NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.HULLURAPPA SREEVATHSA**	**UHID**	**: UHJA23018084**
Age / Sex	: 51 Years / Male	OP NO/Reg Dt	: OP240000018477 / 08-03-2025 08:36 AM
Father Name	:	Department	:
Spouse Name	: HULLURAPPA	Refered By	:
Address	: # 697,BDA Layout BSK 6th Stage 3rd Block Chikkegowdana Palya Thalaghattapura Banglore, BANGALORE CITY H O,	Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

HT= 168 cm
WT: 59.4 kg
BP: 127/81 mmHg

Investigations:

Sp. 98 %
Pr 75 bpm

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME :	**Mr. HULLURAPPA SREEVATHSA**	**DATE :**	**07/03/25**
AGE :	**51 years GENDER: MALE**	**PATIENT ID :**	**23018084**
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 : TRIVIAL MR
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-27mmHg
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

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Hullurappa Sreevathsa	**Date**	08/03/25
Age	51 years	**Hospital ID**	UHJA23018084
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 (9.3 x 3.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (9.5 x 4.3 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 ~ 18.3 cc. *There is a small cyst measuring 4 mm in the prostatic parenchyma.*

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

IMPRESSION:

- **No definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Hullurappa Sreevathsa	**Date**	08/03/25
Age	51 years	**Hospital ID**	UHJA23018084
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

ID:23018084 8-Mar-2025 AM9:22:15

Name:Mr.Hullurappa

lex:M Birth date: 51 years 1100 Sinus rhythm

cm kg / mmHg 9110 ** normal ECG **

ledication:

lymptoms:

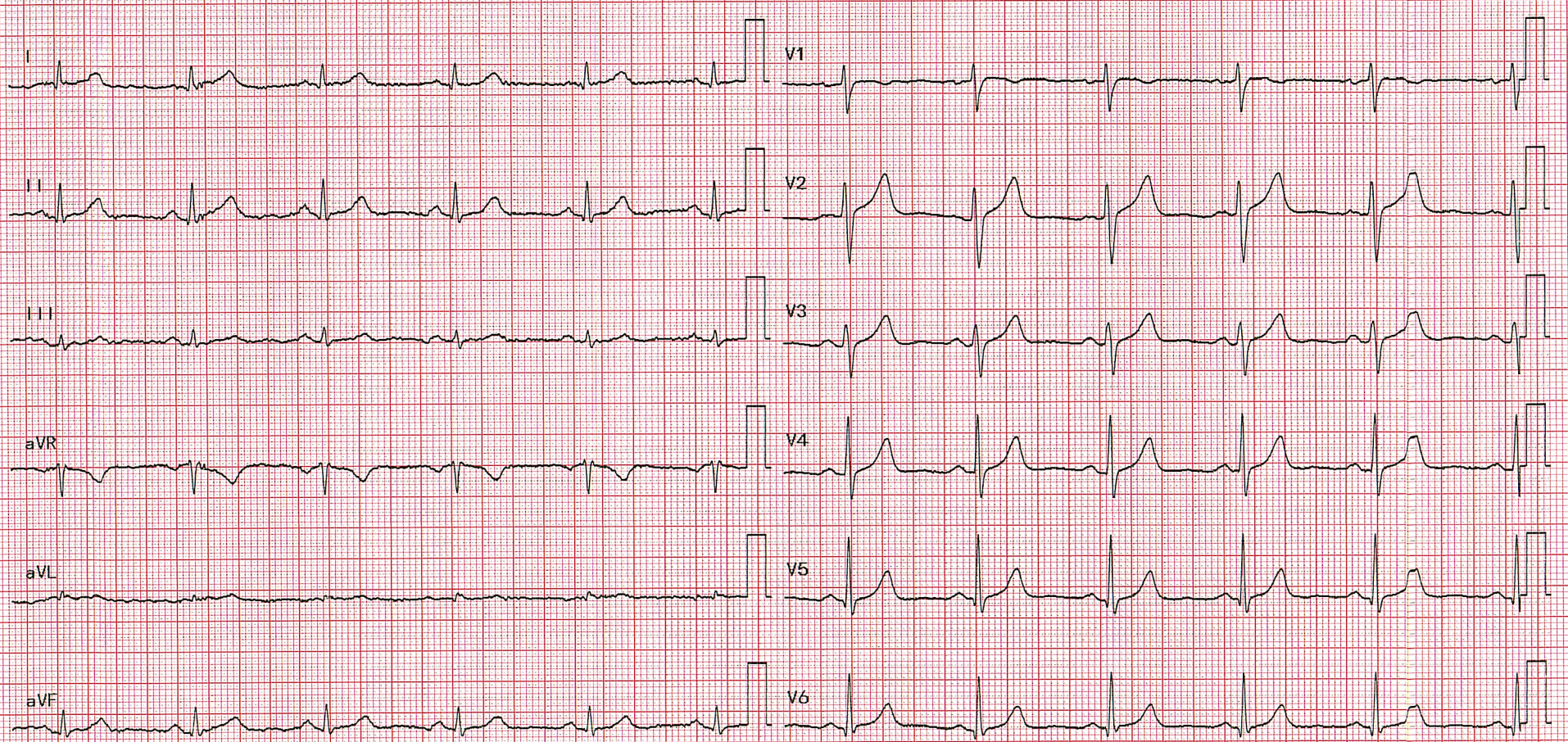
listory:

