

SENTINI HOSPITALS

D.No:54-15-5, B&C, Beside Vinayaka Theatre,
Ring Road, Vijayawada - 520 008.Ph:0866-6677869

Department Of Laboratory

Name	: Mr. VENKATESWARA NAIK .D	Age /Sex	: 56 Y(s)/Male
Bill Date	: 24-Aug-2024 09:00 AM	UMR No.	: UMR2410855
Rept. Dt	: 24-Aug-2024 11:57 AM	Bill No.	: BIL24017264
Ref By	: Dr.GENERAL HEALTH CHECK UP	Result No	: 0 / RES24016656

<u>Parameter</u>	<u>Result</u>	<u>Normal Values</u>
RFT (RENAL FUNCTION TEST)		
BLOOD UREA	: 19 mg/dl	13 - 45 mg/dl
Serum Creatinine	: 0.8 mg/dl	0.7 - 1.4 mg/dl
TFT (THYROID FUNCTION TEST)		
T3 (TRI IODO THYRONINE)	: 121 ng/dl	80 - 200 ng/dl
T4 (THYROXINE)	: 8.1 ug/dl	5.1 - 14.1 ug/dl
TSH (THYROID STIMULATING HORMONE)	: 2.4 mIU/l	0.3 - 4.2 mIU/l
PSA	: 3.1 ng/ml	0.0 - 4.0 ng/ml
LIPID PROFILE		
Fasting Blood Sugar	: * 119 mg/dl	70 - 110 mg/dl
Total Cholesterol	: 174 mg/dl	150 - 240 mg/dl
Triglycerides	: 122 mg/dl	50 - 200 mg/dl
HDL Cholesterol	: 43 mg/dl	35 - 80 mg/dl
LDL Cholesterol	: 107 mg/dl	80 - 160 mg/dl
VLDL	: 24 mg/dl	10 - 50 mg/dl
Cholesterol / HDL ratio	: 4.0	< 6
LDL / HDL	: 2.5	< 4
LFT(LIVER FUNCTION TEST)		
Total Bilirubin	: 0.6 mg/dl	0.1 - 1.2 mg/dl
Direct Bilirubin	: 0.2 mg/dl	0.0 - 0.3 mg/dl
Indirect Bilirubin	: 0.4 mg/dl	
SGOT	: 34 IU/L	5 - 55 IU/L
SGPT	: 24 IU/L	5 - 55 IU/L
Alkaline Phosphatase	: 76 IU/L	Adult : 35 - 125 IU/L Children : 125 - 330 IU/L
Total Protein	: 7.2 gm/dl	6.0 - 8.3 gm/dl
Albumin	: 4.0 gm/dl	3.2 - 5.0 gm/dl
Globulin	: * 3.2 gm/dl	2.5 - 3.0 gm/dl
A / G RATIO	: * 1.2	1.51 - 1.81
ESR	: 40 mm/1hour	0 - 10 mm/1hour
CBC (COMPLETE BLOOD COUNT)		
HAEMOGLOBIN	: * 11.3 g/dl	12.0 - 17.0 g/dl

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Ref By	: Dr.GENERAL HEALTH CHECK UP	Result No	: 0 / RES24016656

<u>Parameter</u>	<u>Result</u>	<u>Normal Values</u>
Total WBC Count	: 6,400 cells/cumm	4000 - 11000 cells/cumm
DC COUNT		
Neutrophils	: 67 %	50 - 70 %
Lymphocytes	: 28 %	15 - 40 %
Eosinophils	: 03 %	0 - 7 %
Monocytes	: 02 %	0 - 4 %
Basophils	: 00 %	0 - 1 %
RBC COUNT	: * 4.0 millions/cumm	4.5 - 6.5 millions/cumm
PLATELET COUNT	: 3.0 lakhscells/cumm	1.5 - 4.0 lakhscells/cumm

URINE ROUTINE EXAMINATION

Sugar	: Nil
Albumin	: Nil
Microscopic Examination	
Pus cells	: 1-2 /HPF
Epithelial cells	: 1-2 /HPF
RBC	: Absent /HPF

Blood Grouping & Rh Typing : "B" POSITIVE

*** End Of Report ***

Lab Tech.

Bio-Chemist

Lab In-Charge

Incharge Pathologist

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Department Of Laboratory

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Bill Date	: 24-Aug-2024 09:00 AM	UMR No.	: UMR2410855
Rept. Dt	: 24-Aug-2024 12:32 PM	Bill No.	: BIL24017264
Ref By	: Dr.GENERAL HEALTH CHECK UP	Result No	: 0 / RES24016665

<u>Parameter</u>	<u>Result</u>	<u>Normal Values</u>
Fasting Blood Sugar	: * 119 mg/dl	70 - 110 mg/dl
HB A1C	: 6.1 %	Non Diabetic : < 6.0 % Good Control : 6.0 - 7.5 % Fair control : 7.5 - 8.5 % Poor Control : > 8.5 %
Post Prandial Blood Sugar	: * 217 mg/dl	80 - 199 mg/dl

*** End Of Report ***

Lab Tech.

Bio-Chemist

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Incharge Pathologist

Correlate Clinically

We use only sterilised disposable syringes & needles.

This report is to help you for better management of patient and not valid for medicolegal purpose.

Discrepancies due to technical or typing errors should be reported within 3 days for correction.

D. VENKATESWARA NAIK

Date: 24/08/2024

UMR : 2410855

Age/Sex: 56Y/M

Ref: GENERAL

REAL TIME ULTRASONOGRAPHY OF THE ABDOMEN

LIVER: Normal in size, shape and outline. Parenchymal echotexture normal. No focal cystic or solid mass lesion. No intrahepatic biliary dilatation. Intrahepatic portion of IVC is normal.

Portal vein is normal. Porta hepatis is normal.

G. B: Normal.

C.B.D: Not dilated.

PANCREAS: Parenchymal texture normal. No ductal dilatation. No calculi.

SPLEEN: Normal in size & echotexture.

KIDNEYS: **Right kidney** 9.4 x 3.4 cm

Normal in size, shape and outline. Parenchymal echotexture normal. Corticomedullary differentiation is well made out and is normal. No evidence of calculi/ Hydronephrosis.

Left kidney 9.6 x 4.2 cm

Normal in size, shape and outline. Parenchymal echotexture normal. Corticomedullary differentiation is well made out and is normal. No evidence of calculi / Hydronephrosis.

U.B: Normal wall thickness; No calculus /mass.

Prostate : Enlarged in size (27cc)

* No evidence of free fluid / lymphadenopathy.

IMPRESSION:

➤ **GRADE I PROSTATOMEGALY.**

· For clinical correlation & follow up.

[Consultant Radiologist]

