

## DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. TAMMANA LAKSHMI HARITHA	Order No	: 1000120063
UHID	: UHJ A24013012	Registered On	: 09/03/2025 08:19:07 AM
Age/Sex	: 35/Years Female	Collected On	: 09/03/2025 08:41:40 AM
Ward / Bed No	:	Reported On	: 09/03/2025 01:12:01 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJ A240018332
Station	: At Hospital	Mobile No	: 8867372899
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	97	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	92	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	4.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
<b>Estimated Average Glucose (eAG)</b> (Method: Calculated)	85	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method: CLIA)	1.63	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method: CLIA)	11.63	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method: CLIA: Ultra-sensitive)	3.87	μIU/mL	0.34 - 5.60 μIU/mL (Non Pregnant) 0.3 - 4.5 μIU/mL (I trimester) 0.5 - 5.2 μIU/mL (II & III trimester)
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method: CHOD-POD)	190	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method: Enzymatic GPO-POD)	123	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method: ENZYMATIC METHOD)	48.8	mg/dL	< 40 - Low ≥ 60 - High

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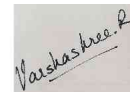
Test Name	Result	Unit	Bio. Ref. Interval
<b>LDL CHOLESTEROL</b> (Method: Calculated)	116.60	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
<b>VLDL CHOLESTEROL</b> (Method: Calculated)	24.60	mg/dL	< 30
<b>TOTAL CHOLESTEROL : HDL RATIO</b> (Method: Calculated)	3.89		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
<b>LDL/HDL CHOLESTEROL RATIO</b> (Method: Calculated)	2.39		< 2.5 Optimal
<b>NON HDL CHOLESTEROL</b> (Method: Calculated)	141.20	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	4.2	mg/dL	2.6-6.0
<b>BLOOD UREA NITROGEN(BUN)</b> (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	0.74	mg/dL	0.6-1.1
<b>LIVER FUNCTION TEST</b>			
<b>TOTAL BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.78	mg/dL	0.3-1.2
<b>DIRECT BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.15	mg/dL	0.0-0.2
<b>INDIRECT BILIRUBIN</b> (Method: Calculated)	0.63	mg/dL	0.2-1.0
<b>TOTAL PROTEIN</b> (Method:BIURET)	7.3	g/dL	6.6-8.3
<b>ALBUMIN</b> (Method:BCG)	4.05	g/dL	3.5-5.2
<b>GLOBULIN</b> (Method: Calculated)	3.25	g/dL	2.3-3.5

Sample: Serum

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AG RATIO (Method: Calculated)	1.25		2:1
SERUM SGOT (Method:IFCC without P5P)	19	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	14	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	87	U/L	46-122
GGT (Method:IFCC)	8	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)

<b>HAEMOGLOBIN</b> (Method:Photometric Measurement: Oxyhemoglobin method)	11.84	g/dL	12-16
<b>PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)</b> (Method: Calculated)	35.9	%	37-47
<b>TOTAL WBC COUNT (TLC)</b> (Method:Coulter Principle)	6320	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> (Method:Optical/Impedance)	66.82	%	40-75
<b>LYMPHOCYTES</b> (Method:Optical/Impedance)	23.56	%	20-45
<b>EOSINOPHILS</b> (Method:Optical/Impedance)	2.81	%	0-6
<b>MONOCYTES</b> (Method:Optical/Impedance)	6.51	%	2-10
<b>BASOPHILS</b> (Method:Optical/Impedance)	0.30	%	0-2
<b>RED BLOOD CORPUSCLES(RBC)</b> (Method:Coulter Principle)	4.15	million/cum	4.0-5.2
<b>MCV</b> (Method:Derived from RBC Histogram)	86.6	fL	78-100
<b>MCH</b> (Method: Calculated)	28.5	pg	27-31
<b>MCHC</b> (Method: Calculated)	33.0	g/dL	31-37
<b>RDW - CV</b> (Method: Calculated)	13.9	%	11.5-14.5
<b>PLATELET COUNT</b> (Method:Electrical Impedance)	2.57	Lakhs/Cum	1.5-4.5


