC (Method: Calculated)	32.9	g/dL	31-37
RDW - CV (Method: Calculated)	14.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.26	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)	7.88	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.5	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4600	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	450	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1750	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	520	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	19	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	5.5		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)	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	0-2	/HPF	0-5
PUS CELLS	2-4	/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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