UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. LAKSHMIDEVAMMA	Order No	: 1000102709
UHID	: UHJA24007784	Registered On	: 09/11/2024 08:25:34 AM
Age/Sex	: 36/Years Female	Collected On	: 09/11/2024 08:37:31 AM
Ward / Bed No	:	Reported On	: 09/11/2024 03:17:49 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240010511
Station	: At Hospital	Mobile No	: 9066639003
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	84	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	90	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.8	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	91.18	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.03	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.12	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.55	ı IU/mL	0.34 - 5.60 ı IU/mL (Non Pregnant) 0.3 - 4.5 ı IU/mL (I trimester) 0.5 - 5.2 ı IU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	122	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	32	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.9	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	67.70	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	6.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	2.55		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.41		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	74.10	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.4	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	7	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.60	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.58	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.16	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.42	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.9	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.00	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.90	g/dL	2.3-3.5

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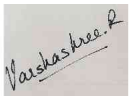
Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.38		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	12	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	65	U/L	46-122
GGT (Method:IFCC)	13	U/L	< 38



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

UNITED HOSPITAL
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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) Remarks: Microcytic hypochromic anemia. Kindly evaluate for iron deficiency status and correlate clinically.	7.67	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	25.8	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6180	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	61.61	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	27.79	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.97	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.36	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.27	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.30	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	60.1	fL	78-100
MCH (Method: Calculated)	17.8	pg	27-31
MCHC (Method: Calculated)	29.7	g/dL	31-37
RDW - CV (Method: Calculated)	21.9	%	11.5-14.5

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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET COUNT (Method:Electrical Impedance)	3.50	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.80	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	51.8	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	3810	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	310	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1720	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	330	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	38	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
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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	6.0		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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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
Rashmita

---End of Report---

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

ID:24007784
Name:MRS LAKSHMIDEVAMMA
ex:F Birth date:
cm kg / mmHg
edication:
ymptoms:
istory:

9-Nov-2024 AM8:57:30

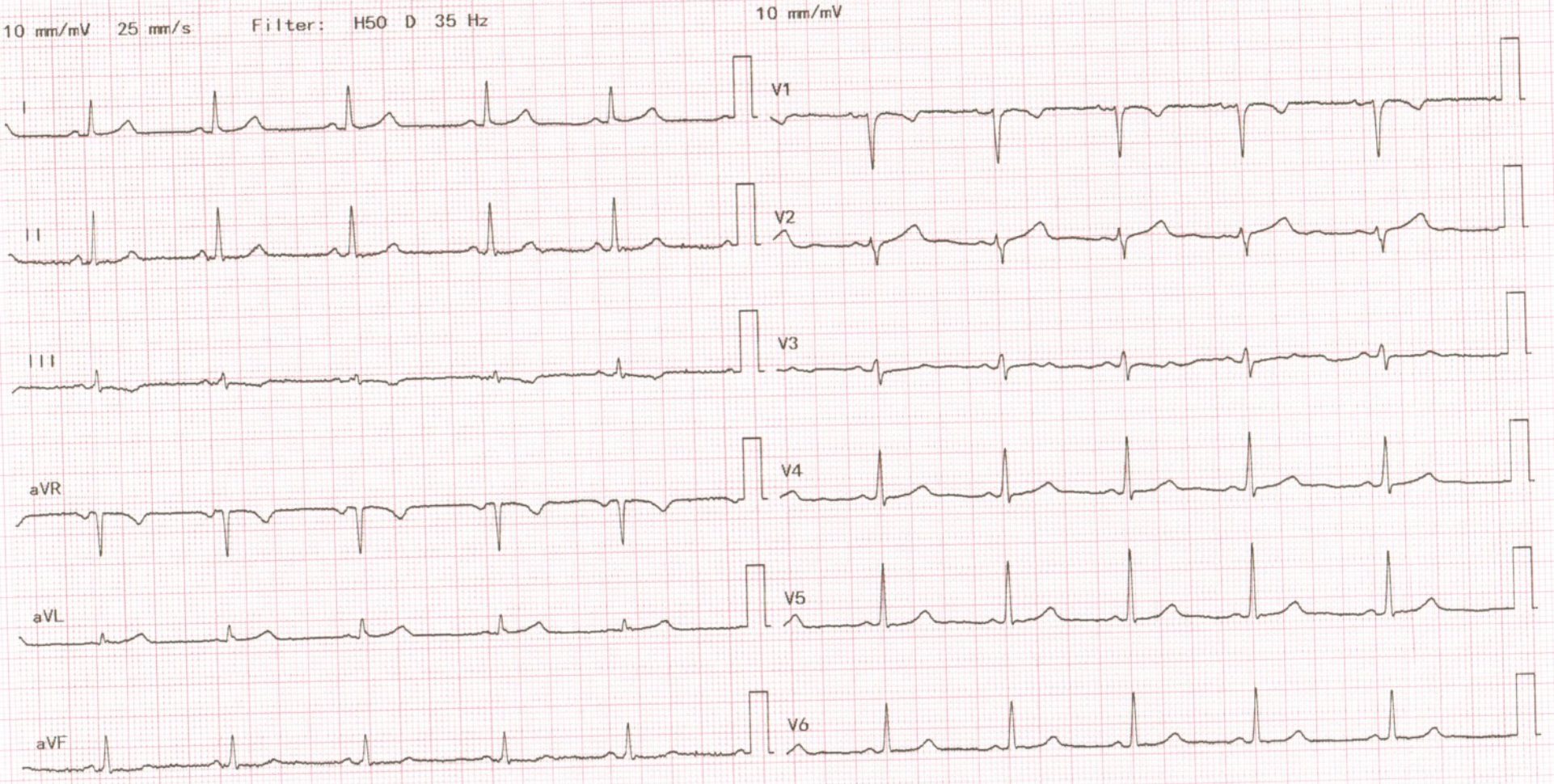
41 years

1100 Sinus rhythm
9110 ** normal ECG **

ent. rate	70	bpm
R int	126	ms
RS dur	74	ms
T/QTc(E) int	380/ 402	ms
/QRS/T axis	51/ 41/ 16	°
V5/SV1 amp	1.24/ 0.91	mV
V5+SV1 amp	2.15	mV

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. LAKSHMIDEVAMMA	Date :	09/11/24
Age :	41 years GENDER: FEMALE	Patient ID :	24007784
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 : 4.4 (3.5-5.5)	MV EV : 0.9	AV : 0.6	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.8 (2.4-4.2)	AV : 1.3		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.9		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 0.8 (0.9-1.2)	TV EV : ------	AV : ------	TR : TRIVIAL TR, PASP-30mmHg
TAPSE: 1.8 (>1.6)	LVPWD 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.9 (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	: MID THIN IAS, NO SHUNT ACROSS
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
CONSULTANT CARDIOLOGIST

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.LAKSHMIDEVAMMA**	**UHID**	**: UHJA24007784**
Age / Sex	: 41 Years / Female	OP NO/Reg Dt	: 09-11-2024 08:25 AM
Spouse / Father Name	: CHETHAN KUMAR	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 - 152cm
Wt - 58.7 kg
SpO_2 - 99-1.
PR - 88 b/m
BP - 114/74 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Lakshmidevamma	**Date**	09/11/24
Age	36 years	**Hospital ID**	UHJA24007784
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

DEPARTMENT OF RADIODIAGNOSIS

Name	Lakshmidevamma	**Date**	09/11/24
Age	36 years	**Hospital ID**	UHJA24007784
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS (TAS & TVS)

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 evidence of mass or focal lesions.

Right Kidney is normal in size (8.0 x 3.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.0 x 4.8 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 distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and ***mildly bulky in size, measures 9.9 x 6.6 x 4.6 cms.*** Myometrial echoes are normal. Endometrium measures 11.2 mm.
Right ovary is normal in size and echopattern, measures 8 cc. Corpus luteum is seen.
Left ovary is normal in size and echopattern, measures 5.8 cc.
Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

- **Mild fatty infiltration of liver (Grade I).**
- **Mild bulky uterus.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Mrs. Lakshmidevamma
41Yrs / Female

Gynaecology
9/11/24
Dr. Deepu K. Hebba

Menst calender.

- HB - 7pm. - In case of x's bleeding repeat mimed.

- Review after 3-6m
repeat USG - pelvis (TVS).

[signature]

No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Lakshmidevamma
37Yr/F

Opthal
9/11/24
Dr. Shwetha

Routine eye check

nil systemic

Vn — 6/6, 6/6 } N6

Ant seg: OU Normal

Fundus: OU CD ratio 0.3:1
FR (+)

IOP: OU clinically normal

9/11/24.

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Out Patient Record

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Hb. 7.67.

estigations:

Treatment / Care of Plan / Provisional Diagnosis :

Rx

(1)

Inv
Iron profile
Vit B12
folic acid
Peripheral smear.

1. Tab. Zentel 400mg
0 0 1.

3 wks.

2. Cap. Omefex XL total
0 1 0

Follow Up Advice :

Signature of the Doctor