



NABH



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME :	Mr. BODDI RAMESH	DATE :	07/03/25
AGE :	35 years GENDER: MALE	PATIENT ID :	24012961
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-26mmHg
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 :

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



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Boodi Ramesh	Date	08/03/25
Age	35 years	Hospital ID	UHJA24012961
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 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 (11.4 x 4.1 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.3 x 4.5 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 ~ 16.2 cc.

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

IMPRESSION:

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

Dr. Elluru Santosh Kumar
Consultant Radiologist



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DEPARTMENT OF RADIODIAGNOSIS

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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. boodi ramesh Birth date: / / mmHg 35 years

Sex: M Weight: kg

Indication: /

Symptoms: /

History: /

Heart rate: 64 bpm

RR interval: 152 ms

RS duration: 90 ms

QT/QTc(E) interval: 388/398 ms

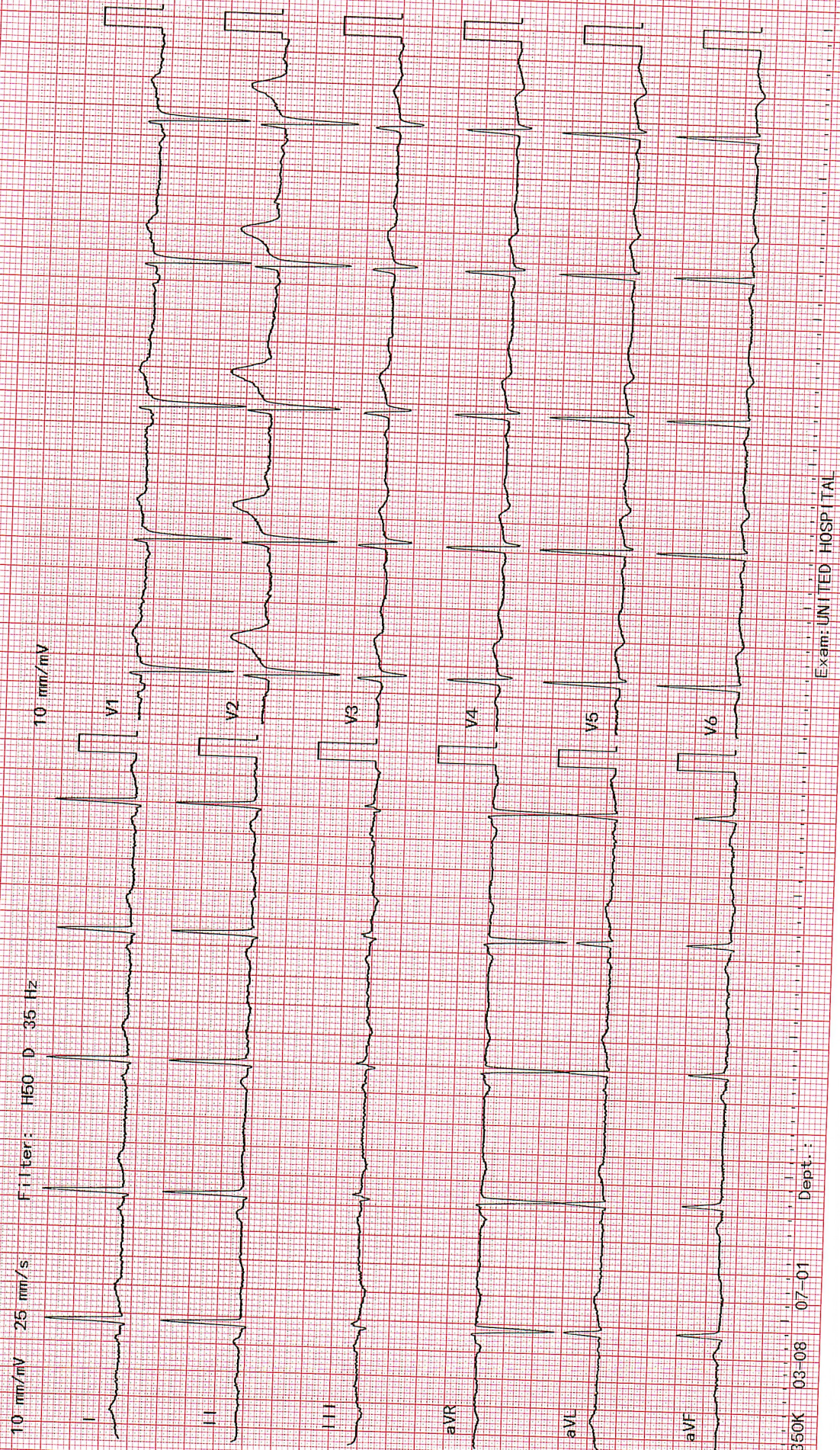
QT/QTc(T) interval: 41/30/-10 ms

V5/SV1 amplitude: 1.49/1.70 mV

V5+SV1 amplitude: 3.19 mV

1100 Sinus rhythm
 4068 Nonspecific T wave abnormality [flat T or negative T (I, II, aVL, aVF, V4, V5, V6)]
 9130 **borderline ECG**

Unconfirmed Report
 Reviewed by:





NABH



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Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr. BOODI RAMESH	UHID	: UHJA24012961
Age / Sex	: 35 Years / Male	OP NO/Reg Dt	: 08-03-2025 08:35 AM
Spouse / Father Name	: KUSUMA BOODI	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: 80 kg

Bp: 160/80 mmHg

Investigations:

SpO2: 99%

PP: 86 bpm

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. BOODI RAMESH	Order No	: 1000119871
UHID	: UHJ A24012961	Registered On	: 08/03/2025 08:35:16 AM
Age/Sex	: 35/Years Male	Collected On	: 08/03/2025 08:49:50 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:53:27 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJ A240018257
Station	: At Hospital	Mobile No	: 9538517466
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	108	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	106	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.52	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	9.86	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	1.58	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	223	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	181	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	40.2	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	146.60	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	36.20	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.55		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.65		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	182.80	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.1	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	1.10	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.61	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.14	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.47	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.72	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.68	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.28		2:1

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	31	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	48	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	123	U/L	50-116
GGT (Method:IFCC)	83	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)	16.70	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	49.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7870	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	54.32	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.32	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.44	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.44	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.48	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.78	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	86.0	fL	78-100
MCH (Method: Calculated)	28.9	pg	27-31
MCHC (Method: Calculated)	33.6	g/dL	31-37
RDW - CV (Method: Calculated)	13.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.60	Lakhs/Cum	1.5-4.5


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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.07	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.5	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4270	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	190	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	2860	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	510	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	40	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)	A		
Rh Factor (Method:Agglutination Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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<u>CLINICAL PATHOLOGY</u>			
URINE EXAMINATION, ROUTINE Sample: Urine			
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.5		5.0-8.0
SPECIFIC GRAVITY	1.005		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	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
G Mahesh kumar

---End of Report---



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