

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. SHIVA KUMAR P	Order No : 1000083901
UHID : UHJA24000934	Registered On : 27/04/2024 08:06:15 AM
Age/Sex : 42/Years Male	Collected On : 27/04/2024 08:12:24 AM
Ward / Bed No :	Reported On : 27/04/2024 12:21:36 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJA240001218
Station : At Hospital	Mobile No : 8123732542
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	140	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	219	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	7.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	157.06	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	0.99	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	6.35	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	3.26	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	241	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	134	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	41.7	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	172.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	26.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.7		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	4.1		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	199.3	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.3	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)	1.22	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	8.1		12-20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.66	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.14	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.53	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.49	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.91	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.54		2:1
SERUM SGOT (Method:IFCC without P5P)	27	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	43	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	67	U/L	50-116
GGT (Method:IFCC)	29	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.59	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)	21.6	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)	14.95	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.5	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5710	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	56.74	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	30.20	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.20	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.64	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.22	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.31	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	85.7	fL	78-100
MCH (Method: Calculated)	28.2	pg	27-31
MCHC (Method: Calculated)	32.9	g/dL	31-37
RDW - CV (Method: Calculated)	14.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.04	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.56	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.5	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	08	mm/hour	1-15

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Method)	B
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

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.025		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	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)	Present (1.0%)		

Verified By
Rashmita

---End of Report---



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

*NABL renewal under process.



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.SHIVA KUMAR P	UHID	: UHJA24000934
Age / Sex	: 42 Years / Male	OP NO/Reg Dt	: 27-04-2024 08:06 AM
Spouse / Father Name	: PUTTANNAIAH	Department	:
Address	: 56 3rd cross 1st phase chandralayout, , Bengaluru Urban, Karnataka, INDIA,	Referred By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

WT 65 kg
 HT. ~~175~~ 182 cm
 BP. 113/76
 SpO₂ 98%
 PR 86 bpm

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Shiva Kumar P	Date	27/04/24
Age	42 years	Hospital ID	UHJA24000934
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



NABH



NABL



No.1

Patient name :	Mr. SHIVA KUMAR P	Date :	27/04/24
Age :	42 years GENDER: MALE	Patient ID :	24000934
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.0 (2.5-3.7)	LVIDD : 4.9 (3.5-5.5)	MV EV : 56.8	AV : 48.0	MR : NORMAL
LA : 3.9 (1.9-4.0)	LVIDS : 3.3 (2.4-4.2)	AV : 73.3		AR : NORMAL
RA : 2.4 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 71.1		PR : NORMAL
RV : 2.3 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>1.6)	LVPWD : 0.8 (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, TRIVIAL TR, JET GRDT-20mmHg
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 PULMONARTERY HYPERTENSION
 NO REGIONAL WALL MOTION ABNORMALITIES
 NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
 CONSULTANT CARDIOLOGIST

Sex: M
cm kg
Birth date: /
mmHg

42 years

1100 Sinus rhythm
4038 Nonspecific ST elevation [ST elevation (I, II, V3, V4, V5)]
9130 ** border line ECG **

Indication:

Symptoms:

Int. rate

R int

RS dur

QT/QTc(E) int

VQRS/T axis

N5/SV1 amp

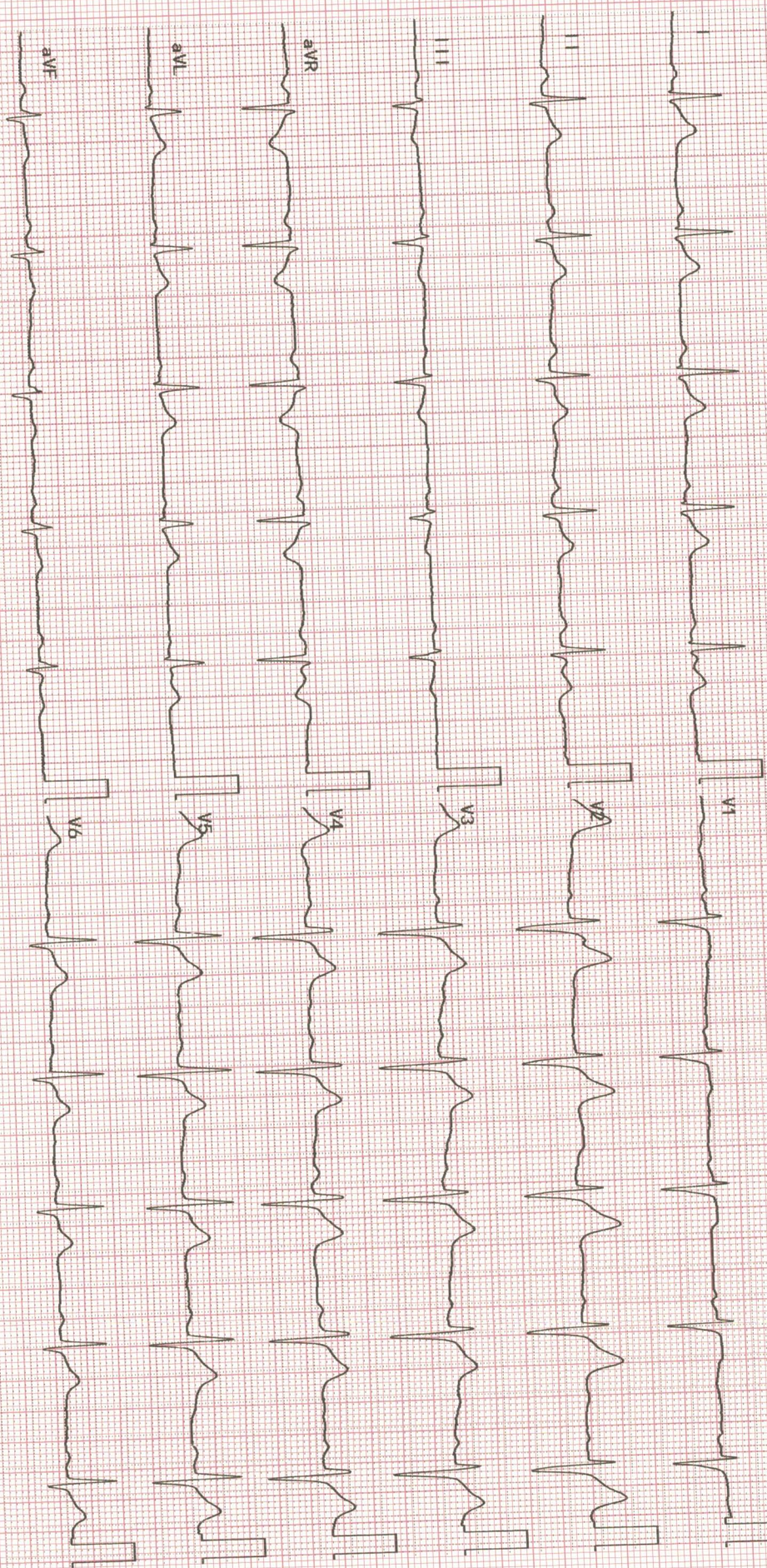
N5+SV1 amp

67	bpm
182	ms
104	ms
364/ 379	ms
43/ 7/ 16	°
0.84/ 0.88	mV
1.72	mV

Unconfirmed Report
Reviewed by:

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

10 mm/mV



DEPARTMENT OF RADIODIAGNOSIS

Name	Shiva Kumar P	Date	27/04/24
Age	42 years	Hospital ID	UHJA24000934
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

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

Right Kidney is normal in size (10.9 x 4.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.7 x 4.5 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 ~ 15.1 cc.

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

IMPRESSION:

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



Dr. Elluru Santosh Kumar
Consultant Radiologist