

## DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. VINAY R	Order No	: 1000074169
UHID	: UHJ A23018942	Registered On	: 23/02/2024 09:34:27 AM
Age/Sex	: 36/Years Male	Collected On	: 23/02/2024 09:40:33 AM
Ward / Bed No	:	Reported On	: 27/02/2024 11:23:39 AM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230023412
Station	: At Hospital	Mobile No	: 9964544644
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	95	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	101	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	4.8	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	91.05	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method: CLIA)	1.23	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method: CLIA)	8.11	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method: CLIA: Ultra-sensitive)	6.03	μIU/mL	0.34-5.60
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method: CHOD-POD)	217	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method: Enzymatic GPO-POD)	93	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method: ENZYMATIC METHOD)	53.9	mg/dL	< 40 - Low ≥ 60 - High

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<b>LDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	144.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
<b>VLDL CHOLESTEROL</b> (Method: Calculated)	18.60	mg/dL	< 30
<b>TOTAL CHOLESTEROL : HDL RATIO</b> (Method: Calculated)	4.0		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
<b>LDL/HDL CHOLESTEROL RATIO</b> (Method: Calculated)	2.6		< 2.5 Optimal
<b>NON HDL CHOLESTEROL</b> (Method: Calculated)	163.1	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	5.6	mg/dL	3.5-7.2
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	1.04	mg/dL	0.9-1.3
<b>LIVER FUNCTION TEST</b>			Sample: Serum
<b>TOTAL BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.71	mg/dL	0.3-1.2
<b>DIRECT BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.14	mg/dL	0.0-0.2
<b>INDIRECT BILIRUBIN</b> (Method: Calculated)	0.57	mg/dL	0.2-1.0
<b>TOTAL PROTEIN</b> (Method:BIURET)	7.5	g/dL	6.6-8.3
<b>ALBUMIN</b> (Method:BCG)	4.61	g/dL	3.5-5.2
<b>GLOBULIN</b> (Method: Calculated)	2.88	g/dL	2.3-3.5
<b>AG RATIO</b> (Method: Calculated)	1.59		2:1

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SERUM SGOT (Method:IFCC without P5P)	13	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	15	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	46	U/L	50-116
GGT (Method:IFCC)	22	U/L	< 55



**Dr. Shanthakumar Muruda**  
Sr CONSULTANT BIOCHEMIST  
KMC No : 54192

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**HAEMATOLOGY**
**COMPLETE BLOOD COUNT(CBC)**

Sample: Whole blood (EDTA)

<b>HAEMOGLOBIN</b> (Method:Photometric Measurement: Oxyhemoglobin method)	15.21	g/dL	13.5-17.5
<b>PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)</b> (Method: Calculated)	45.7	%	42-52
<b>TOTAL WBC COUNT (TLC)</b> (Method:Coulter Principle)	4630	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> (Method:Optical/Impedance)	52.21	%	40-75
<b>LYMPHOCYTES</b> (Method:Optical/Impedance)	36.17	%	20-45
<b>EOSINOPHILS</b> (Method:Optical/Impedance)	4.43	%	0-6
<b>MONOCYTES</b> (Method:Optical/Impedance)	7.05	%	2-10
<b>BASOPHILS</b> (Method:Optical/Impedance)	0.14	%	0-2
<b>RED BLOOD CORPUSCLES(RBC)</b> (Method:Coulter Principle)	5.19	million/cum	4.5-5.9
<b>MCV</b> (Method:Derived from RBC Histogram)	88.1	fL	78-100
<b>MCH</b> (Method: Calculated)	29.3	pg	27-31
<b>MCHC</b> (Method: Calculated)	33.3	g/dL	31-37
<b>RDW - CV</b> (Method: Calculated)	14.0	%	11.5-14.5
<b>PLATELET COUNT</b> (Method:Electrical Impedance)	2.74	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.21	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.1	fl	9-19
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	10	mm/hour	1-15
<b>BLOOD GROUPING &amp; RH TYPING</b>			
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
**URINE EXAMINATION, ROUTINE**

Sample: Urine

**PHYSICAL EXAMINATION**

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.5		5.0-8.0
SPECIFIC GRAVITY	1.005		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**

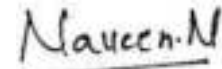
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EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
<b>URINE SUGAR, FASTING</b> (Method:GOD-POD)	Absent		
<b>URINE SUGAR (POST PRANDIAL)</b>	Absent		

Verified By  
PRAVEEN T

---End of Report---



**Dr. Naveen Kumar**  
CONSULTANT PATHOLOGIST  
KMC NO : 71418

Name: mr. vinay r

Birth date: / /

36 years

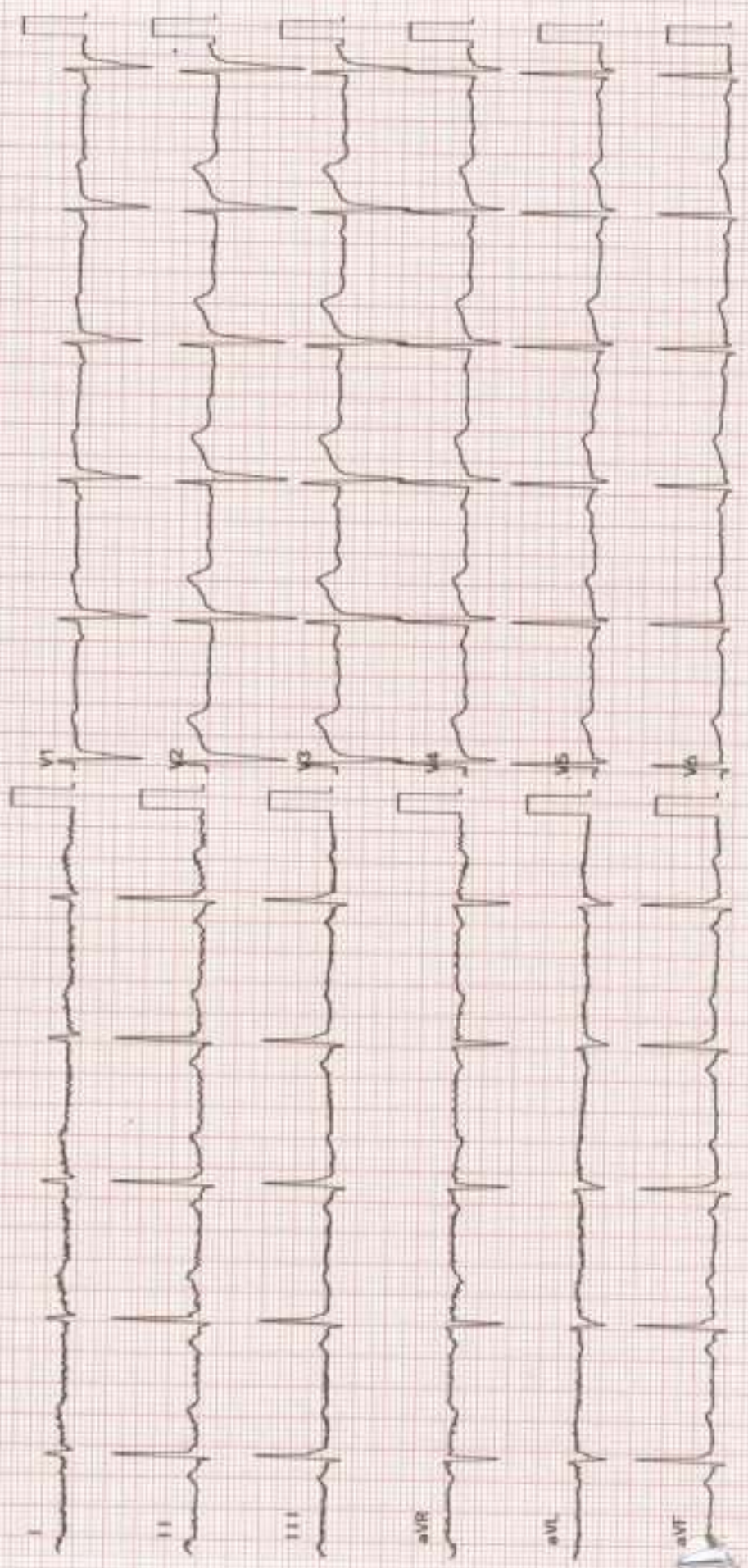
1100 Sinus rhythm  
0102 ARTIFACT PRESENT  
9110 \*\* normal ECG \*\*

sex: M  
cm  
kg  
mmHg

Indications:  
Symptoms:  
History:  
Heart rate: 66 bpm  
R int: 154 ms  
RS dur: 100 ms  
I/QTc(E) int: 396/410 ms  
VQRS/T axis: 71/ 82/ 52  
V5/SV1 amp: 1.49/ 1.18 mV  
V5+SV1 amp: 2.68 mV

Unconfirmed Report  
Reviewed by:

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







NABH



NABL



No.1



**UNITED HOSPITAL**

Care For Excellence  
Jayanagar, Bangalore

### Out Patient Record

<b>Patient Name</b> :	Mr. VINAY R	<b>UHID</b> :	UHJA23018942
<b>Age / Sex</b> :	36 Years / Male	<b>OP NO/Reg Dt</b> :	OP230000022393 / 23-02-2024 09:34 AM
<b>Father Name</b> :	RANGARAVIAH	<b>Department</b> :	
<b>Spouse Name</b> :		<b>Referred By</b> :	
<b>Address</b> :	Sapthagiri 60 Feet Road Tumkur, BANGALORE CITY H O, Bengaluru Urban, Karnataka, INDIA, 560002	<b>Consultant</b> :	Dr. Preventive Health Check Up
		<b>KMC No.</b> :	Dr. Sheetha [Optico]

#### Complaints / Findings / Observations :

Vision in RE has been low from before

#### Investigations:

$V_n$   $\left\{ \begin{array}{l} 6/9p \\ 6/6 \end{array} \right.$   
 (far)

nd 6

nil extra

AL 5 OU mod

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

Rx: 20 C.D. 0.25:1  
 (signature)

#### Follow Up Advice :

Rf. Rf. E.

Signature of the Doctor



NABH



NABL



No.1



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Jayanagar, Bangalore

**Out Patient Record**

<b>Patient Name</b>	: Mr.VINAY R	<b>UHID</b>	: UHJA23018942
<b>Age / Sex</b>	: 36 Years / Male	<b>OP NO/Reg Dt</b>	: OP230000022393 / 23-02-2024 09:34 AM
<b>Father Name</b>	: RANGARAVIAH	<b>Department</b>	:
<b>Spouse Name</b>	:	<b>Referred By</b>	:
<b>Address</b>	: Saphagiri 60 Feet Road Tumkur, BANGALORE CITY H O, Bengaluru Urban, Karnataka, INDIA, 560002	<b>Consultant</b>	: Dr.Preventive Health Check Up
		<b>KMC No.</b>	:

**Complaints / Findings / Observations :**

HT - 175.  
 WT - 79.8 kg.  
 BP - 109/82 mm/hg  
 P - 64 bpm.  
 SpO2 - 99%.

**Investigations:**

LDL - 144.  
 TG - 6.08

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

Repeat  
 TG / FPG / FPG  
 after 4 wks.

Rx  
 Tab. Roscard  
 10mg

**Follow Up Advice :**

Fasting lipid profile  
 after 3 wks.

Signature of the Doctor

**EXERCISE STRESS TEST REPORT**

Patient Name: MR. VINAY R.  
 Patient ID: 18942  
 Height: 175 cm  
 Weight: 79 kg

DOB: 08.06.1986  
 Age: 37yrs  
 Gender: Male  
 Race: Indian

Study Date: 27.02.2024  
 Test Type: Treadmill Stress Test  
 Protocol: BRUCE

Referring Physician: DR. RAHUL PATIL  
 Attending Physician: DR. RAHUL PATIL  
 Technician: YAMINI/THABITHA

**Medications:**

**Medical History:**  
 NO H/O DM & HTN

**Reason for Exercise Test:**  
 Screening for CAD

**Exercise Test Summary**

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:10	0.00	0.00	70	110/80	
	STANDING	00:19	0.00	0.00	69	110/80	
	HYPERV.	00:01	0.00	0.00	70	110/80	
	WARM-UP	00:15	0.00	0.00	66	110/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	99	110/80	
	STAGE 2	03:00	2.50	12.00	118	120/80	
	STAGE 3	02:11	3.40	14.00	141	130/90	
RECOVERY		05:38	0.00	0.00	72	130/90	

The patient exercised according to the BRUCE for 8:11 mins, achieving a work level of Max. METS: 10.10. The resting heart rate of 70 bpm rose to a maximal heart rate of 141 bpm. This value represents 77 % of the maximal, age-predicted heart rate. The resting blood pressure of 110/80 mmHg, rose to a maximum blood pressure of 130/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

**Interpretation**

Summary: Resting ECG: normal.  
 Functional Capacity: normal.  
 HR Response to Exercise: appropriate.  
 BP Response to Exercise: normal resting BP - appropriate response.  
 Chest Pain: none.  
 Arrhythmias: none.  
 ST Changes: none.  
 Overall impression: Normal stress test.

**Conclusions**

GOOD EFFORT TOLERANCE  
 NORMAL HR AND BP RESPONSE  
 NO ANGINA OR ARRHYTHMIAS NOTED  
 NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician \_\_\_\_\_

Technician \_\_\_\_\_

**MIR VINAY R,**  
 Patient ID 18942  
 27.07.2024  
 12-19-20pm

Male 175 cm 79 kg  
 37yrs Indian  
 Meets:

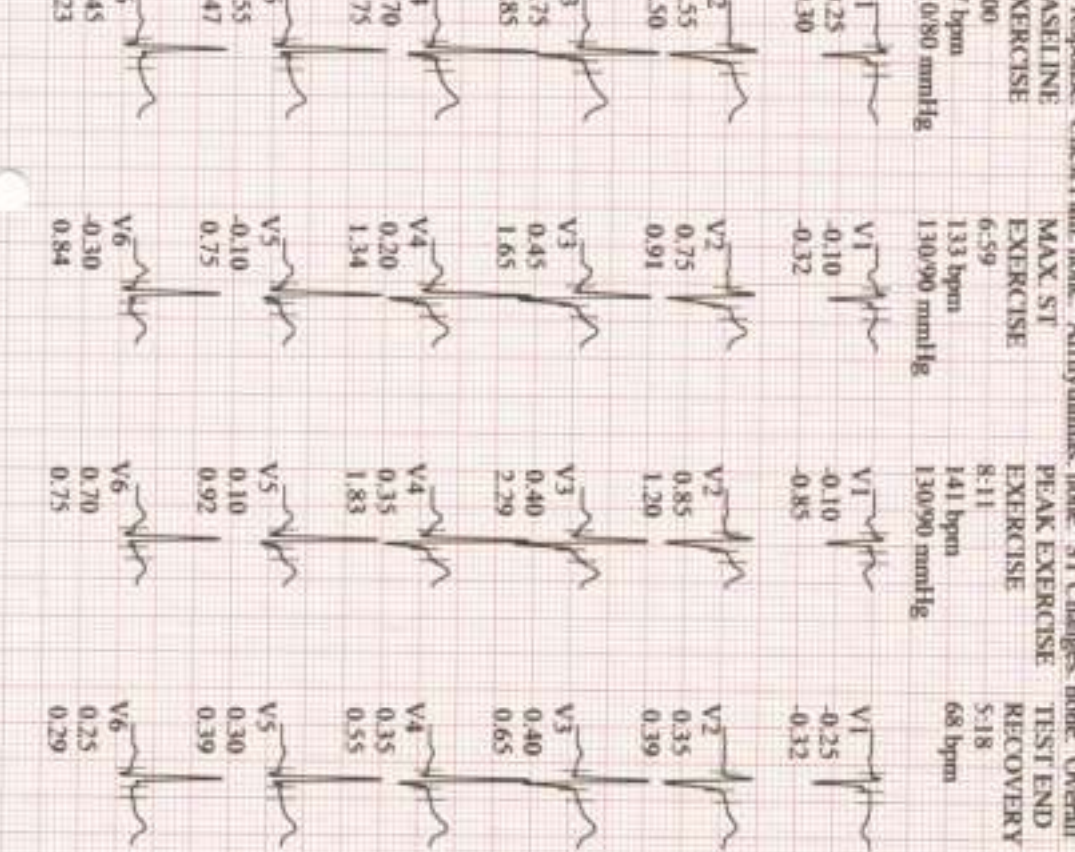
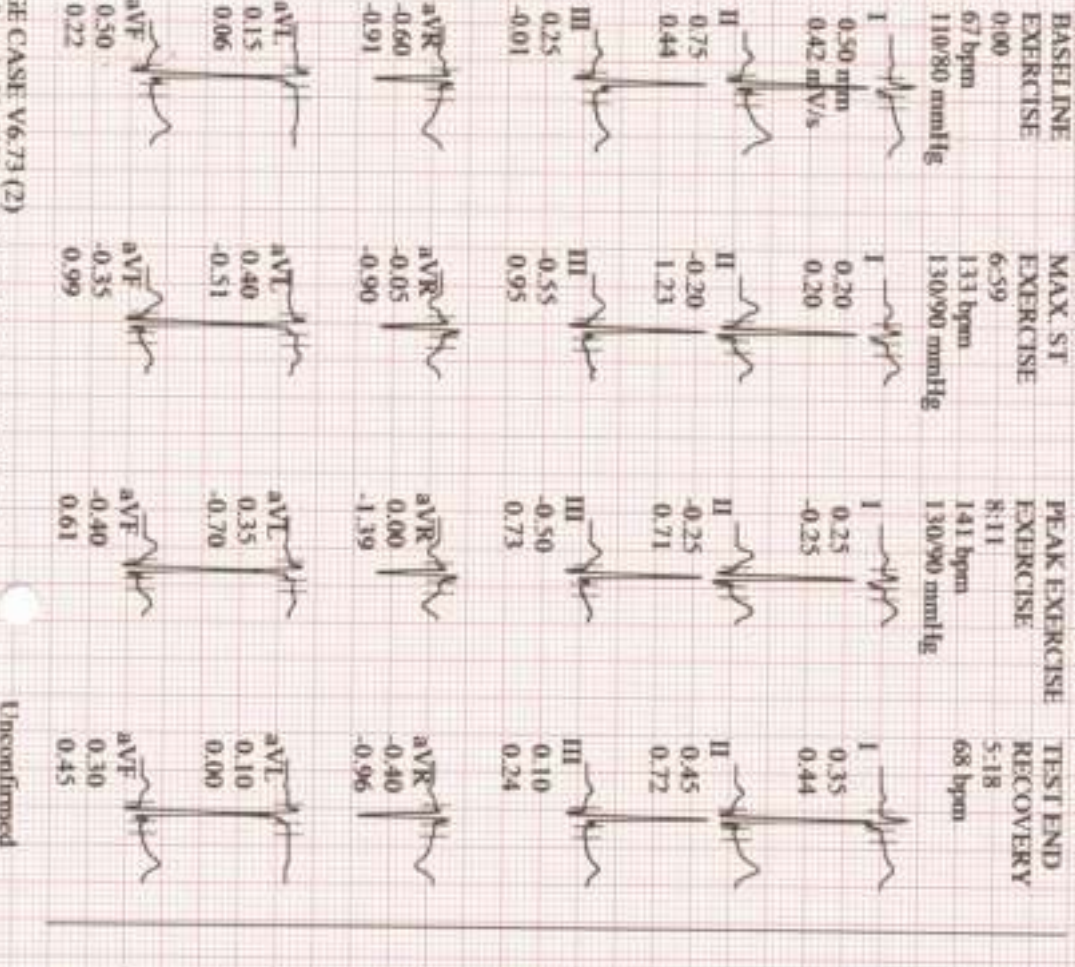
Test Reason: Screening for CAD  
 Medical History: NO H/O DM & HTN

Ref: MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL  
 Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test  
 Comment:

BRUCE: Total Exercise Time: 08:11  
 Max HR: 141 bpm 77% of max predicted 183 bpm HR at rest: 70  
 Max BP: 130/90 mmHg BP at rest: 110/80 Max RPP: 18330 mmHg\* bpm  
 Maximum workload: 10.10 METS  
 Max ST: -0.55 mm, 0.00 mV/s in III; EXERCISE STAGE 3 06:59  
 Arrhythmic: PVC:5, PSVC:1  
 ST/HR index: 0.68  $\mu$ V/bpm

Reasons for Termination: Target heart rate achieved

Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmic: none. ST Changes: none. Overall



Unconfirmed

Attending MD: DR. RAHUL PATIL

MR. VINAY R.  
Patient ID: 18942

27.02.2024  
12:19:20pm  
Male 175 cm 79 kg  
37yrs Indian

Meds:

Test Reason: Screening for CAD  
Medical History: NO H/O DM & HTN

Ref MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL  
Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test  
Comment:

BRUCE: Total Exercise Time 08:11  
Max HR: 141 bpm 77% of max predicted 183 bpm HR at rest: 70  
Max BP: 130/90 mmHg BP at rest: 110/80 Max RPP: 18330 mmHg\* bpm  
Maximum Workload: 10.10 METS  
Max ST: -0.55 mm, 0.00 mV/s in III, EXERCISE STAGE 3 06:59  
Arrhythmia: PVC: 5, PSVC: 1  
ST/HR index: 0.68  $\mu$ V/bpm  
Reasons for Termination: Target heart rate achieved  
Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall impression: Normal stress test.  
Conclusion: GOOD EFFORT TOLERANCE  
NORMAL HR AND BP RESPONSE  
NO ANGINA OR ARRHYTHMIAS NOTED  
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION: STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA  
Location Number: \* 0 \*

68 bpm  
110/80 mmHg

LINKED MEDIANS

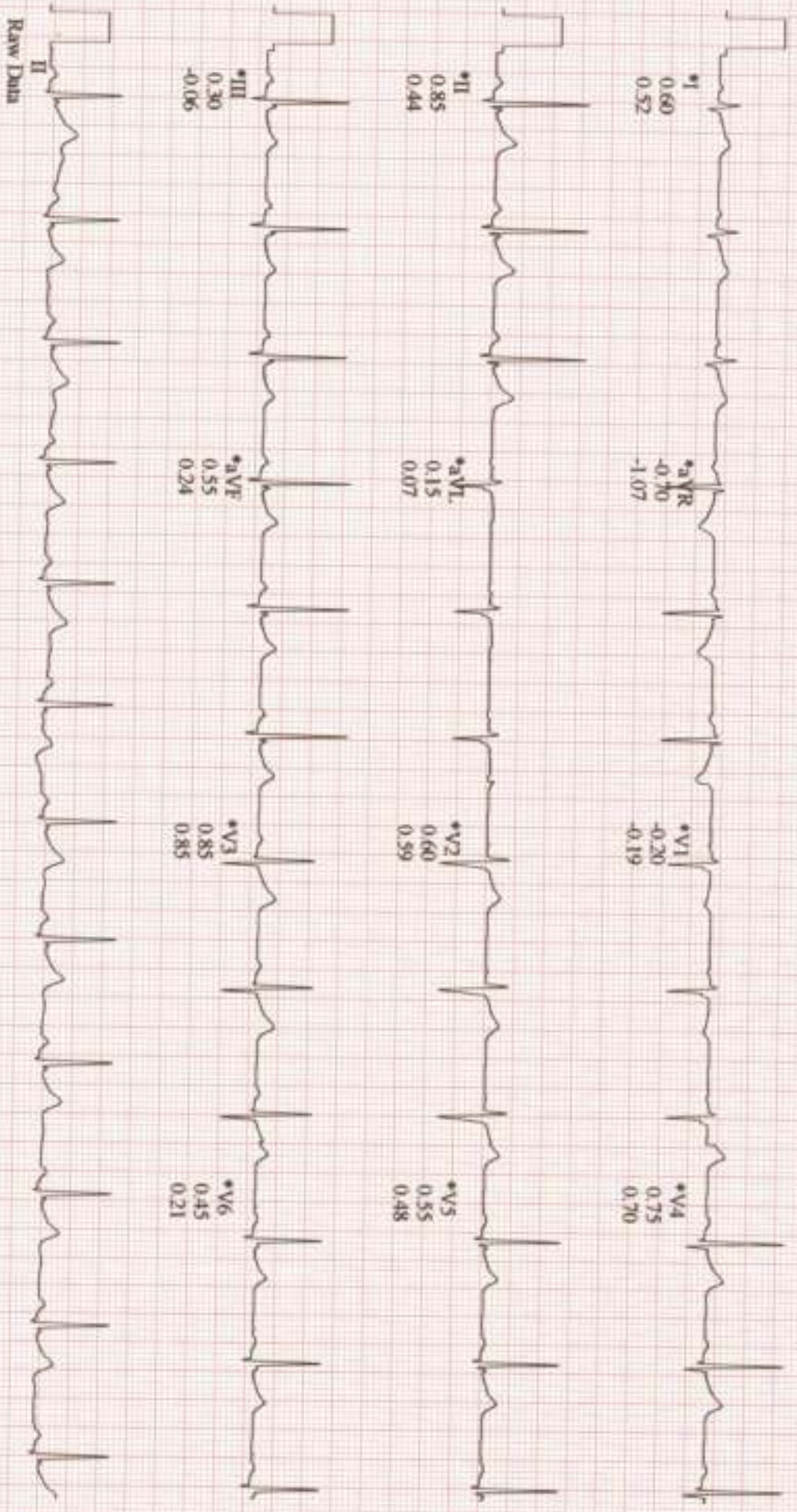
PRETEST  
STANDING  
00:27

BRUCE  
0.0 mph  
0.0 %

UNITED HOSPITAL

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



\*Computer Synthesized Rhythms

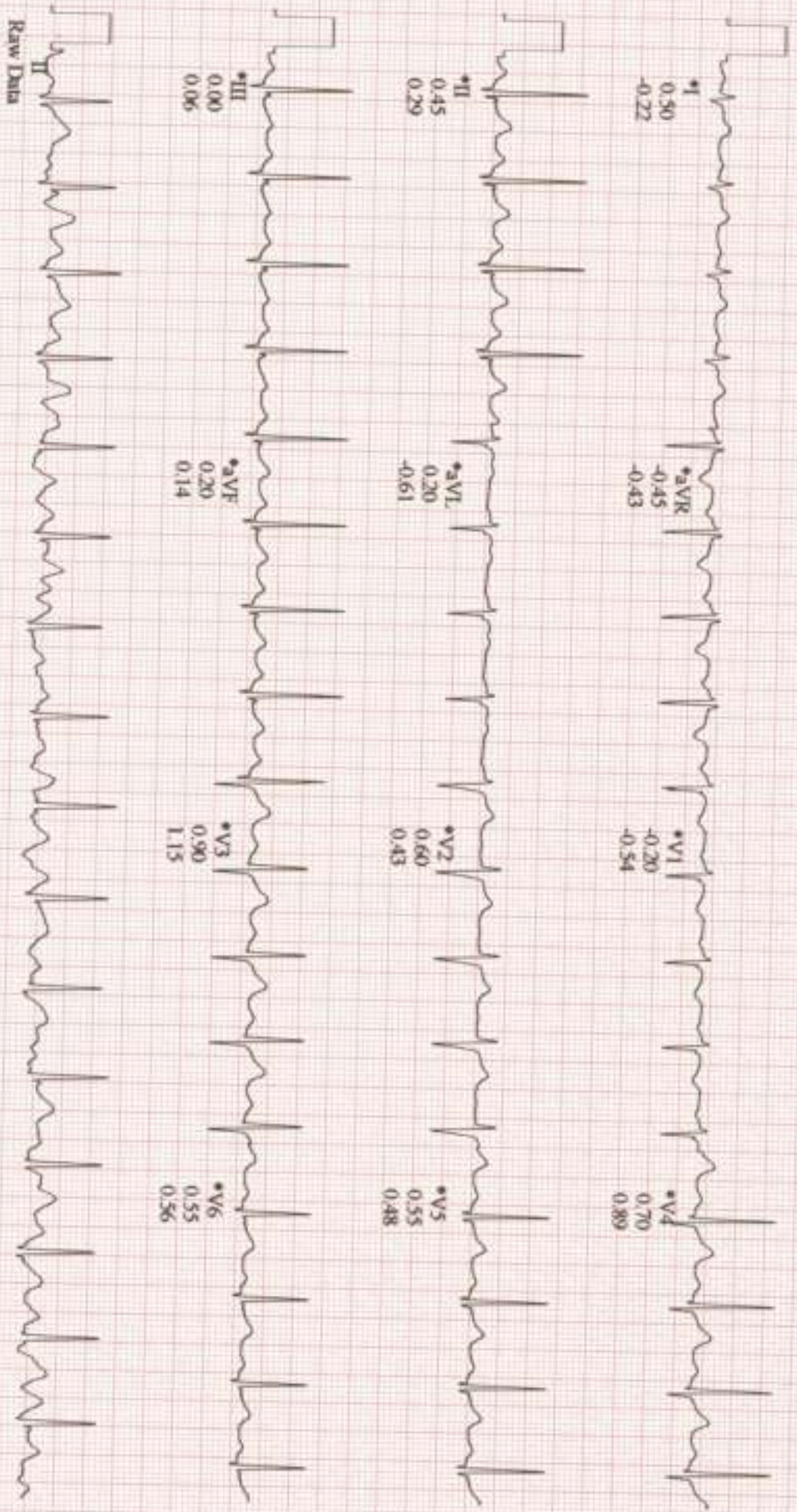
100 bpm  
110/80 mmHg

EXERCISE  
STAGE 1  
02:50

BRUCE  
1.7 mph  
