

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SINGH SHAIENDRA KUMAR	Order No	: 1000079054
UHID	: UHJ A23021017	Registered On	: 23/03/2024 09:46:34 AM
Age/Sex	: 49/Years Male	Collected On	: 23/03/2024 10:32:48 AM
Ward / Bed No	:	Reported On	: 23/03/2024 04:56:22 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230026007
Station	: At Hospital	Mobile No	: 7995565207
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	118	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	113	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	114.01	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.13	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	11.34	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	2.39	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	155	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	104	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	33.2	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	101	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	20.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.7		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.0		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	121.8	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.4	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.71	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	14.08		12~20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.74	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.57	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.02	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.08	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.30		2:1
SERUM SGOT (Method:IFCC without P5P)	20	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	20	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	87	U/L	50-116
GGT (Method:IFCC)	20	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.32	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)	22.4	mg/dL	17-43
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Dr. Shobha Emmanuel
 MBBS, M.D(Pathology)
 CONSULTANT PATHOLOGIST
 KMC:66136

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.51	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.2	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6310	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	45.50	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	42.59	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.10	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.39	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.42	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.33	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	84.8	fL	78-100
MCH (Method: Calculated)	27.2	pg	27-31
MCHC (Method: Calculated)	32.1	g/dL	31-37
RDW - CV (Method: Calculated)	13.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.94	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	9.62	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	15	mm/hour	1-15
BLOOD GROUPING & RH TYPING			
Sample: Whole blood (EDTA)			
ABO Group (Method:Agglutination Gel Method)	B		
Rh Factor (Method:Agglutination Gel Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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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	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.020		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	Absent		
(Method:GOD-POD)			

Verified By
NAGARATNA

---End of Report---



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*NABL renewal under process.

EXERCISE STRESS TEST REPORT

Patient Name: SINGH SHAILENDRA KUMAR ,
Patient ID: 21017
Height:
Weight:

DOB: 01.11.1974
Age: 49yrs
Gender: Male
Race: Indian

Study Date: 23.03.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR RAHUL PATIL
Technician: YAMINI T

Medications:

--

Medical History:

NIL

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	00:48	0.00	0.00	71	130/80	
	STANDING	00:15	0.00	0.00	74		
	HYPERV.	00:01	0.00	0.00	74	130/80	
EXERCISE	WARM-UP	00:22	0.90	0.00	73	130/80	
	STAGE 1	03:00	1.70	10.00	110	130/80	
	STAGE 2	03:00	2.50	12.00	127	140/80	
	STAGE 3	02:04	3.40	14.00	153	150/80	
RECOVERY		03:14	0.00	0.00	88	130/80	

The patient exercised according to the BRUCE for 8:03 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 72 bpm rose to a maximal heart rate of 153 bpm. This value represents 89 % of the maximal, age-predicted heart rate. The resting blood pressure of 130/80 mmHg, rose to a maximum blood pressure of 150/80 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
NO SIGNIFICANT ST-CHANGES
IMPRESSION;-STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician _____

Technician _____

NGH SHAILENDRA KUMAR,

Patient ID 21017
 03,2024
 Male
 49yrs Indian
 :17:31am
 Meds:

Test Reason: Screening for CAD
 Medical History: NIL

Ref. MD: Ordering MD:
 Technician: YAMINI T Test Type: Treadmill Stress Test
 Comment:

BRUCE: Total Exercise Time 08:03
 Max HR: 153 bpm 89% of max predicted 171 bpm HR at rest: 72
 Max BP: 150/80 mmHg BP at rest: 130/80 Max RPP: 22950 mmHg* bpm
 Maximum Workload: 10.10 METS
 Max ST: -0.65 mm, 0.00 mV/s in I; EXERCISE STAGE 3 08:04
 ST/HR index: 0.79 μ 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

MAX. ST EXERCISE	PEAK EXERCISE	TEST END RECOVERY
8:04 153 bpm 150/80 mmHg	8:04 153 bpm 150/80 mmHg	2:57 92 bpm 130/80 mmHg

BASELINE EXERCISE	MAX. ST EXERCISE
0:01 75 bpm 130/80 mmHg	8:04 153 bpm 150/80 mmHg

