9-Mar-2024 AM9:41:15

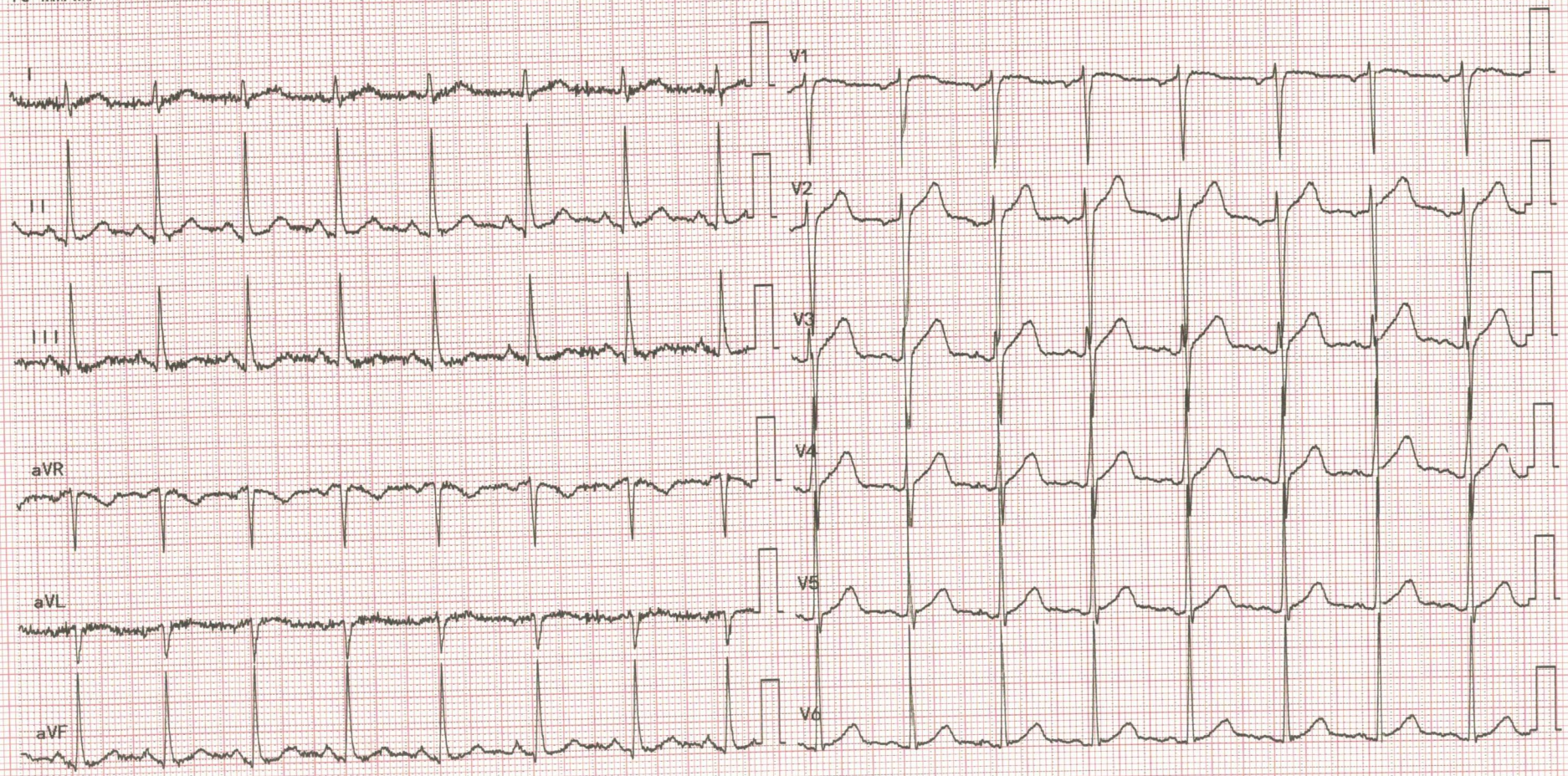
ID:
Name:mr.tadas
ex:M Birth date: 47 years
cm kg / mmHg
edication:
ymptoms:
istory:

1100 Sinus rhythm
4038 Nonspecific ST elevation [ST elevation (V3, V4)]
0102 ARTIFACT PRESENT
9130 ** borderline ECG **

ent. rate	99	bpm
R int	140	ms
RS dur	82	ms
T/QTc(E) int	344/ 400	ms
/QRS/T axis	73/ 83/ 48	°
V5/SV1 amp	2.04/ 1.32	mV
V5+SV1 amp	3.36	mV

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 100 Hz



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.TADAS NAVEEN KUMAR VASANT**	**UHID**	**: UHJA23019975**
Age / Sex	: 47 Years / Male	OP NO/Reg Dt	: 09-03-2024 08:15 AM
Spouse / Father Name	: BHAGYA SHREE	Department	:
Address	: 286, 21st imain 2nd stage btm laayout, , Bengaluru Urban, Karnataka, INDIA,	Refered By	: opthal
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

VA < 6/6 } 4.
(glass 6/6

Investigations:

As: ou vul

Treatment / Care of Plan / Provisional Diagnosis :

Emb ou vul

If: Ref. Gla.

Follow Up Advice :

Signature of the Doctor

NABH NABL No.1

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Care Par Excellence
Jayanagar, Bangalore

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		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

SIB physician Team.

Reports reviewed.

C/o palpitations in morning.

HT 167 cm
Wt. 59 kg.
BP. - 117/76
SpO2 - 99%
RR - 96/m

Investigations:

2D Echo - Tachycardia noted

Treatment / Care of Plan / Provisional Diagnosis :

Cardiac Screening Package.

Adv :
Cardiologist opinion
Continue Annual health check up.

Follow Up Advice : Treadmill test.

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Tadas Naveen Kumar Vasant	**Date**	09/03/24
Age	47 years	**Hospital ID**	UHJA23019975
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

DEPARTMENT OF RADIODIAGNOSIS

Name	Tadas Naveen Kumar Vasant	**Date**	09/03/24
Age	47 years	**Hospital ID**	UHJA23019975
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size measuring 12 cms 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 measuring 9 cms, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (8.5 x 4.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (8.6 x 4.6 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.

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

IMPRESSION:

- **No definite sonological abnormality detected.**

Dr. Manu Srinivas H, MD, RD
Consultant Radiologist

Patient name :	**Mr. TADAS NAVEEN KUMAR**	**Date :**	**09/03/24**
Age :	**47 years GENDER: MALE**	**Patient ID :**	**19975**
Ref by :	**DR.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 : 4.6 (3.5-5.5)	MV EV : 62.1	AV : 51.3	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 85.2		AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 100		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ------	AV : ------	TR : TRIVIAL TR
TAPSE: 1.7 (>1.6)	LVPWD : 1.1 (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
Aortic Valve	:NORMAL
Tricuspid Valve	: NORMAL, TRIVIAL TR, PASP-20mmHg
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

TACHYCARDIA OBSERVED DURING THE STUDY (105bpm)

NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. TADAS NAVEEN KUMAR VASANT	Order No	: 1000076188
UHID	: UHJA23019975	Registered On	: 09/03/2024 08:15:59 AM
Age/Sex	: 47/Years Male	Collected On	: 09/03/2024 08:35:50 AM
Ward / Bed No	:	Reported On	: 09/03/2024 01:50:32 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230024672
Station	: At Hospital	Mobile No	: 9741415141
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	95	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	100	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	82.45	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.47	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.00	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.09	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	160	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	56	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	41.8	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	107.0	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	11.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.8		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.5		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	118.2	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.1	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.75	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	17.3		12¯20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.61	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.34	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.28	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.6	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.77	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.83	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.68		2:1
SERUM SGOT (Method:IFCC without P5P)	31	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	26	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	51	U/L	50-116
GGT (Method:IFCC)	14	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.58	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)	28.0	mg/dL	17-43

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)	15.75	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	46.2	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4630	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	54.67	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.57	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.24	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.28	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.24	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.35	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	86.3	fL	78-100
MCH (Method: Calculated)	29.4	pg	27-31
MCHC (Method: Calculated)	34.1	g/dL	31-37
RDW - CV (Method: Calculated)	14.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.03	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)	7.19	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.1	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

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

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	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	7.5		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			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/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---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418