UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. PRAMANICK RAJARSHI	Order No	: 1000102721
UHID	: UHJA24007788	Registered On	: 09/11/2024 08:39:27 AM
Age/Sex	: 35/Years Male	Collected On	: 09/11/2024 08:56:35 AM
Ward / Bed No	:	Reported On	: 09/11/2024 01:05:56 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240010514
Station	: At Hospital	Mobile No	: 8617639756
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	90	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	101	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.0	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	97	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.06	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.26	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	4.66	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	116	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	84	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	45.4	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	53.80	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	2.56		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.19		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	70.60	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.2	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.81	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization) Remarks: Kindly correlate with clinical findings	3.13	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.60	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	2.53	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.63	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.67	g/dL	2.3-3.5

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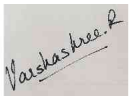
Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.73		2:1
SERUM SGOT (Method:IFCC without P5P)	34	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	31	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	100	U/L	50-116
GGT (Method:IFCC)	16	U/L	< 55



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

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Test Name	Result	Unit	Bio. Ref. Interval
HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	12.15	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	39.1	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6520	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.59	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	20.86	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.54	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.84	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.17	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	6.22	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram) Remarks: Correlate clinically. In view of low RBC indices and increased RBC counts, kindly evaluate for iron deficiency status and hemoglobinopathy	62.9	fL	78-100
MCH (Method: Calculated)	19.5	pg	27-31
MCHC (Method: Calculated)	31.1	g/dL	31-37
RDW - CV (Method: Calculated)	18.4	%	11.5-14.5

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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET COUNT (Method:Electrical Impedance)	0.92	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	10.03	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	39.9	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4280	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	360	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1360	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	510	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	10	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	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

Dr. Varsha Shree R
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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.5		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	0-2	/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
Rashmita

---End of Report---

Varshashree.R

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

9-Nov-2024 AM9:07:50

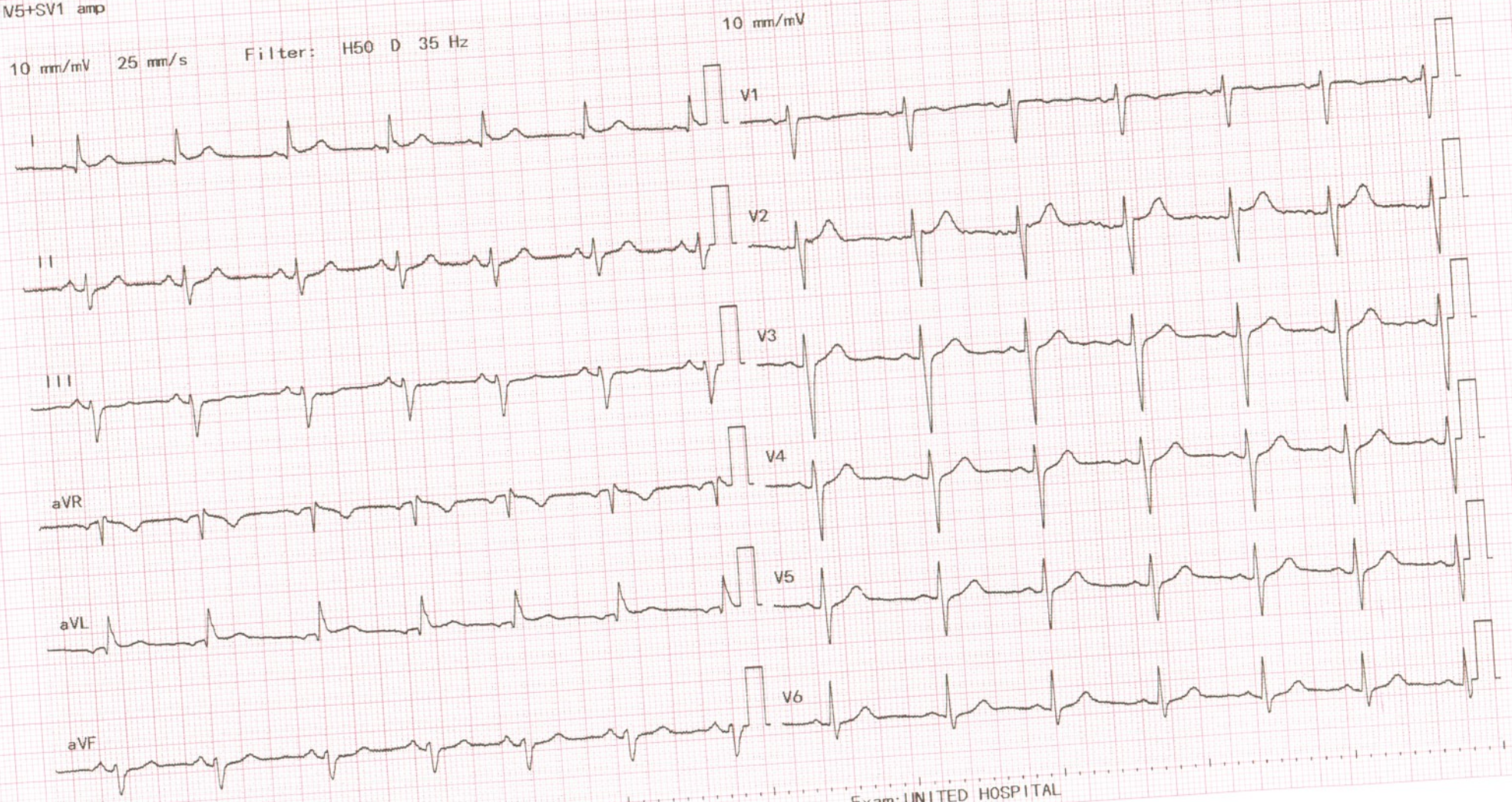
ID:24007788
Name:MR PRAMANICK
Birth date:
ex:M 35 years
cm kg / mmHg
edication:
ymptoms:
istory:

1100 Sinus rhythm
7202 Moderate left axis deviation [-30 deg. =< QRS axis < -20 deg.]
9110 ** normal ECG **

ent. rate	83	bpm
R int	142	ms
RS dur	94	ms
T/QTc(E) int	346/ 386	ms
/QRS/T axis	74/ -25/ 39	°
V5/SV1 amp	0.70/ 0.69	mV
V5+SV1 amp	1.40	mV

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mr. PRAMANICK RAJARSHI**	**Date :**	**09/11/24**
Age :	**35 years GENDER: MALE**	**Patient ID :**	**24007788**
Ref by :	**CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 4.4 (3.5-5.5)	MV EV : 0.6	AV : 0.5	MR : NORMAL
LA : 2.8 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 0.9		AR : NORMAL
RA : 1.9 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.7		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : TRIVIAL TR, PASP-30mmHg
TAPSE: 1.8 (>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

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	Pramanick Rajarshi	**Date**	09/11/24
Age	35 years	**Hospital ID**	UHJA24007788
Sex	Male	**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 normal in size, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (9.6 x 3.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (9.0 x 4.2 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 distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 7.7 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.
There is an abdominal wall subcutaneous lipoma measuring 1.3 x 0.5 cms in the right lumbar region.

IMPRESSION:

- **No significant sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Pramanick Rajarshi	**Date**	09/11/24
Age	35 years	**Hospital ID**	UHJA24007788
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

NABH No.1

Out Patient Record

UNITED HOSPITAL
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Jayanagar, Bangalore

Patient Name	: Mr.PRAMANICK RAJARSHI	UHID	: UHJA24007788
Age / Sex	: 35 Years / Male	OP NO/Reg Dt	: 09-11-2024 08:39 AM
Spouse / Father Name	: SIMA PRAMANICK HALDAR	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA.	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

Ht - 174 cms
Wt - 64.4 kg
BP - 127/80 mm
PR - 88 bpm
SPO2 - 99%

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Pramanicle Rajeswari
35 Yrs/Male

Ophthalmology
9/11/24
Dr. Shweta

VA 6/6 · } N.
6/6

nil systemic.

Mig OU Normal

Fundis OU CDR 0.3:1
(Normal)

IOP OU Within normal

9/11/24

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

No.1

Out Patient Record

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/ Sex	: 35 Years / Male	OP NO/Reg Dt	: 09-11-2024 08:39 AM
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		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

mplaints / Findings / Observations :

History noted

Ht - 174 cm
Wt - 64.4 kg
BP - 127/84
PR - 88 b/m
SpO2 - 99%

Pt is Thalassemia carrier
No comorbids
H/O migraine - not on Rx

estigations:

T. Bilirubin 3.13 mg/dl
USG - (N)
ECG - non significant changes

d/g: USG: ? Gilbert's. Icterus (+)

Advice

atment / Care of Plan / Provisional Diagnosis :

Hb - 12.15 g/dl

(1) life style modifications as advice
(2) Review SOS
(3) T. Pan-D 1-0-0 x 7 days (B/F)

low Up Advice :

Dr. Azfar Fazal [signature]

Signature of the Doctor

UNITED HOSPITAL (A Unit of United Brotherss Healthcare Services Private Limited)

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