



NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. JANAKI UDAYA HEGDE	Date :	27/02/24
Age :	52 years GENDER: FEMALE	Patient ID :	19193
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 : 4.2 (3.5-5.5)	MV EV : 74.7	AV : 67.9	MR : MILD MR
LA : 3.6 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 105		AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 85.9		PR : NORMAL
RV : 2.1 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>1.6)	LVPWD : 1.2 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (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, MILD MR
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL, TRIVIAL TR, PASP-25mmHg
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

27-Feb-2024 AM9:38:57

ID: 19193

Name: Mrs. Janaki udaya H

Birth date: / /

52 years

1100 Sinus rhythm

kg / mmHg

4012 Moderate ST depression [0.05+ mV ST depression (I, aVF, V5, V6)]

Indication:

Symptoms:

History:

Heart rate

84 bpm

RR interval

134 ms

RR duration

92 ms

PR/QTc (E) interval

364/404 ms

PR/QT axis

61/15/265

RV5/SV1 amplitude

0.69/1.02 mV

RV5+SV1 amplitude

1.71 mV

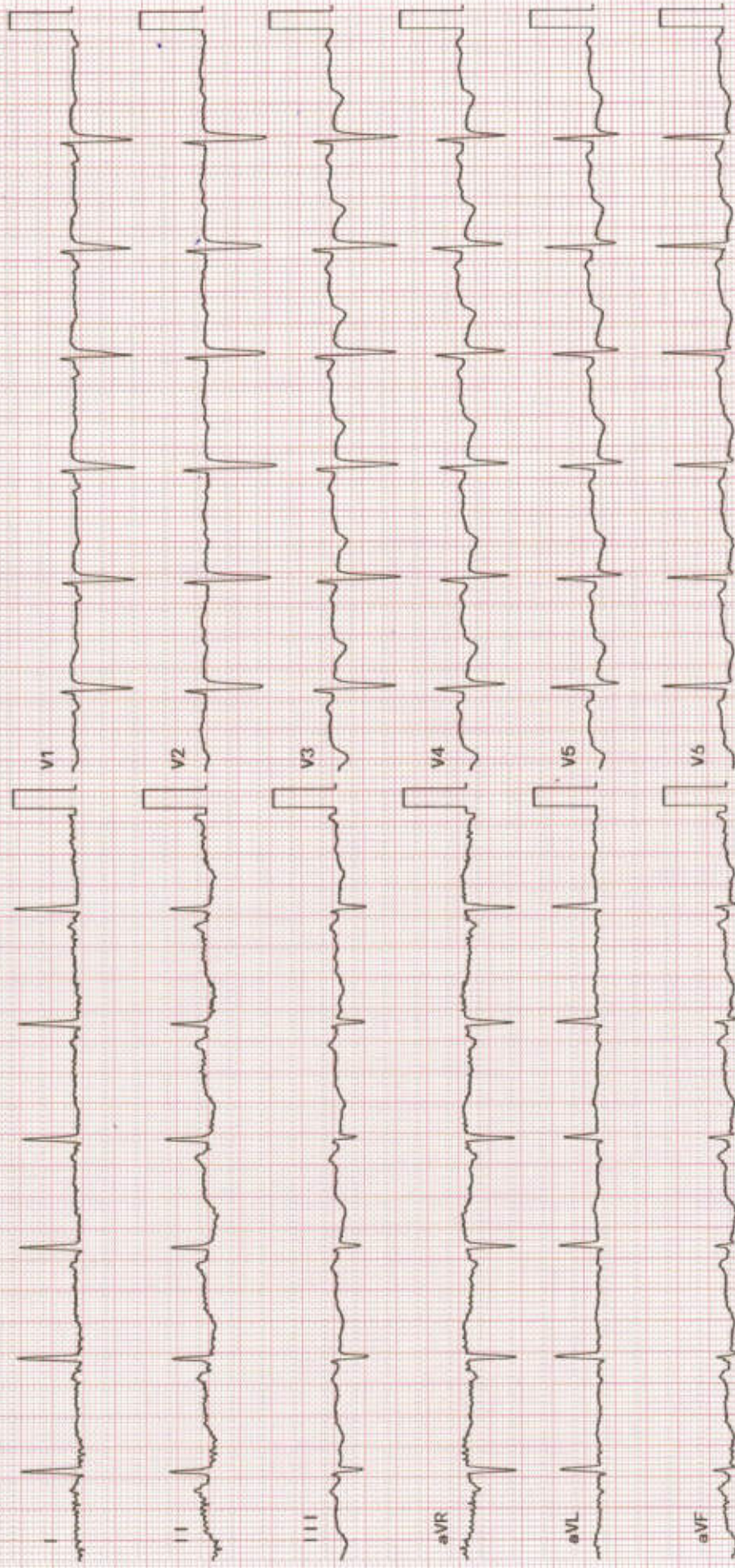
Unconfirmed Report

Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s





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Out Patient Record

Patient Name : Mrs. JANAKI UDAYA HEGDE **UHID** : UHJA23019193
Age / Sex : 52 Years / Female **OP NO/Reg Dt** : 27-02-2024 08:29 AM
Spouse / Father Name : UDAY GANAPATHI HEGDE **Department** :
Address : a1 402 cavery block natural games villages koramangala, Bengaluru Urban, Karnataka, **Referred By** :
Consultant : Dr. Preventive Health Check Up
KMC No. : *Dr. Vijalakshmi Gyn*