10.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



Raw Data

\*Computer Synthesized Rhythms

118 bpm  
120/80 mmHg

EXERCISE  
STAGE 2  
05:50

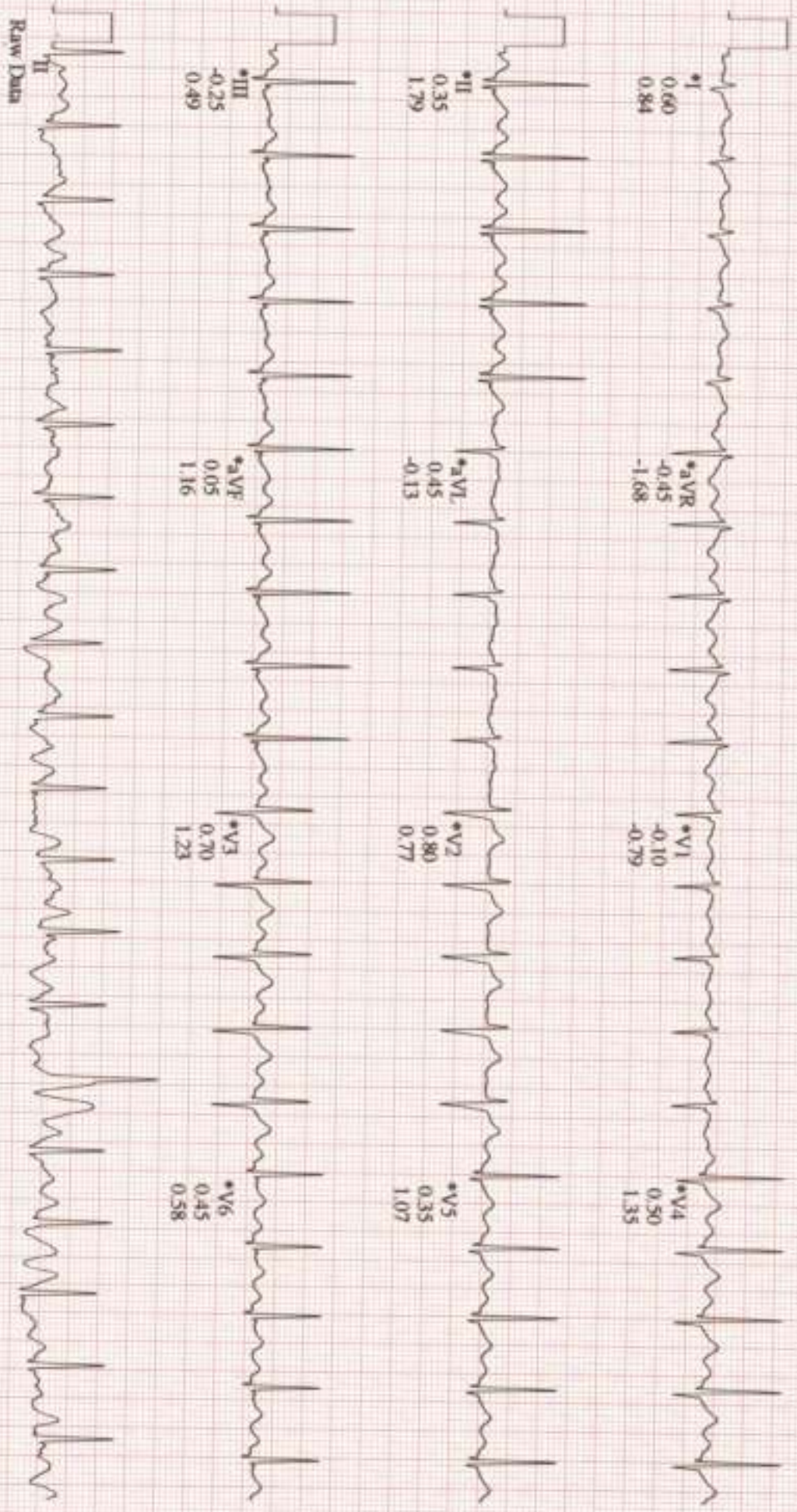
BRUCE  
2.5 mph  
12.0%

LINKED MEDIANS

UNITED HOSPITAL

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



Raw Data

\*Computer Synthesized Rhythms



LINKED MEDIANS  