PEAK EXERCISE	TEST END RECOVERY
8:04 153 bpm 150/80 mmHg	2:57 92 bpm 130/80 mmHg

BASELINE EXERCISE
 5 bpm
 30/80 mmHg
 0.50 mm
 -0.44 mV/s

I -0.65
 II 1.15
 III 1.60
 4.26

I -0.65
 II 1.15
 III 1.60
 4.26

I 0.10
 II 0.85
 III 0.75
 1.03

V1 -0.60
 V2 0.25
 V3 -0.25
 -0.85

VT -1.00
 V2 -0.15
 V3 0.20
 -0.45

VT -1.00
 V2 -0.15
 V3 0.20
 -0.45

VT -0.35
 V2 0.00
 V3 0.15
 0.14

I 1.85
 II 1.15
 III 1.40
 0.88

I 1.85
 II 1.15
 III 1.40
 0.88

I 1.85
 II 1.15
 III 1.40
 0.88

I 1.85
 II 1.15
 III 1.40
 0.88

V1 -0.60
 V2 0.25
 V3 -0.25
 -0.85

VT -1.00
 V2 -0.15
 V3 0.20
 -0.45

VT -1.00
 V2 -0.15
 V3 0.20
 -0.45

VT -0.35
 V2 0.00
 V3 0.15
 0.14

aVR 1.20
 aVL -0.45
 -1.12
 -2.13

aVR -0.25
 aVL -1.15
 -2.03
 -3.52

aVR -0.25
 aVL -1.15
 -2.03
 -3.52

aVR -0.45
 aVL -0.35
 -1.00
 -2.29

V4 0.85
 V5 0.80
 0.29

V4 0.55
 V5 0.50
 2.42

V4 0.55
 V5 0.50
 2.42

V4 0.60
 V5 0.40
 0.69

aVF 1.60
 1.13

aVF 1.40
 4.80

aVF 1.40
 4.80

aVF 0.80
 1.20

V6 0.85
 -0.29

V6 0.35
 0.81

V6 0.35
 0.81

V6 0.25
 0.56

Unconfirmed

Attending MD: DR RAHUL PATIL

NGH SHAILENDRA KUMAR,

Patient ID 21017

03.2024

17:31am

Male

49yrs Indian

Meds:

Test Reason: Screening for CAD

Medical History: NIL

Ref. MD: Ordering MD:

Technician: YAMINI T Test Type: Treadmill Stress Test

Comment:

BRUCE: Total Exercise Time 08:03

Max HR: 153 bpm 89% of max predicted 171 bpm HR at rest: 72

Max BP: 150/80 mmHg BP at rest: 130/80 Max RPP: 22950 mmHg* bpm

Maximum Workload: 10.10 METS

Max. ST: -0.65 mm, 0.00 mV/s in I; EXERCISE STAGE 3 08:04

Arrhythmia: A:80, PVC:3, PSVC:1

ST/HR index: 0.79 μ 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

NO SIGNIFICANT ST-CHANGES

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Prognosis:

Duke Treadmill Score: 3

Risk Category: moderate

5 Year Survival: 94.5%

Average Annual Mortality: 1.1%

Location Number: * 0 *

Unconfirmed

Attending MD: DR RAHUL PATIL

DEPARTMENT OF RADIODIAGNOSIS

Name	Singh Shailendra Kumar	Date	23/03/24
Age	49 years	Hospital ID	UHJA23021017
Sex	Male	Ref.	Healthcheck

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

Disclaimer for Radiology Scans and Procedures :

- 1) Radiology results should be correlated and interpreted by qualified medical professionals only. In case of any clarification, the referring doctors or patients can contact the reception/respective department/doctor.
- 2) Radiology results are affected by patient body habitus, food consumption, bowel contents, hydration status, foreign bodies and artifacts.
- 3) Small renal/ureteric stones, some of the pathologies of bowel, peritoneum and retroperitoneum may not be detected on ultrasound study.
- 4) Antenatal ultrasound: Maternal body variables, gestational age, fetal position at the time of the scan affects the scanning. Patient should come for review scan if and when recommended. Chromosomal anomalies cannot be diagnosed on ultrasound only. If ultrasound markers indicate high risk for chromosomal anomalies, further evaluation including karyotyping may be needed.
- 5) Duplicate reports can be provided only upto 30 days from the date of scan/procedure.
- 6) X-ray is a screening modality and not a diagnostic test. It should be correlated clinically and complemented by other requisite imaging modalities and lab tests. X-ray cannot detect soft tissue injuries (like tendon/ ligament injuries) and small renal/ ureteric stones.
- 7) All disputes relating to the reports are subject to jurisdiction of courts at Bengaluru city only.