UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. R TAMIL SELVI	Order No	: 1000068742
UHID	: UHJA23016572	Registered On	: 27/01/2024 08:38:35 AM
Age/Sex	: 41/Years Female	Collected On	: 27/01/2024 08:41:25 AM
Ward / Bed No	:	Reported On	: 27/01/2024 12:25:43 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230020636
Station	: At Hospital	Mobile No	: 7829129094
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	97	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	124	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105.40	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.00	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	13.06	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	6.31	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)	165	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	69	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	37.6	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	113.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	13.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.3		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.0		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	127.4	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)	0.49	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.41	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.72	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.57	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.03		2:1
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	10	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	96	U/L	46-122
GGT (Method:IFCC)	13	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	21.6	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.57	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	17.5		12-20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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Test Name	Result	Unit	Bio. Ref. Interval
HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	11.85	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.3	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6340	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	75.54	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	14.48	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.85	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.91	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.22	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.47	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	83.4	fL	78-100
MCH (Method: Calculated)	26.5	pg	27-31
MCHC (Method: Calculated)	31.8	g/dL	31-37
RDW - CV (Method: Calculated)	15.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.58	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)	8.32	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	22.1	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-20

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

ABO Group (Method:Agglutination Gel Method)	O		
Rh Factor (Method:Agglutination Gel Method)	Positive		

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	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.030		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	0-2	/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
PRAVEEN T

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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TOTAL CHOLESTEROL (Method:CHOD-POD)	165	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
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TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.3		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.0		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	127.4	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)	0.49	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.41	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.72	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.57	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.03		2:1
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 35

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ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	96	U/L	46-122
GGT (Method:IFCC)	13	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	21.6	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.57	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	17.5		12-20 : 1

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HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	11.85	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.3	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6340	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	75.54	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	14.48	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.85	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.91	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.22	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.47	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	83.4	fL	78-100
MCH (Method: Calculated)	26.5	pg	27-31
MCHC (Method: Calculated)	31.8	g/dL	31-37
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PLATELET COUNT (Method:Electrical Impedance)	3.58	Lakhs/Cum	1.5-4.5

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PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	22.1	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-20

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

ABO Group (Method:Agglutination Gel Method)	O		
Rh Factor (Method:Agglutination Gel Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed

Naveen.N

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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	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.030		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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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
PRAVEEN T

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

Out Patient Record

Patient Name	**: Mrs.R TAMIL SELVI**	**UHID**	**: UHJA23016572**
Age / Sex	: 41 Years / Female	OP NO/Reg Dt	: 27-01-2024 08:38 AM
Spouse / Father Name	: SWAMINATHAN	Department	:
Address	: # G07 MBR Scapple Apartment Gottigere Bannarghatta Road Banglore , BANGALORE	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Routine Eye test

Investigations:

VA 6/6 N6 Both

ARD

Treatment / Care of Plan / Provisional Diagnosis :

Refraction

Follow Up Advice : Eye Checkup

Add

Yearly once

Signature of the Doctor

27/1/24

Dw LOL - ⓑ

N/G 41.09
41.09 } NG

Adv progressive / Amiodarone

2/11/24

27-Jan-2024 AM9:40:17

ID:16572

Name: Mrs.R.Tamil Selvi

Birth date:

41 years

lex:

cm kg / mmHg

ledication:

lymptoms:

listory:

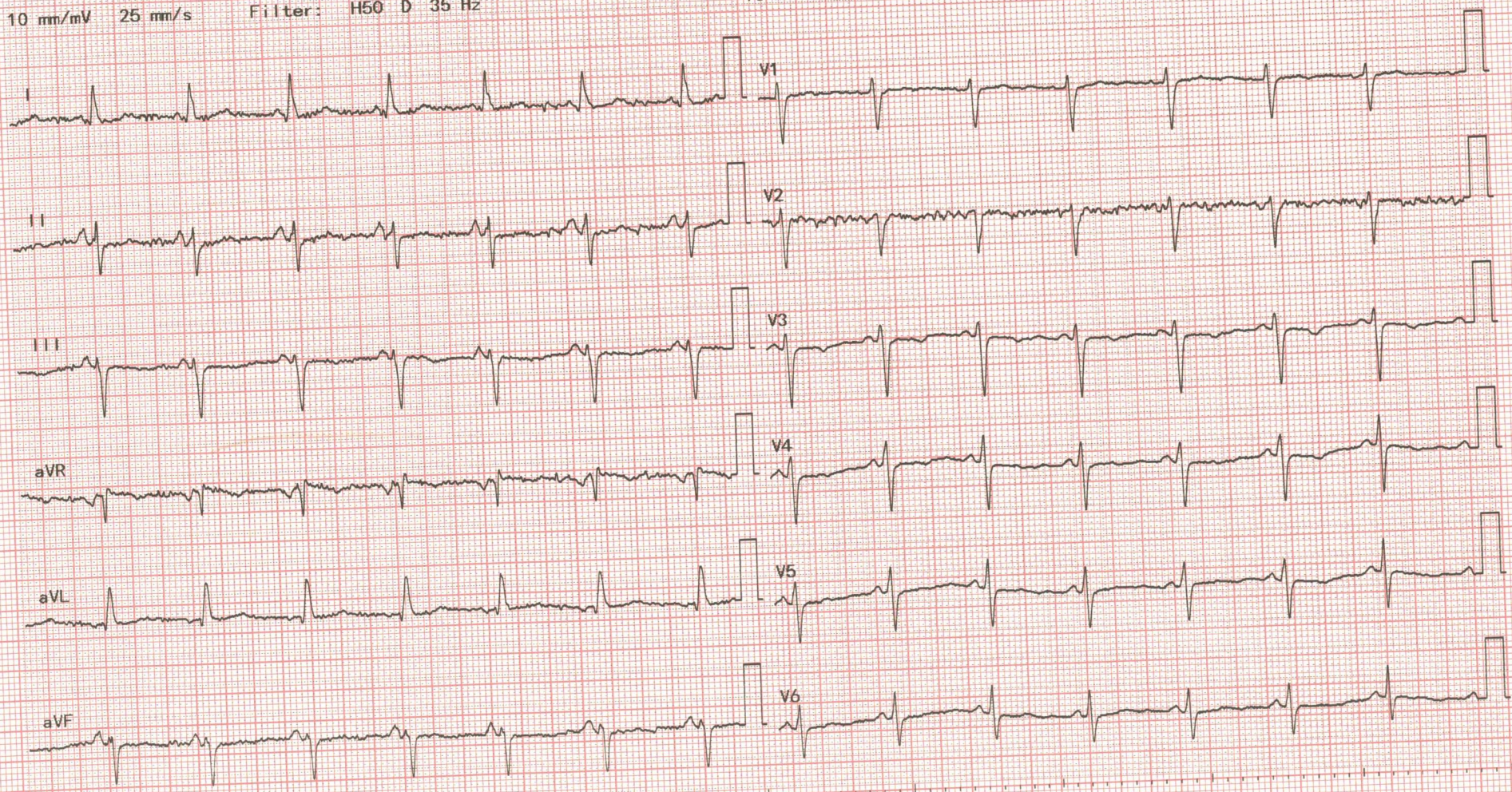
lent. rate	90	bpm
IR int	102	ms
IRS dur	98	ms
IT/QTc(E) int	344/ 392	ms
I/QRS/T axis	68/ -45/ 13	°
IV5/SV1 amp	0.51/ 0.73	mV
IV5+SV1 amp	1.25	mV

1100 Sinus rhythm
2210 Short PR interval [PR int. < 120 ms]
4068 Nonspecific Twave abnormality [flat T or negative T (aVL, V5)]
7200 Abnormal left axis deviation [-90 deg. < QRS axis < -30 deg.]
9150 ** abnormal ECG **

Unconfirmed Report
Reviewed by:

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

10 mm/mV



Exam: UNITED HOSPITAL

2350K 03-08 07-01 Dept.:

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mrs. R TAMIL SELVI**	**Date :**	**27/01/24**
Age :	**41 years GENDER: FEMALE**	**Patient ID :**	16572
Ref by :	**DR. CMO**	**OP/ IP :**	**HEALTH CHECKUP**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 3.4 (3.5-5.5)	MV EV : 87.8	AV : 75.2	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.3 (2.4-4.2)	AV : 130		AR : NORMAL
RA : 2.4 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 69.8		PR : NORMAL
RV : 2.1 (<3.5)	IVSS : 0.8 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.7 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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, JET GRDT-10mmHg
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

Out Patient Record

Patient Name	**: Mrs.R TAMIL SELVI**	**UHID**	**: UHJA23016572**
Age / Sex	: 41 Years / Female	OP NO/Reg Dt	: 27-01-2024 08:38 AM
Spouse / Father Name	: SWAMINATHAN	Department	: Health check
Address	: # G07 MBR Scapple Apartment Gottigere Bannarghatta Road Banglore , BANGALORE	Refered By	: Mediwheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Vignesh

Complaints / Findings / Observations : ENT Prescription

Came for Routine ENT check up.

Investigations: OE:- B/L Ears, Nose, Oral Cavity, Oropharynx WNL

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

DR. VIGNESH J
MBBS, DLO(MANIPAL), DNB(DELHI), FHNS(KIDWAI)
ENT, HEAD AND NECK CANCER SURGEON
REG. NO: 92095

Signature of the Doctor

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	R Tamil Selvi	**Date**	27/01/24
Age	41 years	**Hospital ID**	UHJA23016572
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

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. Giridhar V S
Consultant Radiologist

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	R Tamil Selvi	**Date**	27/01/24
Age	41 years	**Hospital ID**	UHJA23016572
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size measuring 15.3 cms 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 (9.3 x 1.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.0 x 1.5 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 well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus is retroflexed and normal in size, measures 8 x 5.5 x 4.2 cms. Myometrial and endometrial echoes are normal. Endometrium measures 7 mm.
Right ovary is normal in size.
Left ovary is normal in size.
Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

- **Grade I fatty liver.**
- **No other definite sonological abnormality detected.**

Dr. Giridhar V S
Consultant Radiologist

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	R Tamil Selvi	**Date**	27/01/24
Age	41 years	**Hospital ID**	UHJA23016572
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. Giridhar V S
Consultant Radiologist