lent. rate	69	bpm
IR int	146	ms
IRS dur	88	ms
IT/QTc(E) int	382/ 402	ms
I/QRS/T axis	63/ 52/ 48	°
IV5/SV1 amp	1.25/ 0.58	mV
IV5+SV1 amp	1.83	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

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HULLURAPPA SREEVATHSA	Order No	: 1000119878
UHID	: UHJA23018084	Registered On	: 08/03/2025 08:36:43 AM
Age/Sex	: 51/Years Male	Collected On	: 08/03/2025 09:08:06 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:30:30 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018259
Station	: At Hospital	Mobile No	: 9449674193
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	106	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	152	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.2	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	103	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.18	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.29	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.54	ı IU/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)	111	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	42.2	mg/dL	< 40 - Low ≥ 60 - High

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HULLURAPPA SREEVATHSA	Order No	: 1000119878
UHID	: UHJA23018084	Registered On	: 08/03/2025 08:36:43 AM
Age/Sex	: 51/Years Male	Collected On	: 08/03/2025 09:08:06 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:30:30 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018259
Station	: At Hospital	Mobile No	: 9449674193
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	160.60	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	22.20	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.33		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.81		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	182.80	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.5	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.96	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	8.33		12¯20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.38	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.25	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.13	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HULLURAPPA SREEVATHSA	Order No	: 1000119878
UHID	: UHJA23018084	Registered On	: 08/03/2025 08:36:43 AM
Age/Sex	: 51/Years Male	Collected On	: 08/03/2025 09:08:06 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:30:30 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018259
Station	: At Hospital	Mobile No	: 9449674193
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.38	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.92	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.50		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	18	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	62	U/L	50-116
GGT (Method:IFCC)	18	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	1.27	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	16.8	mg/dL	17-43

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

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HULLURAPPA SREEVATHSA	Order No	: 1000119878
UHID	: UHJA23018084	Registered On	: 08/03/2025 08:36:43 AM
Age/Sex	: 51/Years Male	Collected On	: 08/03/2025 09:08:06 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:30:30 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018259
Station	: At Hospital	Mobile No	: 9449674193
Payer Name	: Mediwheel	Report Status	: Final Report

HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC) — Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	16.13	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	47.8	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5060	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	58.38	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	26.93	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.90	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.34	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.45	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.41	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	88.3	fL	78-100
MCH (Method: Calculated)	29.8	pg	27-31
MCHC (Method: Calculated)	33.7	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.69	Lakhs/Cum	1.5-4.5

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HULLURAPPA SREEVATHSA	Order No	: 1000119878
UHID	: UHJA23018084	Registered On	: 08/03/2025 08:36:43 AM
Age/Sex	: 51/Years Male	Collected On	: 08/03/2025 09:08:06 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:30:30 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018259
Station	: At Hospital	Mobile No	: 9449674193
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	9.81	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.1	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	2950	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	300	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1360	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	420	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	05	mm/hour	1-20

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
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HULLURAPPA SREEVATHSA	Order No	: 1000119878
UHID	: UHJA23018084	Registered On	: 08/03/2025 08:36:43 AM
Age/Sex	: 51/Years Male	Collected On	: 08/03/2025 09:08:06 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:30:30 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018259
Station	: At Hospital	Mobile No	: 9449674193
Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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			

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HULLURAPPA SREEVATHSA	Order No	: 1000119878
UHID	: UHJA23018084	Registered On	: 08/03/2025 08:36:43 AM
Age/Sex	: 51/Years Male	Collected On	: 08/03/2025 09:08:06 AM
Ward / Bed No	:	Reported On	: 08/03/2025 12:30:30 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018259
Station	: At Hospital	Mobile No	: 9449674193
Payer Name	: Mediwheel	Report Status	: Final Report

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
Dr Varsha Shree R

---End of Report---

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