UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. G SHRUTHI	Order No	: 1000096104
UHID	: UHJA24005537	Registered On	: 14/09/2024 09:14:14 AM
Age/Sex	: 33/Years Female	Collected On	: 14/09/2024 09:48:52 AM
Ward / Bed No	:	Reported On	: 14/09/2024 01:06:04 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240007650
Station	: At Hospital	Mobile No	: 8147385447
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	94	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	103	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (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	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.26	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.10	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	4.96	ı IU/mL	0.34 - 5.60 ı IU/mL (Non Pregnant) 0.3 - 4.5 ı IU/mL (I trimester) 0.5 - 5.2 ı IU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	134	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	100	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	37.6	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	76.40	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	20.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.56		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.03		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	96.40	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.2	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	7	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.72	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.52	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.42	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.24	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.96	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.43		2:1
SERUM SGOT (Method:IFCC without P5P)	26	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	31	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	55	U/L	46-122
GGT (Method:IFCC)	19	U/L	< 38

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
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)	12.58	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	38.9	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6110	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	50.70	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	38.88	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.54	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.66	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.22	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.54	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	85.6	fL	78-100
MCH (Method: Calculated)	27.7	pg	27-31
MCHC (Method: Calculated)	32.3	g/dL	31-37
RDW - CV (Method: Calculated)	13.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.27	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)	7.35	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	56	mm/hour	1-20

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

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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)	Trace		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	2-4	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Rashmita

---End of Report---

Dr. Shobha Emmanuel
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CONSULTANT PATHOLOGIST
KMC:66136

ID:553
Name:sIruthi

14-Sep-2024 AM10:09:17

ex:M Birth date: 33 years

cm Ki / mmHg

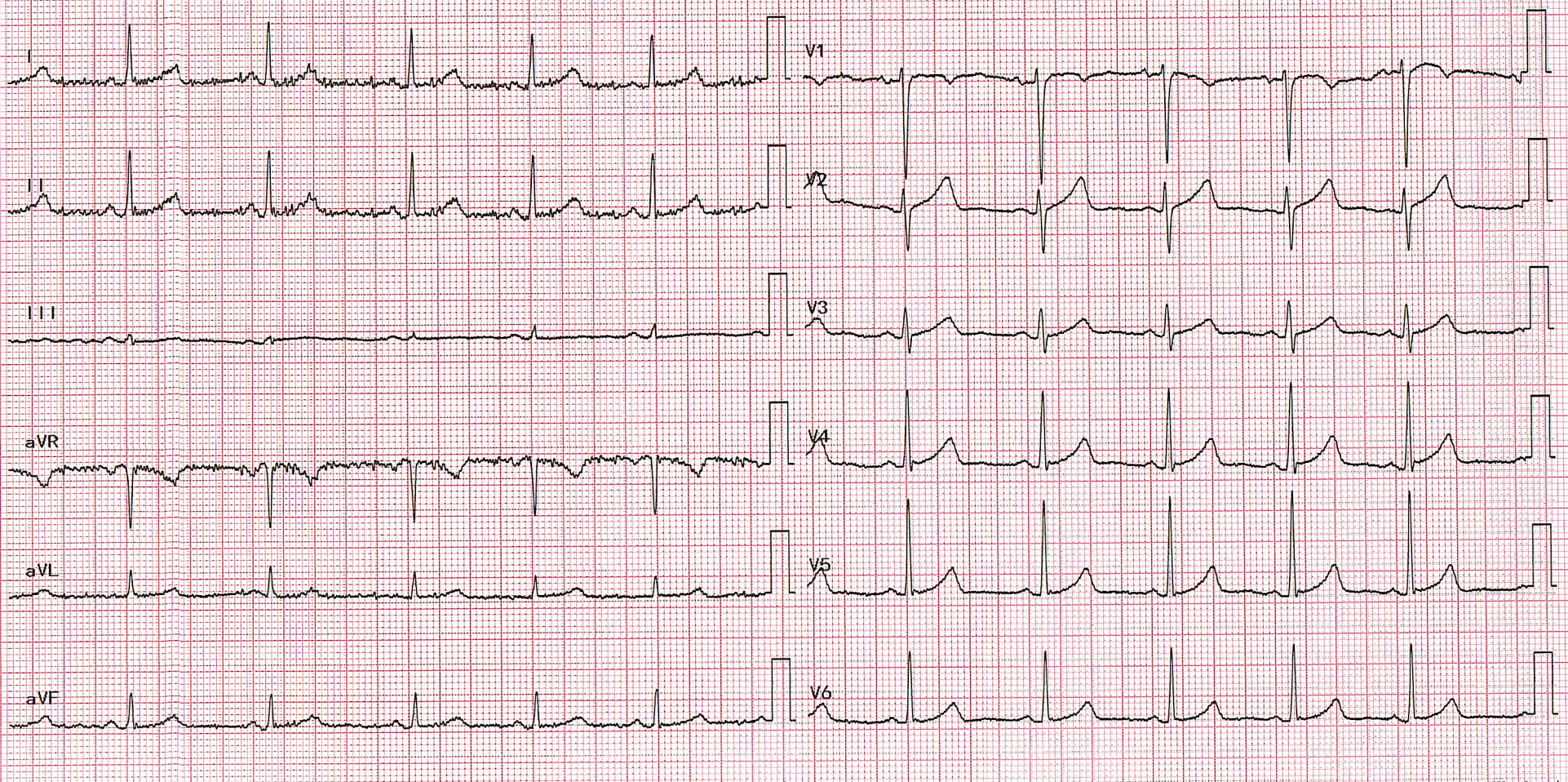
edication:
ymptoms:
istory:

ent. rate	72	bpm
R int	132	ms
RS dur	78	ms
T/QTc(E) int	392/ 416	ms
/QRS/T axis	56/ 34/ 36	°
V5/SV1 amp	1.74/ 1.59	mV
V5+SV1 amp	3.33	mV

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

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mrs. G SHRUTHI**	**Date :**	**14/09/24**
Age :	**33 years GENDER: FEMALE**	**Patient ID :**	**24005537**
Ref by :	**DR.CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV : 0.9	AV : 0.6	MR : NORMAL
LA : 3.0 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 1.0		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.8		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : MILD TR, PASP-25mmHg
TAPSE: 2.0 (>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
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

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

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Shruthi
33Yr / F

14/9/24.

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

For [illegible] [illegible]

BP - 130/90

No h/o DM, HTN, Thyroid

No h/o any [illegible] [illegible]

P/S
Cx
not taken.
USG - 30/8/24
[illegible]

P/A - Soft.

Not willing for [illegible] [illegible]

Breast

Adv [illegible] BP - [illegible] [illegible]

NABH No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	G Shruthi	**Date**	14/09/24
Age	33 years	**Hospital ID**	UHJA24005537
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (17 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 (10.7 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.1 x 4.1 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is minimally distended.

Uterus is anteverted and normal in size, measures 7.4 x 3.5 x 4.4 cms. Arcute uterine morphology is seen. Myometrial and endometrial echoes are normal. Endometrium measures 8 mm.
Right ovary is normal in size and echopattern, measures 7.4 cc.
Left ovary is normal in size and echopattern, measures 11.1 cc.
Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

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

Note: *Suboptimal evaluation due to minimally distended urinary bladder. Suggested review scan with full bladder.*

Dr. Elluru Santosh Kumar
Consultant Radiologist

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NABH No.1

UNITED HOSPITAL
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DEPARTMENT OF RADIODIAGNOSIS

Name	G Shruthi	**Date**	14/09/24
Age	33 years	**Hospital ID**	UHJA24005537
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

NABH No.1

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Out Patient Record

Patient Name	**: Mrs.G SHRUTHI**	**UHID**	**: UHJA24005537**
Age / Sex	: 33 Years / Female	OP NO/Reg Dt	: 14-09-2024 09:14 AM
Spouse / Father Name	: SURENDRA N	Department	:
Address	: BEML LAYOUT, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

HT: 169 cm
WT: 82.4 kg
SpO_2: 98 %
PR: 86 bpm
Bp: 130 / 94 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor