UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. NAGAVEENA M R	Order No	: 1000120067
UHID	: UHJA24013013	Registered On	: 09/03/2025 08:21:57 AM
Age/Sex	: 55/Years Female	Collected On	: 09/03/2025 08:45:09 AM
Ward / Bed No	:	Reported On	: 09/03/2025 01:12:58 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018333
Station	: At Hospital	Mobile No	: 9632777883
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	113	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	93	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	111	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.32	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.61	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.87	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	237	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	125	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	64.1	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	147.90	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	25.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.70		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.31		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	172.90	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.7	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.14	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.22	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.92	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.05	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.15	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.29		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	18	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	73	U/L	46-122
GGT (Method:IFCC)	12	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	19.7	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.75	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	12		12¯20 : 1

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)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	12.73	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.2	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	3700	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	55.92	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.81	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.59	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.31	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.37	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.07	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	91.5	fL	78-100
MCH (Method: Calculated)	31.3	pg	27-31
MCHC (Method: Calculated)	34.2	g/dL	31-37
RDW - CV (Method: Calculated)	12.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.05	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)	7.41	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.2	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	2070	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	100	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1250	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	270	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	10	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	35	mm/hour	1-30

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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CLINICAL PATHOLOGY

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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	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		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Sridhar Kandukuri

---End of Report---

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

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Nagaveena M R	**Date**	09/03/25
Age	55 years	**Hospital ID**	UHJA24013013
Sex	Female	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral prominent broncho vascular markings are seen in lung fields.

Bilateral lung fields are grossly normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **Bilateral prominent broncho vascular markings in lung fields.**
- **No radiographic abnormality.**

Dr. Varun
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Nagaveena M R	**Date**	09/03/25
Age	55 years	**Hospital ID**	UHJA24013013
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 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 evidence of mass or focal lesions.

Right Kidney is normal in size (9.7 x 4.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.3 x 4.5 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 atrophic, measures 6.0 x 2.3 cms. ***Endometrium thickened 8.5 mm.***
Heteroechoic lesion measuring 17 x 15 x 12 mm noted in the anterior wall - likely fibroid.
Both ovaries could not be visualized - likely atrophic.
Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

- **Uterine fibroid.**
- **Thickened endometirum.**

Dr. Varun
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
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DEPARTMENT OF RADIODIAGNOSIS

Name	Nagaveena M R	**Date**	09/03/25
Age	55 years	**Hospital ID**	UHJA24013013
Sex	Female	**Ref.**	Health check

BILATERAL SONOMAMMOGRAPHY

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **No significant abnormality detected in this study.**

Dr. Varun
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.NAGAVEENA M R**	**UHID**	**: UHJA24013013**
Age / Sex	: 55 Years / Female	OP NO/Reg Dt	: 09-03-2025 08:21 AM
Spouse / Father Name	: .	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 - 179 Cms.
Wt - 72 kg.
SpO2 - 96 %
PR - 73/min
BP - 90/60 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

ID:24013013

Name:Mrs. Nagaveena

9-Mar-2025 AM9:53:59

SCHILLER

lex:F Birth date: 55 years

cm kg / mmHg

1100 Sinus rhythm

9110 ** normal ECG **

ledication:

lymptoms:

listory:

