

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mrs. POORNIMA.S	Order No : 1000119883
UHID : UHJ A23018085	Registered On : 08/03/2025 08:38:18 AM
Age/Sex : 43/Years Female	Collected On : 08/03/2025 09:12:25 AM
Ward / Bed No :	Reported On : 08/03/2025 12:30:39 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJ A240018261
Station : At Hospital	Mobile No : 9449674193
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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BIOCHEMISTRY

**FASTING GLUCOSE** 104 mg/dL  
(Method: Hexokinase)  
ADA Guidelines  
< 100 mg/dl - Normal  
100 to 125 mg/dl - Prediabetes  
≥ 126 mg/dl - Diabetes

**POST PRANDIAL GLUCOSE** 153 mg/dL  
(Method: Hexokinase)  
70-140

**GLYCOSYLATED HAEMOGLOBIN (HBA1C)** Sample: Whole blood (EDTA)

**HBA1C** 5.3 %  
(Method: HPLC)  
ADA Guidelines  
< 5.7% - Normal  
5.7 to 6.4% - Prediabetes  
≥ 6.5% - Diabetes

**Estimated Average Glucose (eAG)** 105 mg/dL  
(Method: Calculated)

**THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)** Sample: Serum

**TOTAL T3** 1.21 ng/mL  
(Method:CLIA)  
0.87-1.78

**TOTAL T4** 12.25 µg/dL  
(Method:CLIA)  
5.1-14.1

**THYROID STIMULATING HORMONE (TSH)** 4.49 µIU/mL  
(Method:CLIA: Ultra-sensitive)  
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)

**LIPID PROFILE** Sample: Serum

**TOTAL CHOLESTEROL** 228 mg/dL  
(Method:CHOD-POD)  
ATP III Guidelines  
< 200 - Desirable  
200-239 - Borderline high  
≥ 240 - High

**TRIGLYCERIDES** 102 mg/dL  
(Method:Enzymatic GPO-POD)  
< 150 - Normal  
150-199 - Borderline High  
200-499 - High  
≥ 500 - Very High

**HDL CHOLESTEROL** 51.3 mg/dL  
(Method:ENZYMATIC METHOD)  
< 40 - Low  
≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	156.30	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	20.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.44		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.05		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	176.70	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	5.4	mg/dL	2.6-6.0
<b>LIVER FUNCTION TEST</b>			
Sample: Serum			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.12	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.22	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.90	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.51	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.59	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.26		2:1
SERUM SGOT (Method:IFCC without P5P)	32	U/L	< 35

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<b>SERUM SGPT</b> (Method:IFCC without P5P)	26	U/L	< 35
<b>ALKALINE PHOSPHATASE, SERUM</b> (Method:PNPP AMP Buffer)	121	U/L	46-122
<b>GGT</b> (Method:IFCC)	27	U/L	< 38
<b>UREA</b> (Method:Urease GLDH - Kinetic)	18.9	mg/dL	17-43
<b>BUN/CREATININE RATIO</b>			
<b>BLOOD UREA NITROGEN(BUN)</b> (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	0.64	mg/dL	0.6-1.1
<b>BUN/CRE-RATIO</b> (Method: Calculated)	14.09		12~20 : 1

Sample: Serum



**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)	14.19	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	41.6	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7400	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
NEUTROPHILS (Method:Optical/Impedance)	59.90	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	28.51	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.31	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.91	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.37	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.17	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	80.4	fL	78-100
MCH (Method: Calculated)	27.4	pg	27-31
MCHC (Method: Calculated)	34.1	g/dL	31-37
RDW - CV (Method: Calculated)	14.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.75	Lakhs/Cum	1.5-4.5




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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.35	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.9	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4430	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	390	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	2110	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	440	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	30	Cells/Cum	20-100
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	30	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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<b><u>CLINICAL PATHOLOGY</u></b>			
URINE EXAMINATION, ROUTINE			Sample: Urine
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Turbid		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.010		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)	Present (+)		Negative
BLOOD (Method:Peroxidase Reaction)	Present (+)		Negative
MICROSCOPIC EXAMINATION			

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EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	6-8	/HPF	0-5
RBCs	4-6	/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  
Dr Varsha Shree R

---End of Report---



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



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Jayanagar, Bangalore

PATIENT NAME :	Mrs. POORNIMA S	DATE :	07/03/25
AGE :	43 years GENDER: FEMALE	PATIENT ID :	23018085
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)	MVEV :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-25mmHg
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

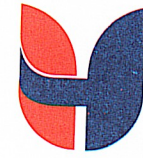




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**UNITED  
HOSPITAL**

Care Par Excellence  
Jayanagar, Bangalore

### DEPARTMENT OF RADIODIAGNOSIS

Name	Poornima S	Date	08/03/25
Age	43 years	Hospital ID	UHJA23018085
Sex	Female	Ref.	Health check

### BILATERAL SONOMAMMOGRAPHY

#### FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Homogeneous fibroglandular background echotexture is seen in both breasts.

*Clustered micro cysts measuring 6 x 5 x 3 mm is seen in the right retroareolar region.*

*Simple cyst measuring 4 mm is seen at 3 o'clock position of right breast.*

*There is a small subcutaneous lipoma measuring 10 x 5 mm at 5 o'clock position in right breast.*

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

#### IMPRESSION:

- Clustered micro cysts and a simple cyst in right breast. BIRADS 2 - Benign.
- No other significant abnormality detected in this study.

Dr. Elluru Santosh Kumar  
Consultant Radiologist





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### DEPARTMENT OF RADIODIAGNOSIS

Name	Poornima S	Date	08/03/25
Age	43 years	Hospital ID	UHJA23018085
Sex	Female	Ref.	Health check

### ULTRASOUND ABDOMEN AND PELVIS

#### FINDINGS:

**Liver is enlarged in size (15.1 cms) and shows mild 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 shows few polyps, largest measures 3 mm.** There is no 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 (9.5 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

**Left Kidney** is normal in size (10.3 x 3.3 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 5.5 x 2.5 x 3.2 cms. Endometrium measures 3.9 mm. **Both ovaries** appear 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:

- Few small gall bladder polyps.
- Mild hepatomegaly with mild fatty infiltration (Grade I).



Dr. Elluru Santosh Kumar  
Consultant Radiologist





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### DEPARTMENT OF RADIODIAGNOSIS

Name	Poornima S	Date	08/03/25
Age	43 years	Hospital ID	UHJA23018085
Sex	Female	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



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### Out Patient Record

<b>Patient Name</b>	: Mrs.POORNIMA.S	<b>UHID</b>	: UHJA23018085
<b>Age / Sex</b>	: 43 Years / Female	<b>OP NO/Reg Dt</b>	: OP240000018479 / 08-03-2025 08:38 AM
<b>Father Name</b>	:	<b>Department</b>	:
<b>Spouse Name</b>	: H SREEVATHSA	<b>Referred By</b>	:
<b>Address</b>	: # 697,Banashankari 6th Stage Chikkegowda Palya Thalaghatpura Banglroe , BANGALORE CITY H O, Bengaluru Urban,	<b>Consultant</b>	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		<b>KMC No.</b>	: 02M1087

**Complaints / Findings / Observations :**

HTc 150 cm  
 Wt 61.8 kg  
 Bp = 150/90 mmHg  
 SpO2 = 98 %  
 PR 84 bpm

**Investigations:**

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

**Follow Up Advice :**

Signature of the Doctor



Name: mr's poorima

Birth date: /

43 years

1100 Sinus rhythm

4068 Nonspecific T wave abnormality [flat T or negative T (I, V3, V4, V5, V6)]

9130 \*\* border-line ECG \*\*

sex: F cm kg Birth date: mmHg

Indication:

Symptoms:

History:

Int. rate

83 bpm

R int

130 ms

RS dur

92 ms

IT/QTc(E) int

362/402 ms

I/QRS/T axis

58/20/1 °

V5/SV1 amp

1.01/0.74 mV

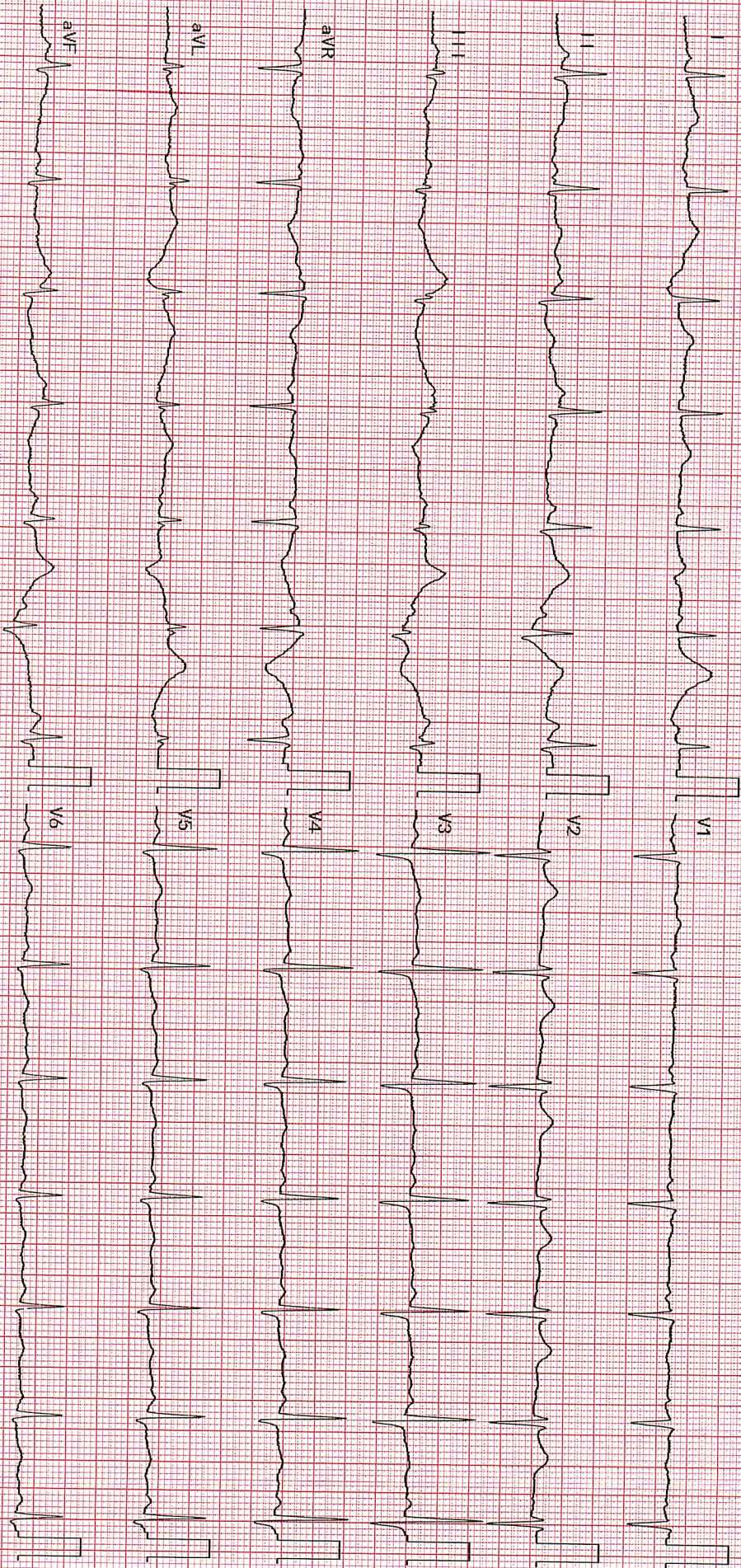
V5+SV1 amp

1.75 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