DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SUVARNA CHANDRA	Order No	: 1000099423
UHID	: UHJA24006706	Registered On	: 17/10/2024 08:36:38 AM
Age/Sex	: 39/Years Female	Collected On	: 17/10/2024 08:57:46 AM
Ward / Bed No	:	Reported On	: 17/10/2024 12:44:10 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240009202
Station	: Corp	Mobile No	: 9449352895
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	90	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	103	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	111	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.05	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.65	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.80	µIU/mL	0.34 - 5.60 µIU/mL (Non Pregnant) 0.3 - 4.5 µIU/mL (I trimester) 0.5 - 5.2 µIU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	**272**	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	**278**	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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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	**168.50**	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	**55.60**	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	**5.68**		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	**3.52**		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	**224.10**	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.4	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	**6**	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	**0.56**	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.36	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.05	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.31	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.98	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.12	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.28		2:1
SERUM SGOT (Method:IFCC without P5P)	19	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	22	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	71	U/L	46-122
GGT (Method:IFCC)	16	U/L	< 38

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

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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)	12.25	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7420	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	59.18	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	32.52	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	0.87	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.16	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.27	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.42	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	84.0	fL	78-100
MCH (Method: Calculated)	27.7	pg	27-31
MCHC (Method: Calculated)	33.0	g/dL	31-37
RDW - CV (Method: Calculated)	13.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.39	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)	**6.55**	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	**19.6**	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4390	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	60	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	2410	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	530	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	**45**	mm/hour	1-20

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

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

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.010		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			

DEPARTMENT OF LABORATORY MEDICINE

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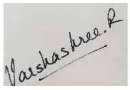
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
G Mahesh kumar

---End of Report---



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NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SUVARNA CHANDRA**	**UHID**	**: UHJA24006706**
Age / Sex	: 39 Years / Female	OP NO/Reg Dt	: 17-10-2024 08:36 AM
Spouse / Father Name	: .	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 - 157cm
Wt - 48.1kg
BP - 100/65
PR - 94b/m
SPO2 - 98%

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

Mrs. Suvarna Chandra 39y 17/10/24

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and Gynecologist, Laparoscopy and IVF Specialist
KMC Reg. No. 90384

[illegible] check

BP 110/65
PR – 94

No h/o DM, HTN, Thy
No h/o any Surgery
any [illegible] Cert

P/A – Soft

O/E [illegible]

Adv
Strict usage of condoms

[illegible]
[illegible]
[illegible]: 29/9/24
[illegible] = regular

Breast [illegible]

DEPARTMENT OF RADIODIAGNOSIS

Name	Suvarna Chandra	**Date**	17/10/24
Age	39 years	**Hospital ID**	UHJA24006706
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (16.3 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 (10.6 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.1 x 4.4 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 over distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and normal in size, measures 9.8 x 5.0 x 2.8 cms. Endometrium measures 4.2 mm. ***There is a fundal intramural fibroid measuring 2.2 x 2.0 x 1.8 cms indenting the endometrium.***
Right ovary is normal in size and echopattern, measures 5.4 cc.
Left ovary is normal in size and echopattern, measures 6.9 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:

- **Small uterine fibroid.**
- **Mild hepatomegaly with mild fatty infiltration (Grade I).**

Dr. Eluri Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Suvarna Chandra	**Date**	17/10/24
Age	39 years	**Hospital ID**	UHJA24006706
Sex	Female	**Ref.**	Self

BILATERAL SONOMAMMOGRAPHY

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

Two tiny cysts measuring 2-3 mm are seen in left breast.

No focal solid lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **Two tiny cysts in left breast.**
- **No other significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

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Patient name :	**Mrs. SUVARNA CHANDRA**	**Date :**	**17/10/24**
Age :	**39 years GENDER: FEMALE**	**Patient ID :**	**24006706**
Ref by :	**CMO**	**OP/IP :**	**HEALTH CHECK**

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 : 0.7	AV :0.4	MR : TRIVIAL MR
LA : 3.2 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 0.8		AR : NORMAL
RA : 1.9 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.9		PR : NORMAL
RV : 1.8 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : TRIVILA TR
TAPSE: 1.7 (>1.6)	LVPWD 1.1 (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
Pulmonary Valve	: NORMAL
IAS	: INTACT
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

DEPARTMENT OF RADIODIAGNOSIS

Name	Suvarna Chandra	**Date**	17/10/24
Age	39 years	**Hospital ID**	UHJA24006706
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