Complaints / Findings / Observations :

General health check up

Investigations:

- Underwent TLH 1 year ago Ovarian Ret
i/vlo - AUB - L

o/H - P_LL₂ - Both F/TND

Treatment / Care of Plan / Provisional Diagnosis :

past h/o - N.S
Medical h/o - 2. Thyroidism 75 sug
Family h/o - N.S No malignancy in family

o/f
Follow Up Advice: *Bill - Breast NAD*

PA - SST

pls
vault + healthy
vault smear taken

Mammography

[Signature]
 Signature of the Doctor



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 Spouse / Father Name : UDAY GANAPATHI HEGDE
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UHID : UHJA23019193
 OP NO/Reg Dt : 27-02-2024 08:29 AM
 Department :
 Referred By :
 Consultant : Dr. Preventive Health Check Up
 KMC No. : Dr. Ashwitha padma

Complaints / Findings / Observations :

no symptoms of dyspnoea or palpitations.

*Wt - 59.4 kg.
 HT - 152 cm
 Bp - 145/80
 SpO2 - 99%
 PR - 82b/m*

Investigations:

LDL - 192.

Treatment / Care of Plan / Provisional Diagnosis :

3 mths

Fasting lipid profile.

R

Tab. Rosavel ASP 25/10
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Follow Up Advice :

High fibre diet

L
 Signature of the Doctor

-DEPARTMENT OF RADIODIAGNOSIS

Name	Janaki Udaya Hedge	Date	27/02/24
Age	52 years	Hospital ID	UHJA23019193
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. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Janaki Udaya Hedge	Date	27/02/24
Age	52 years	Hospital ID	UHJA23019193
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is enlarged in size (16.8 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 (9.8 x 3.1 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (11.3 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 well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.

Uterus is surgically absent.

Both ovaries could not be visualized.

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

IMPRESSION:

- Mild hepatomegaly with mild fatty infiltration (Grade I).
- No other definite sonological abnormality detected.



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Age	52 years	Hospital ID	UHJA23019193
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 LABORATORY MEDICINE

Patient Name : Mrs. J ANAKI UDAYA HEGDE	Order No : 1000074711
UHID : UHJ A23019193	Registered On : 27/02/2024 08:29:30 AM
Age/Sex : 52/Years Female	Collected On : 27/02/2024 08:38:05 AM
Ward / Bed No :	Reported On : 27/02/2024 01:52:56 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230023743
Station : At Hospital	Mobile No : 8805457241
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	105	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	108	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	108.28	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.12	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.5	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.28	μIU/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)	151	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	60.3	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	192.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	30.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.6		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.1		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	222.7	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.5	mg/dL	2.6-6.0
LIVER FUNCTION TEST Sample: Serum			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.62	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.50	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.66	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.53	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.31		2:1
SERUM SGOT (Method:IFCC without P5P)	40	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	37	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	94	U/L	46-122
GGT (Method:IFCC)	15	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	18.2	mg/dL	17-43
BUN/CREATININE RATIO			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.66	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	13.6		12~20 : 1

Sample: Serum



Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.61	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.3	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6010	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	61.06	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	29.05	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.38	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.25	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.26	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.54	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	81.7	fL	78-100
MCH (Method: Calculated)	26.4	pg	27-31
MCHC (Method: Calculated)	32.3	g/dL	31-37
RDW - CV (Method: Calculated)	15.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.59	Lakhs/Cum	1.5-4.5

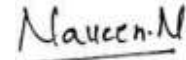
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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.11	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-30
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Gel Method)	A		
Rh Factor (Method:Agglutination Gel Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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

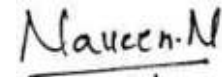
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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---



Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI UDAYA HEGDE	Order No	: 1000074714
UHID	: UHJA23019193 \	Registered On	: 27/02/2024 08:29:30 AM
Age/Sex	: 52/Years Female	Collected On	: 27/02/2024 03:03:30 PM
Ward / Bed No	:	Reported On	: 27/02/2024 04:57:22 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023743
Station	: At Hospital	Mobile No	: 8805457241
Payer Name	: Mediwheel	Report Status	: Final Report

Samples

CERVICAL SMEAR - 27/02/2024 03:03 PM

Test Name :PAP SMEAR

NUMBER OF SLIDES RECEIVED: 02
 TYPE OF THE SMEAR: Conventional
 SOURCE OF THE SMEAR: Vault
 CLINICAL DETAILS: P2L2
 L M P: Post-hysterectomy

SPECIMEN ADEQUACY:
 Satisfactory for evaluation.

MICROSCOPY:
 Smears show predominantly intermediate squamous, intermedio-parabasal and parabasal cells.
 Background shows moderate neutrophilic infiltrate.
 No trichomonads, candida, other parasites or non-specific microorganisms are present.

IMPRESSION: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY (NILM)
 COMMENTS: ATROPHIC SMEAR

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