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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.36	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.5	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4220	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	180	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1490	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	410	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	75	mm/hour	1-20
<b>BLOOD GROUPING &amp; RH TYPING</b> <span style="float: right;">Sample: Whole blood (EDTA)</span>			
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	6.5		5.0-8.0
SPECIFIC GRAVITY	1.015		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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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		
<b>URINE SUGAR, FASTING</b> (Method:GOD-POD)	Absent		
<b>URINE SUGAR (POST PRANDIAL)</b>	Absent		

Verified By  
Sridhar Kandukuri

---End of Report---



**Dr. Varsha Shree R**  
M.D(Pathology)  
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Name: m/s tammara haritha

Birth date: / / mmHg

35 years

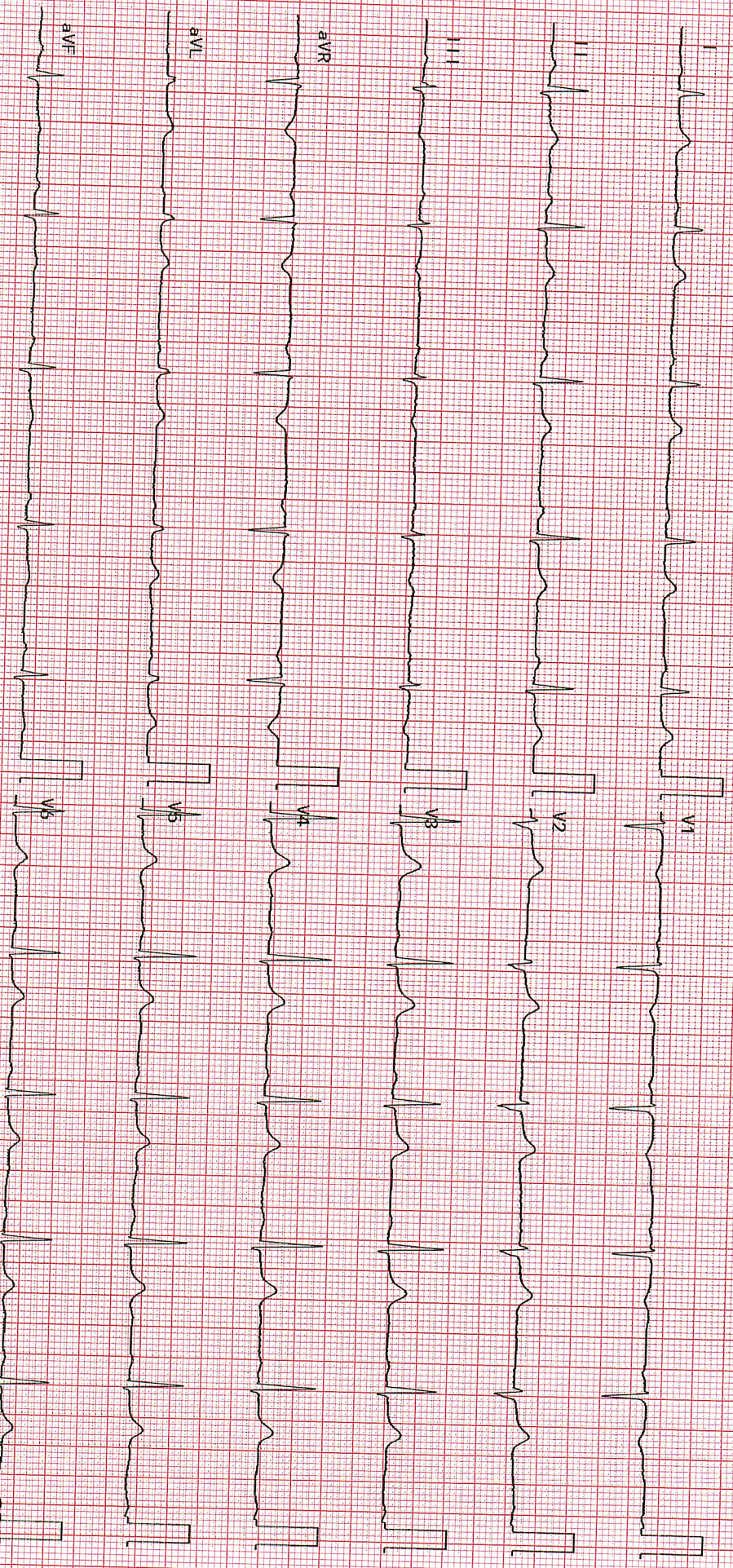
1100 S nus rhythm  
9110 \*\* normal ECG \*\*

Sex: F	cm	kg	mmHg
Medication:			
Symptoms:			
History:			
Heart rate		63	bpm
IR int		182	ms
IRS dur		72	ms
IT/QTc (E) int		406/ 413	ms
I/QRS/T axis		52/ 40/ 19	°
IV5/SV1 amp		1.01/ 0.75	mV
IV5+SV1 amp		1.76	mV

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

10 mm/mV

Unconfirmed Report  
Reviewed by:



2350K 03-08 07-01

Dept: . . . . .

Exam: UNITED HOSPITAL





NABH



No.1



**UNITED  
HOSPITAL**

Care Par Excellence  
Jayanagar, Bangalore

### Out Patient Record

Patient Name : Mrs.TAMMANA LAKSHMI HARITHA UHID : UHJA24013012  
Age / Sex : 35 Years / Female OP NO/Reg Dt : 09-03-2025 08:19 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 :

#### Investigations:

#### Treatment / Care of Plan / Provisional Diagnosis :

#### Follow Up Advice :

Bp -  $\frac{100}{70}$  mmHg

SpO2 - 99%

PR - 84/min

WT - 62kg

HT - 160cm.

Signature of the Doctor



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No.1



### DEPARTMENT OF RADIODIAGNOSIS

Name	Tammana Lakshmi Haritha	Date	09/03/25
Age	35 years	Hospital ID	UHJA24013012
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 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 evidence of mass or focal lesions.

**Right Kidney** is normal in size (9.3 x 4.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

**Left Kidney** is normal in size (9.2 x 4.2 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. Myometrial echoes are normal. Endometrium measures 12 mm.

**Right ovary** is normal in size and echopattern, measures 8.7 cc.


**Left ovary** is normal in size and echopattern, measures 6.9 cc.

**Both adnexa:** Normal. No mass is seen.

There is no ascites.

#### IMPRESSION:

- **Postcholecystectomy status.**
- **No other definite sonological abnormality detected.**

  
**Dr. Varun**  
Consultant Radiologist



NABH



No.1



## DEPARTMENT OF RADIODIAGNOSIS

<b>Name</b>	Tammana Lakshmi Haritha	<b>Date</b>	09/03/25
<b>Age</b>	35 years	<b>Hospital ID</b>	UHJA24013012
<b>Sex</b>	Female	<b>Ref.</b>	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



No.1

Care Par Excellence  
Jayanagar, Bangalore

PATIENT NAME :	Mrs. TAMMANA LAKSHMI HARITHA	Date :	09/03/25
Age :	35 Years	Sex: FEMALE	UHID : 24013012
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 : 4.3 (3.5-5.5)	MV EV : 115	AV : 61.1 MR : NORMAL
LA : 2.6 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 153	AR : NORMAL
RA : 2.7 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 72.3	PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ---	AV : --- TR : TRIVIAL TR, PASP-27mmHg
TAPSE: 2.0 (>1.6)	LVPWD : 0.8 (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*  
**DR. RAHUL PATIL**  
 CONSULTANT CARDIOLOGIST