UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SHASHIKALA.D	Order No	: 1000096065
UHID	: UHJA24005528	Registered On	: 14/09/2024 08:23:20 AM
Age/Sex	: 52/Years Female	Collected On	: 14/09/2024 08:36:29 AM
Ward / Bed No	:	Reported On	: 14/09/2024 12:01:06 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240007638
Station	: At Hospital	Mobile No	: 9741913611
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	329	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	407	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC) Remarks: Results are rechecked. Suggest evaluation for hemoglobin variant if clinically indicated. Kindly correlate clinically.	17.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	453	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.33	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.82	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.95	ı IU/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)	141	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	54.9	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	157.90	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	28.20	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.39		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.88		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	186.10	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.8	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.44	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.06	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.38	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.8	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.03	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.77	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.45		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	19	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	120	U/L	46-122
GGT (Method:IFCC)	25	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	25.6	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	12	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.54	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	22.22		12¯20 : 1

Dr. Shobha Emmanuel
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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)	14.68	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	46.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7540	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	48.68	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	40.27	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.35	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.46	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.24	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.16	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	89.1	fL	78-100
MCH (Method: Calculated)	28.4	pg	27-31
MCHC (Method: Calculated)	31.9	g/dL	31-37
RDW - CV (Method: Calculated)	13.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.90	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)	7.98	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	16	mm/hour	1-30

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

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

Interpretation Notes

Note: Both forward and reverse grouping performed

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Test Name	Result	Unit	Bio. Ref. Interval

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

PHYSICAL EXAMINATION			
VOLUME	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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)	Present (2.0%)		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	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	NIL		
URINE SUGAR, FASTING (Method:GOD-POD)	Present (1.5%)		
URINE SUGAR (POST PRANDIAL)	Present (2.0%)		

Verified By
Sridhar Kandukuri

---End of Report---

Dr. Shobha Emmanuel
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CONSULTANT PATHOLOGIST
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NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SHASHIKALA.D**	**UHID**	**: UHJA24005528**
Age / Sex	: 52 Years / Female	OP NO/Reg Dt	: 14-09-2024 08:23 AM
Spouse / Father Name	: DASEGOWDA	Department	:
Address	: 220,2ND LOOR PP LAYOUT, UTTARAHALLI, , Bengaluru Urban,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

HT: 157 cm
WT: 66.5 kg
SpO_2: 98 %
PR: 83 bpm
BP: 130 / 80 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Shashikala D	**Date**	14/09/24
Age	52 years	**Hospital ID**	UHJA24005528
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is grossly enlarged in size (20 cms) 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 evidence of mass or focal lesions.

Right Kidney is normal in size (10.5 x 4.1 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.7 x 5.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum - Obscured by bowel gas.

Urinary Bladder is distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and atrophic, measures 6.0 x 2.1 x 3.1 cms. Endometrium measures 3.0 mm.
Both ovaries appear atrophic.
Both adnexa: Normal. No mass is seen.

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

IMPRESSION: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Gross hepatomegaly with moderate fatty infiltration (Grade II).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH

No.1

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Mrs Shashikala - D   52yrs   19/7/24

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and
Gynecologist, Laparoscopy
and IVF Specialist
KMC Reg. No. 90384

BP - 130/80

Rcg Lab chy

K/c/o Type II DM

No h/o HTN, Thyroid

Any Surgery

No h/o family Cancer

P3L3
AL AND
Tubectomy
LCB
Surgery - Lscs

P/A — Soft   Breast — Soft

NABH No.1

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DEPARTMENT OF RADIODIAGNOSIS

Name	Shashikala D	**Date**	14/09/24
Age	52 years	**Hospital ID**	UHJA24005528
Sex	Female	**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

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DEPARTMENT OF RADIODIAGNOSIS

Name	Shashikala D	**Date**	14/09/24
Age	52 years	**Hospital ID**	UHJA24005528
Sex	Female	**Ref.**	Health check

BILATERAL SONOMAMMOGRAPHY

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **No significant abnormality detected in this study.**

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Consultant Radiologist

NABH No.1

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Patient name :	**Mrs.SHASHIKALA D**	**Date :**	**14/09/2024**
Age :	**52 years GENDER: FEMALE**	**Patient ID :**	**5528**
Ref by :	**DR.CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.2 (2.5-3.7)	LVIDD : 4.7 (3.5-5.5)	MV EV : 1.0	AV : 0.7	MR : MILD
LA : 3.5 (1.9-4.0)	LVIDS : 3.1 (2.4-4.2)	AV : 1.2		AR : NORMAL
RA : 3.6 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 1.0		PR : NORMAL
RV : 2.5 (<3.5)	IVSS : 1.3 (0.9-1.2)	TV EV : ------	AV : ------	TR : MILD
TAPSE: 1.9 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : GRADE-I LVDD		
	LVPWS : 1.4 (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