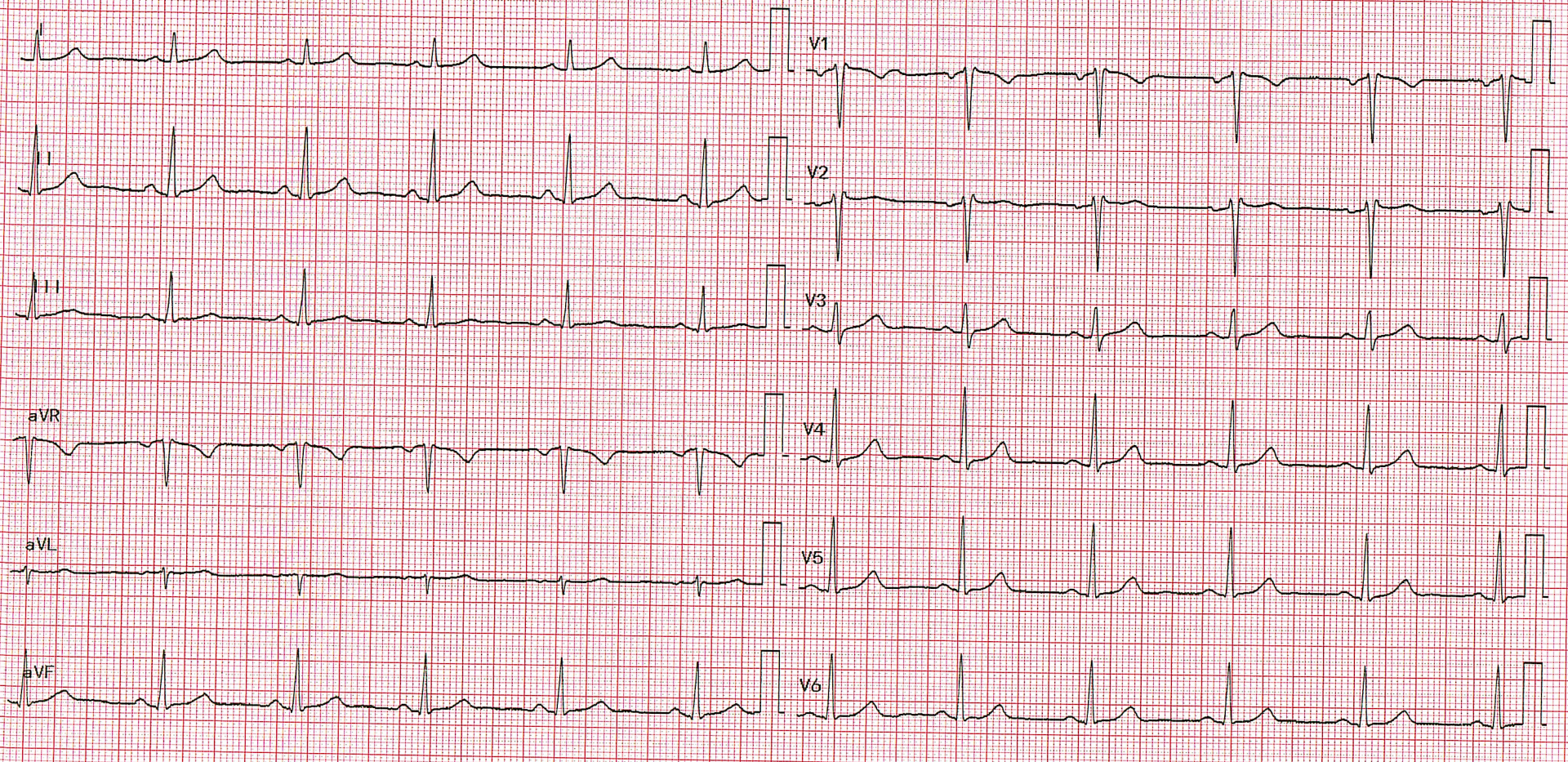
lent. rate	68	bpm
IR int	144	ms
IRS dur	86	ms
IT/QTc(E) int	370/ 388	ms
I/QRS/T axis	55/ 63/ 48	°
IV5/SV1 amp	1.24/ 1.10	mV
IV5+SV1 amp	2.34	mV

Unconfirmed Report

Reviewed by:

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

10 mm/mV



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME:	Mrs. NAGAVEENA M R	DATE:	09/03/25
AGE :	55 Years Sex: FEMALE	UHID :	24013013
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 : 4.5 (3.5-5.5)	MV EV : 96.5	AV : 70.3	MR : NORMAL
LA : 3.5 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 110		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 61.6		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ---	AV : ---	TR : TRIVIAL TR, PASP-28mmHg
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

IMPRESSION :

BRADYCARDIA OBSERVED DURING THE STUDY (HR – 53 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