141 bpm  
130/90 mmHg

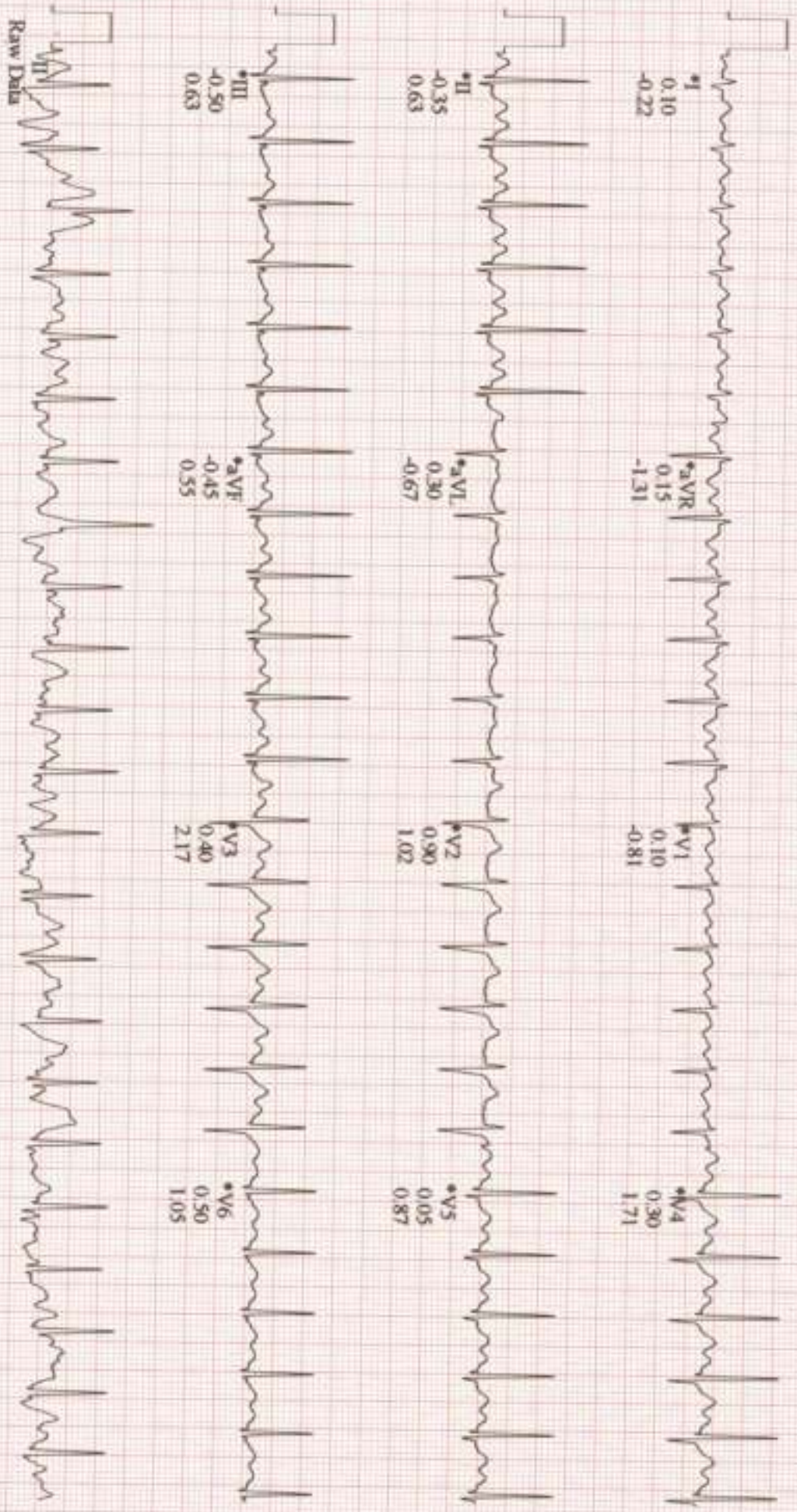
EXERCISE  
STAGE 3  
08:10

BRUCE  
3.4 mph  
14.0%

UNITED HOSPITAL

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



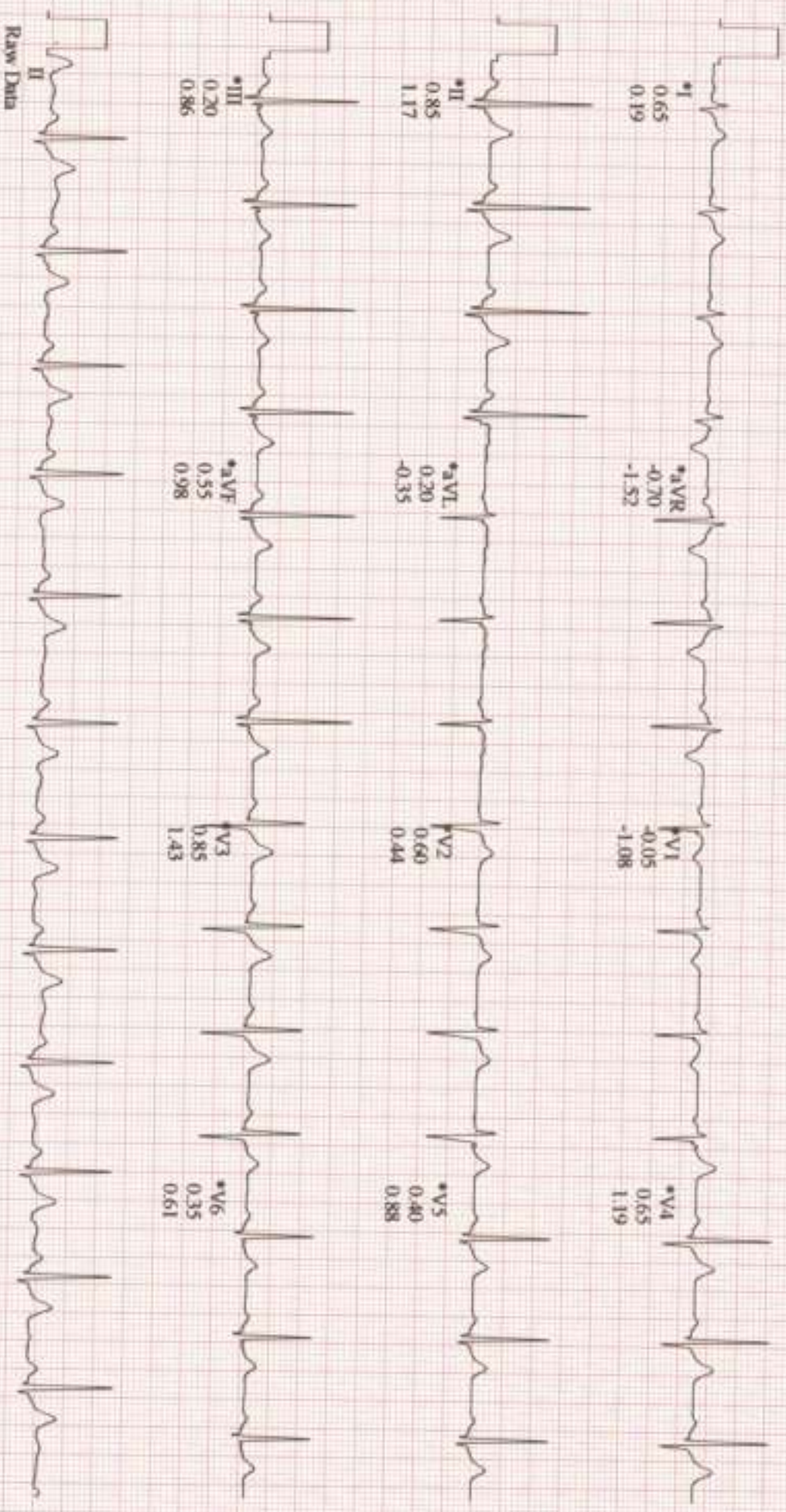
83 bpm  
130-90 mmHg

RECOVERY #1  
01:23

BRUCE  
0.0 mph  
0.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)