56 years
 ready to see doctor now

<< Conclusions >>

SENTINI HOSPITAL, VIJAYAWADA

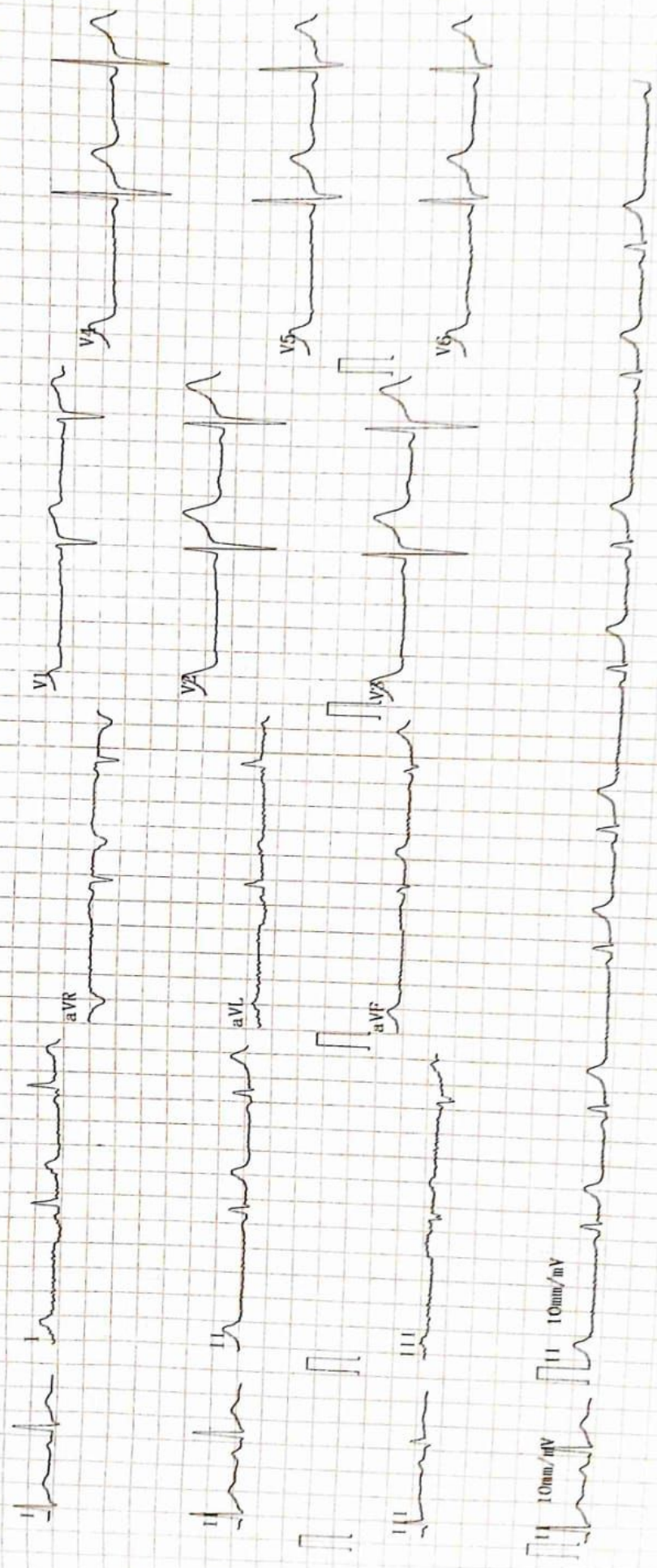
Data for reference only:

HR : 55
 PR Interval : 157 ms
 P Duration : 120 ms
 QRS Duration : 79 ms
 T Duration : 218 ms
 QT/QTc : 415/397 ms
 P/QRS/T Axis : 36.7/11.5/53.9 deg
 R(V5)/S(V1) : 1.07/0.69 mV
 R(V5)+S(V1) : 1.76 mV

Sinus mode Bradycardia
 Longitudinal Left axis deviation
 Report need physician confirm

Physician: _____
 10mm/mV

AUTO 10mm/mV AUTO 10mm/mV





Sentini Hospitals (P) Limited

Cardiology Department

ECHOCARDIOGRAM REPORTS

Name :D. Venkateswara Naik	UMR/OP/IP No :2410855
Age :56 Years	Sex :Male
Date :24 /08/2024	Echo No :601
Technician: Praveen	

MITRAL VALVE : Normal
AORTIC VALVE : Thickened
TRICUSPID VALVE : Normal
PULMONARY VALVE : Normal
AORTA : 30 mm
LEFT ATRIUM : 36 mm
LEFT VENTRICLE : Concentric LVH
RWMA : No LV RWMA
IVS : 15 mm LV IDd : 46 mm
PW : 15 mm LVIDs : 33 mm
LV EF : 60 %
RIGHT ATRIUM : Normal
RIGHT VENTRICLE : Normal
PULMONARY ARTERY : Normal
PULMONARY VEINS : Normal
IAS : Intact
IVS : Intact
PERICARDIUM : Normal
PERICARDIAL EFFUSION : No Effusion

DOPPLER STUDY

MITRAL FLOW : A>E
TRICUSPID FLOW : TRJV- m/s TR Gr :20 mmHg RVSP:30 mmHg
AORTIC JET VELOCITY : 1.6 m/s AV Gr: mmHg
PULMONARY JET VELOCITY : 0.9 m/s
COLOUR DOPPLER : 2+MR 2+TR 2+ AR No PR
IVC : Normal
SVC : Normal
OTHERS :
CONCLUSION :

**Concentric LVH
No LV RWMA
Mild MR, Mild AR
Mild TR, No PAH
Normal LV systolic function
Grade I diastolic dysfunction
No PE /No Clot**

DR RAGHURAM MD.DM
SENIOR INTERVENTIONAL CARDIOLOGIST

DR K. KRISHNA CHAND MD.DNB
SENIOR INTERVENTIONAL CARDIOLOGIST