Name: suvarna chandra

ex: F Birth date: 39 years

cm kg / mmHg

edication:

ymptoms:

istory:

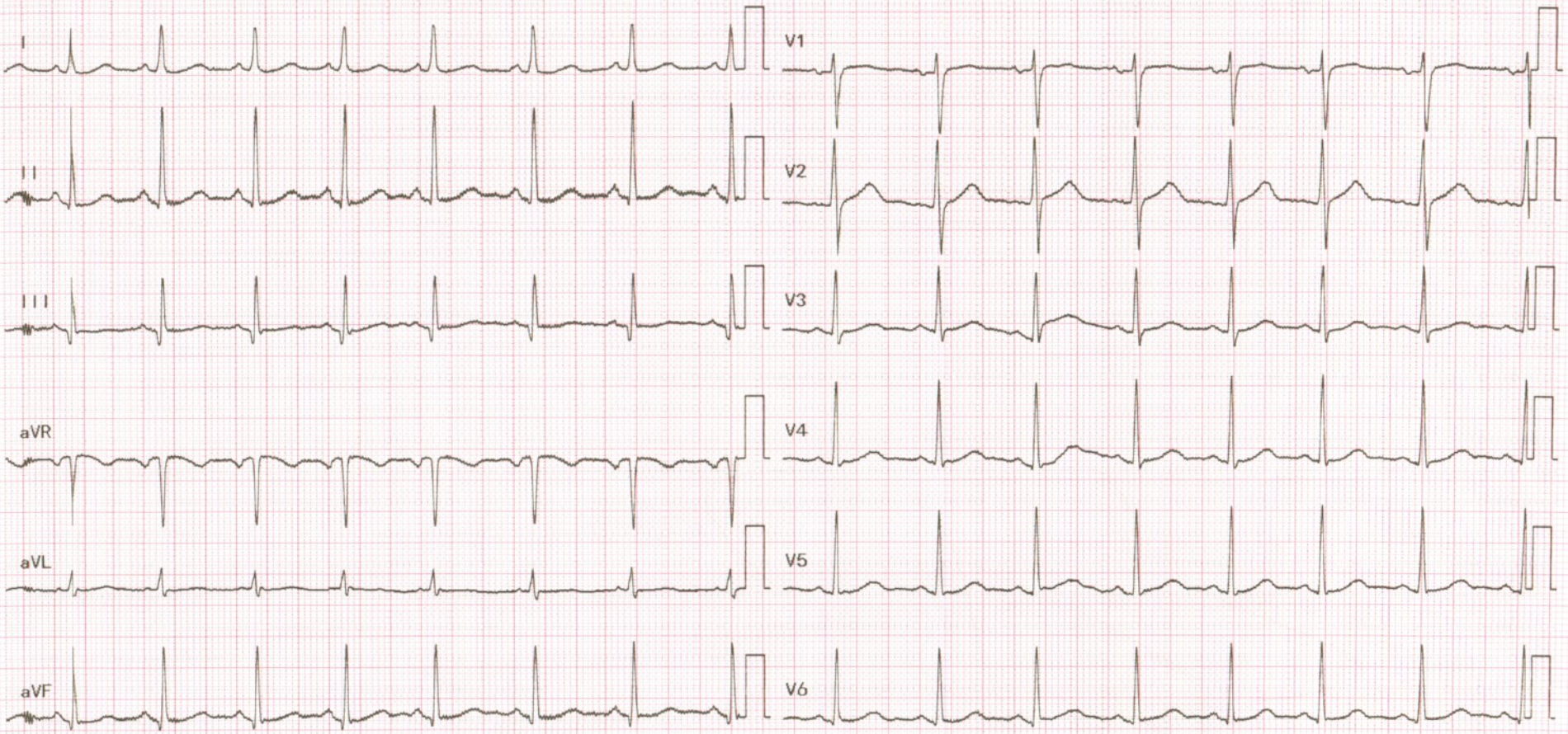
ent. rate	96	bpm
R int	126	ms
RS dur	78	ms
T/QTc(E) int	346/ 400	ms
/QRS/T axis	47/ 61/ 49	°
V5/SV1 amp	1.50/ 1.03	mV
V5+SV1 amp	2.53	mV

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

Unconfirmed Report
Reviewed by:

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

10 mm/mV



2350K 03-08 07-01 Dept.:

Exam: UNITED HOSPITAL