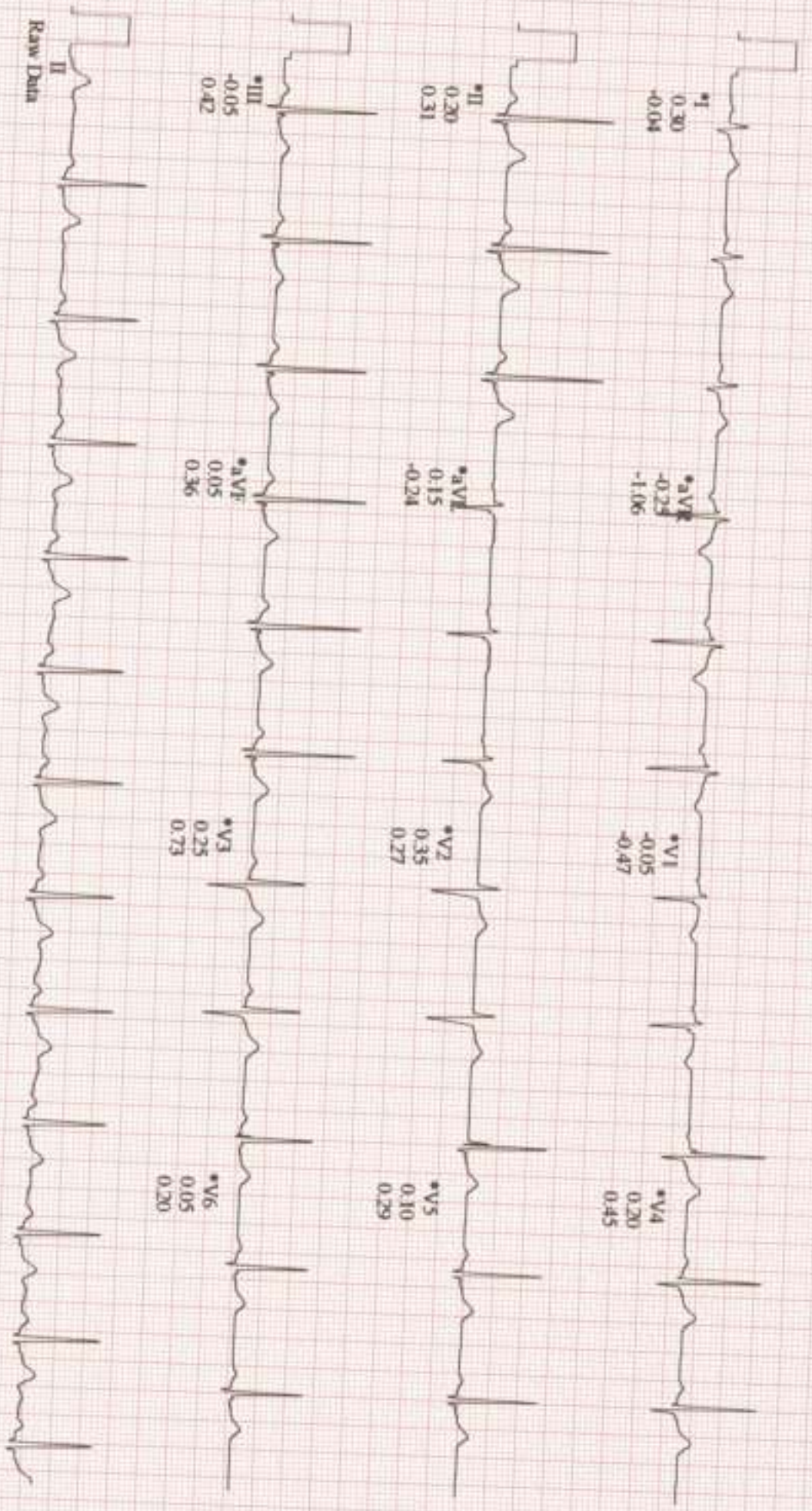


\*Computer Synthesized Rhythms

67 bpm

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



Raw Data

\*Computer Synthesized Rhythms

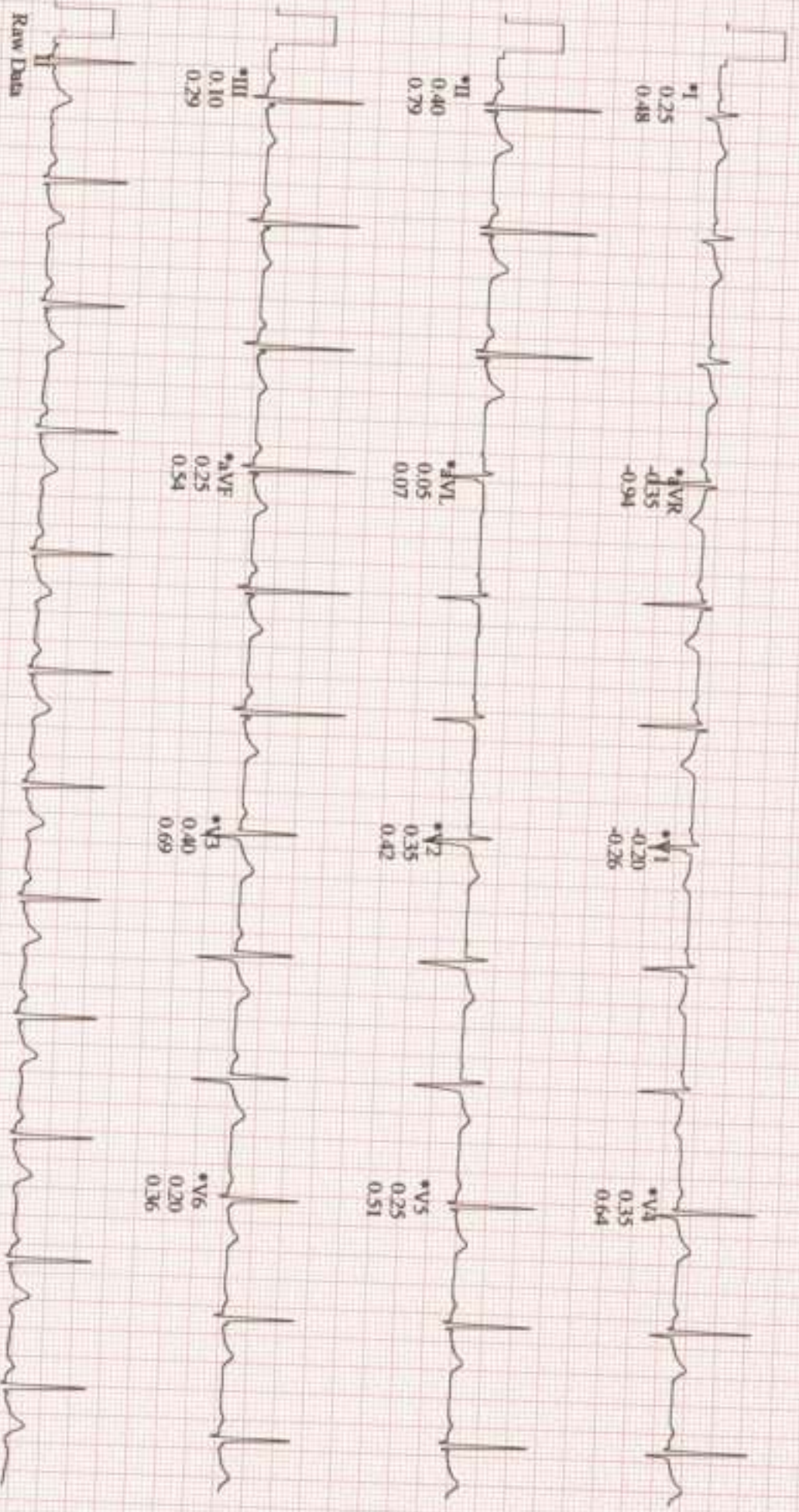
70 bpm  
130/90 mmHg

RECOVERY  
#1  
05:00

BRUCE  
0.0 mph  
0.0 %

ST @ 10mm/mV  
60 ms post J

Lead  
ST Level (mm)  
ST Slope (mV/s)



Raw Data

\*Computer Synthesized Rhythms

**DEPARTMENT OF RADIODIAGNOSIS**

<b>Name</b>	Vinay R	<b>Date</b>	27/02/24
<b>Age</b>	36 years	<b>Hospital ID</b>	UHJA23018942
<b>Sex</b>	Male	<b>Ref.</b>	Healthcheck

**ULTRASOUND ABDOMEN AND PELVIS****FINDINGS:**

**Liver** is normal in size and 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 focal lesion.

**Right Kidney** is normal in size (10.4 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

**Left Kidney** is normal in size (10.2 x 4.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus 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, mass or mural lesion.

**Prostate** is normal in echopattern and size, measures ~ 13.1 cc.

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

**IMPRESSION:**

- **No definite sonological abnormality detected.**





NABH



NABL



No.1



**UNITED  
HOSPITAL**

Care Par Excellence  
Jayanagar, Bangalore

### DEPARTMENT OF RADIODIAGNOSIS

<b>Name</b>	Vinay R	<b>Date</b>	23/02/24
<b>Age</b>	36 years	<b>Hospital ID</b>	UHJA23018942
<b>Sex</b>	Male	<b>Ref.</b>	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