IMPRESSION :

NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE-I LV DIASTOLIC FUNCTION
MILD MR /TR , PASP-30mmHg
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

14-Sep-2024 AM9:16:09

ID:5528
Name:shashikala
Birth date:

Sex:M
cm kg / mmHg
Medication:
Symptoms:
History:

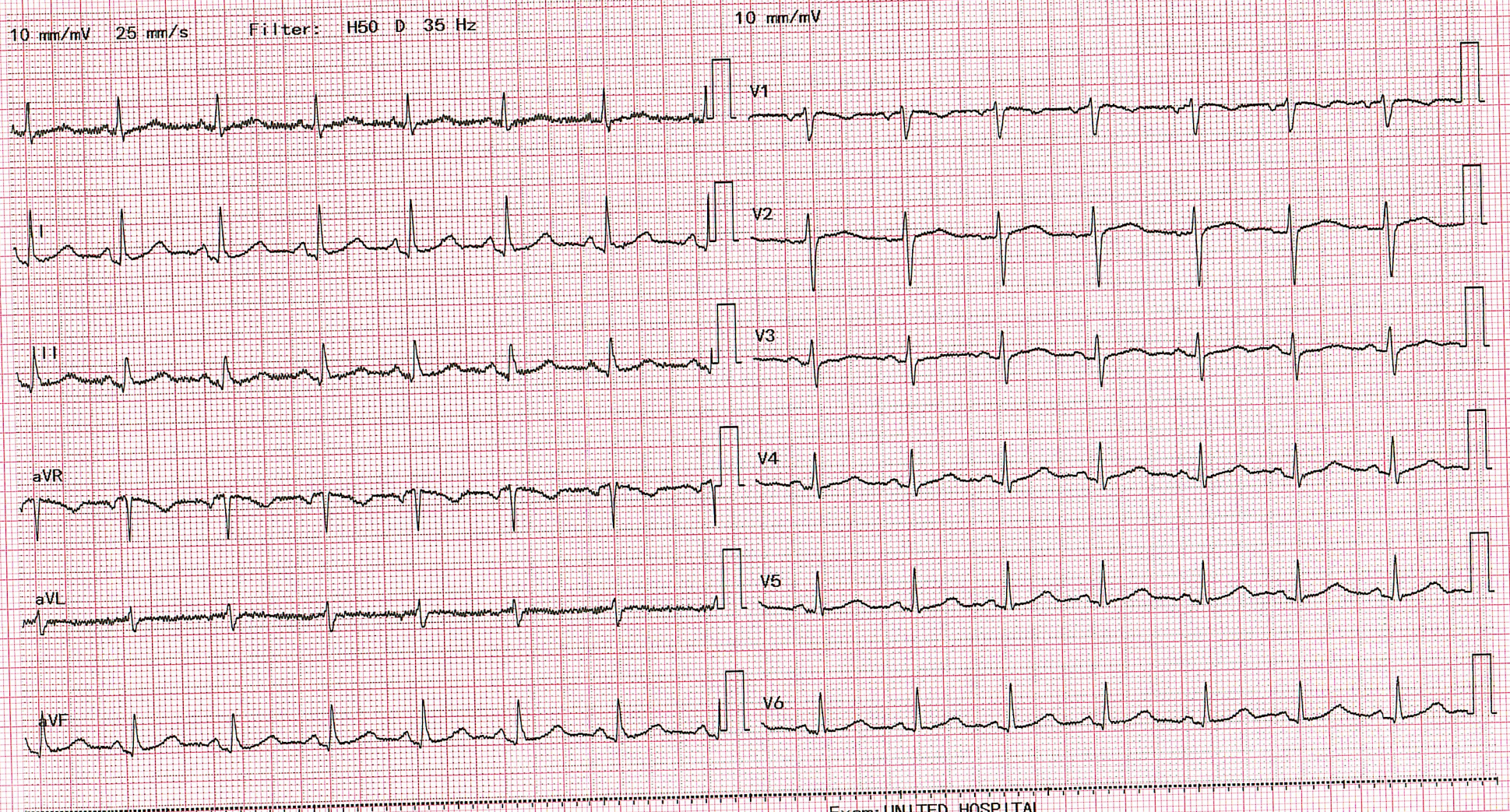
52 years

1100 Sinus rhythm
0102 ARTIFACT PRESENT
9110 ** normal ECG **

Vent. rate	91	bpm
PR int	152	ms
QRS dur	86	ms
QT/QTc(E) int	364/ 412	ms
P/QRS/T axis	60/ 63/ 64	°
V5/SV1 amp	0.84/ 0.55	mV
V5+SV1 amp	1.39	mV

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL