UNITED HOSPITAL
Care Par Excellence

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SANTHOSH KUMAR J HA	Order No	: 1000095338
UHID	: UHJA24005243	Registered On	: 04/09/2024 08:54:47 AM
Age/Sex	: 44/Years Male	Collected On	: 04/09/2024 09:00:58 AM
Ward / Bed No	:	Reported On	: 04/09/2024 12:00:58 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240007232
Station	: At Hospital	Mobile No	: 9702105963
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	162	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	315	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	7.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	163.04	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.24	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.9	≈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)	198	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	119	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	36.2	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	138.0	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	23.8	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.46		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.83		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	161.8	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.2	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.9	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	8.8		12¯20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.97	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.20	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.77	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.5	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.52	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.98	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.51		2:1
SERUM SGOT (Method:IFCC without P5P)	33	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	43	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	86	U/L	50-116
GGT (Method:IFCC)	33	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.68	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	18.0	mg/dL	17-43

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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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)	13.56	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.9	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7290	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	52.16	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	37.35	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.67	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.49	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.33	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle) Remarks: In view of increased RBC count and reduced RBC indices suggest Iron profile and HPLC/HB electrophoresis to rule out hemoglobinopathy. Kindly correlate clinically.	6.68	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	65.7	fL	78-100
MCH (Method: Calculated)	20.3	pg	27-31
MCHC (Method: Calculated)	30.9	g/dL	31-37
RDW - CV (Method: Calculated)	17.4	%	11.5-14.5

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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET COUNT (Method:Electrical Impedance)	1.6	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	12.32	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	32.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	04	mm/hour	1-15

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

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

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

Sample: Urine

URINE EXAMINATION, ROUTINE

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	1.005		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)	Absent		
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)	Present (2.0%)		

Verified By
Dr Shobha Emmanuel

---End of Report---

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

4-Sep-2024 AM9:53:33

ID:24005243
Name:MR SANTHOSH

Sex:M Birth date: 44 years

cm kg / mmHg

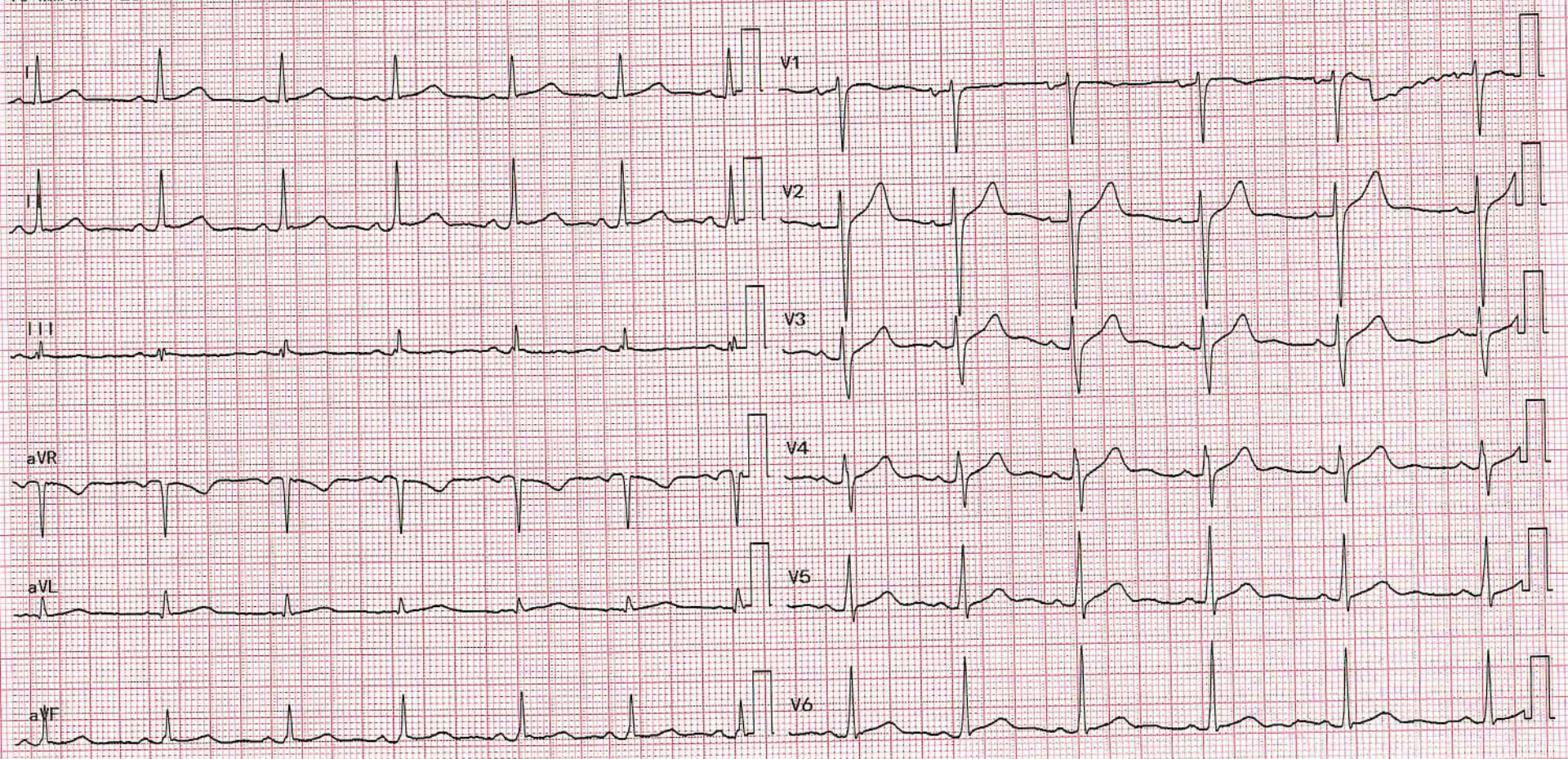
Medication:
Symptoms:
History:

Vent. rate	76	bpm
PR int	152	ms
QRS dur	86	ms
QT/QTc(B) int	370/ 401	ms
P/QRS/T axis	54/ 48/ 34	°
RV5/SV1 amp	1.26/ 1.08	mV
RV5+SV1 amp	2.34	mV

1100 Sinus rhythm
1102 Sinus arrhythmia [RR int. change over 20%]
4038 Nonspecific ST elevation [ST elevation (V5, V6)]
9130 ** borderline 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

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Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.SANTHOSH KUMAR JHA	UHID	: UHJA24005243
Age / Sex	: 44 Years / Male	OP NO/Reg Dt	: 04-09-2024 08:54 AM
Spouse / Father Name	: SANGEETA JHA	Department	:
Address	: brigade road, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Ht - 178 cm
Wt - 93.9 kg
SpO_2 - 99 %
PR - 75 b/m
BP - 140/80 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

PATIENT NAME :	**Mr. SANTHOSH KUMAR JHA**	**DATE :**	**04/09/24**
AGE :	**44 YEARS GENDER : MALE**	**PATIENT ID :**	**24005243**
REF BY :	**CMO**	**OP/ IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(cm)	(cm)	(cm/sec)		
AO : 3.0 (2.5-3.7)	LVIDD : 4.8 (3.5-5.5)	MV EV: 0.7	AV: 0.6	MR : NORMAL
LA : 3.3 (1.9-4.0)	LVIDS : 3.0 (2.4-4.2)	AV : 1.1		AR : NORMAL
RA : 2.1 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 1.0		PR : NORMAL
RV :1.9 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR, PASP-24mmHg
TAPSE : 1.8 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.0 (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 AND COLLAPSING

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 S PATIL
CONSULTANT CARDIOLOGIST

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Santhosh Kumar Jha	**Date**	04/09/24
Age	44 years	**Hospital ID**	UHJA24005243
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and ***shows mildly increased echopattern.*** No intra or extra hepatic biliary duct dilatation. *There is a tiny walled cyst measuring 9 x 8 mm in segment VIII.* 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 (11.7 x 4.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.2 x 3.8 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.

Prostate is normal in echopattern and size, measures ~ 17.9 cc.

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

IMPRESSION:

- **Mild fatty infiltration of liver (Grade I).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
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DEPARTMENT OF RADIODIAGNOSIS

Name	Santhosh Kumar Jha	**Date**	04/09/24
Age	44 years	**Hospital ID**	UHJA24005243
Sex	Male	**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