UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore
A Unit of United Brothers Healthcare Services Private Limited
No. 110(30), Madhavan Park Circle, 10th Main Road, 3rd Block, Jayanagar, Bangalore - 560 011. T: 080 4566 6666 E: appointment@unitedhospital.in W: www.unitedhospital.com

NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Anisha Rajesh	**Date**	08/03/24
Age	47 years	**Hospital ID**	UHJA23019923
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

ID:
Name: anisha r

8-Mar-2024 AM10:57:47

F Birth date: 47 years

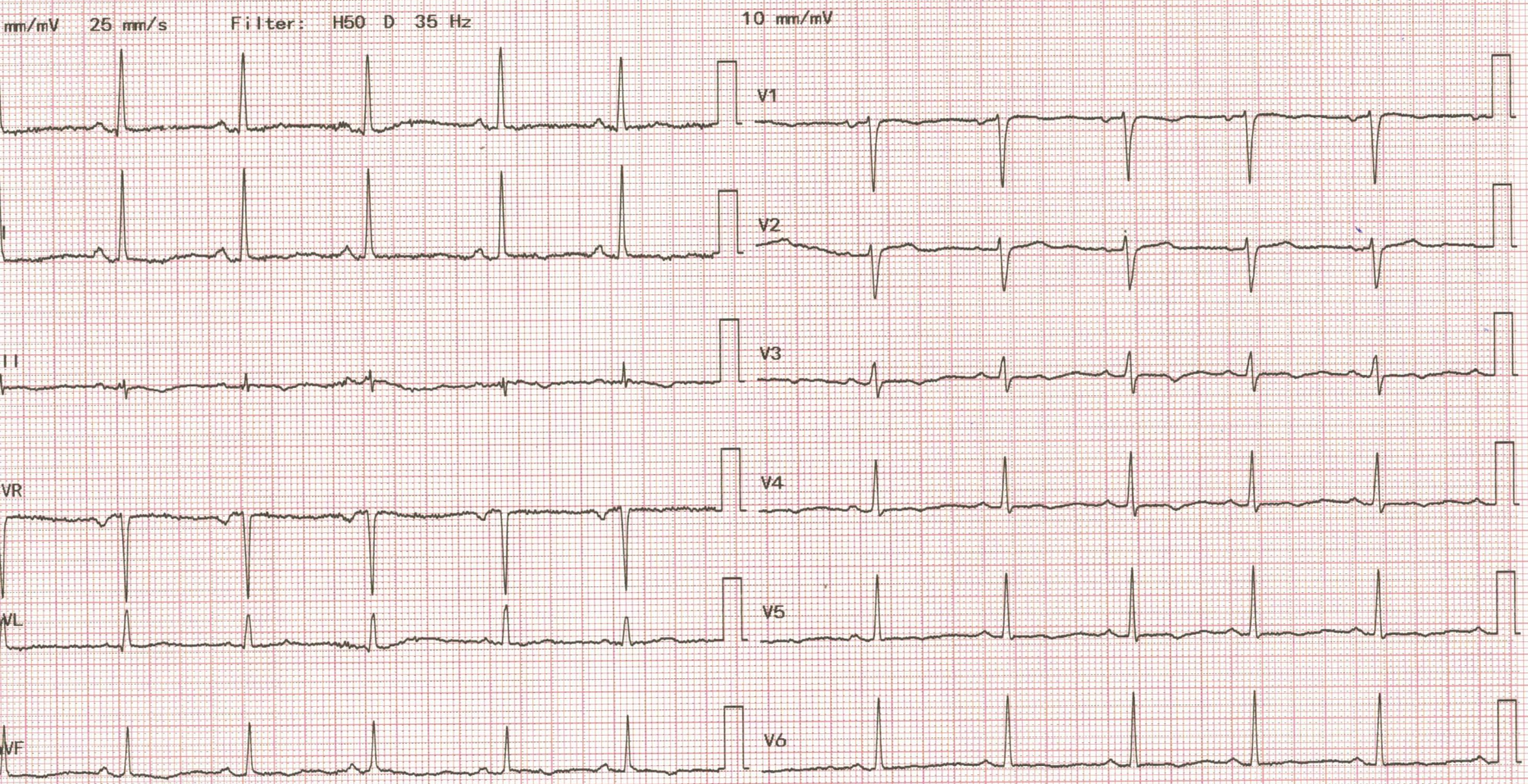
cm kg / mmHg

cation:
toms:
ory:

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

. rate	74	bpm
nt	158	ms
dur	84	ms
Tc(E) int	372/ 399	ms
S/T axis	49/ 44/ -8	°
SV1 amp	1.17/ 1.16	mV
SV1 amp	2.33	mV

Unconfirmed Report
Reviewed by:



Patient name :	**Mrs. ANISHA RAJESH**	**Date :**	**08/03/24**
Age :	**47 years GENDER: FEMALE**	**Patient ID :**	**19923**
Ref by :	**DR. CMO**	**OP/ IP :**	**HEALTH CHECKUP**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.9 (2.5-3.7)	LVIDD : 4.3 (3.5-5.5)	MV EV : 102	AV : 80.5	MR : NORMAL
LA : 2.7 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 93.7		AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 96.2		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>1.6)	LVPWD : 1.1 (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, TRIVIAL TR, PASP-20mmHg
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 PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

Mrs. Anisha Rajesh.

8/March/2024

Dr - Shwetha

V_1 6/18'
(glass) 6/12p

(glass) N/8

AI: OU Normal

Fundis: OU CDratio 0.3:1, FU (-)

Advice: Complete evaluation.

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Anisha Rajesh	**Date**	08/03/24
Age	47 years	**Hospital ID**	UHJA23019923
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (15 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 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 (8.8 x 3.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.9 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 minimally distended.

Uterus is surgically absent.
Both ovaries could not be visualized.

Infraumbilical defect measuring 1.0 x 0.9 cms is seen with herniation of omentum.

IMPRESSION:

- **Mild hepatomegaly with mild fatty infiltration (Grade I).**
- **Small omentum containing infraumbilical hernia.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

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Name	Anisha Rajesh	**Date**	08/03/24
Age	47 years	**Hospital ID**	UHJA23019923
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Homogeneous fatty background echotexture is seen in both breasts with fibroglandular tissue in retro-areolar region.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION: *Suboptimal evaluation due to large fatty breast.*

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

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH NABL No.1

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Jayanagar, Bangal

Out Patient Record

Patient Name	**: Ms.ANISHA RAJESH**	**UHID**	**: UHJA23019923**
Age / Sex	: 47 Years / Female	OP NO/Reg Dt	: 08-03-2024 09:20 AM
Spouse / Father Name	: RAJESH R	Department	: OBG
Address	: prestige zindal city tumkur main road , , Bengaluru Urban, Karnataka, INDIA,	Refered By	Dr Vijaya
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Regular check up
c/o Itching in vulva 5 6 Month
on & off

Investigations: O/H

P1L1 F2 (2007 2010

FIND - 1999 Scan - Myoma

Treatment / Care of Plan / Provisional Diagnosis :

underwent lap hysterectomy 2007 at age -
Both ovaries Re
& Adenomyosis

Follow Up Advice : O/E Bil Breast - NAD

PA soft

PIS - vault healthy
Grade I Cystocele +
vault Smear taken

Signature of the D

(A Unit of United Brotherss Healthcare Services Private Limited)

No Difficulty in passing urine
no incomplete voiding

Adv
- Kegel's Exercise
- Regular check up of your urine

Candid V 6 → 6 Days
PIV 0-0-1

HTI Zole Cream
LA
✓-0-✓

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Address	: prestige zindal city tumkur main road , , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

S/R physician Team

Report reviewed.

No major complains.

Ht - 162 cm
Wt - 73.7 kg
BP - 116/84
PR - 82 bpm
SPO2 - 99%

Investigations:

Lipid Profile - noted

USG Abd & Pelvis - noted.

Treatment / Care of Plan / Provisional Diagnosis :

Lipid Profile after 1 month

Adv: Dietary changes
Lifestyle modifications.

Follow Up Advice :

Consider medications for lipid Profile management but patient wants to repeat it after 1 month & review

Dr Niranjan. P (General Surgeon) to review

Signature of the Doctor

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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. ANISHA RAJESH	Order No	: 1000076050
UHID	: UHJA23019923	Registered On	: 08/03/2024 09:20:27 AM
Age/Sex	: 47/Years Female	Collected On	: 08/03/2024 09:34:33 AM
Ward / Bed No	:	Reported On	: 08/03/2024 01:38:26 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230024609
Station	: At Hospital	Mobile No	: 9945079110
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	98	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	85	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)	102.54	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)	9.51	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	4.10	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	283	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	149	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	61.6	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	191.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	29.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.59		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.11		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	221.4	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.6	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.68	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.57	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.29	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.80	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.52		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	28	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	51	U/L	46-122
GGT (Method:IFCC)	18	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	28.2	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.69	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	18.84		12-20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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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)	13.73	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	40.5	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6050	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	53.54	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	35.70	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.67	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.70	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.39	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.90	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.7	fL	78-100
MCH (Method: Calculated)	28.0	pg	27-31
MCHC (Method: Calculated)	33.9	g/dL	31-37
RDW - CV (Method: Calculated)	13.4	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.92	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)	7.29	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	40	mm/hour	1-20

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	AB	
Rh Factor (Method:Agglutination Gel Method)	Negative	

Interpretation Notes

Note: Both forward and reverse grouping performed

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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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	Cloudy		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.025		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)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	4-6	/HPF	0-5
PUS CELLS	6-8	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418