CARDIOLOGY

UHID / IP NO	224724 (2567)	RISNo./Status:	109378/
Patient Name:	Mrs. VIJAYALAXMI PULLELA	Age/Gender:	38 Y/F
Referred By:	Dr. CMO	Ward/Bed No:	OPD
Bill Date/No:	13/01/2024 9:25AM/ OPCR/24/6849	Scan Date :	
Report Date :	13/01/2024 10:52AM	Company Name:	Final

M- MODE MEASUREMENTS

AO	1.78	cm	RVIDD	1.20	cm
LA	2.58	cm	IVSD	0.86	cm
AO/LA RATIO	0.75	cm	LVIDD	3.73	cm
AV CUP	1.46	cm	LVPWD	1.10	cm
EPSS	0.9	cm	IVSS	0.93	cm
DE	1.83	cm	LVIDS	2.40	cm
EF SLOPE	0.7	cm	LVPWS	0.93	cm
sv	57.41		EDV	59.72	ml
СО			ESV	20.34	ml
HR			EF	65.73	%
LVMI			FS	35.90	%
OTHERS			LV MASS	178.32	grams

DESCRIPTIVE FINDINGS: Technically Adequate Study. Normal Sinus rhythm during Study.

LEFT VENTRICLE	Normal in size
LEFT ATRIUM	Normal in size
RIGHT VENTRICLE	Normal in size
RIGHT ATRIUM	Normal in size
WALL MOTION ANALYSIS	No RWMA
TRICUSPID VALVE	Normal
MITRAL VALVE	Normal
PULMONIC VALVE	Normal
AORTIC VALVE	Normal
IAS & IVS	Intact
AORTA & PA	Normal In Size
SYSTEMIC & PULMONARY VENIS	Normally Draining
PERICARDIUM	Normal
OTHERS	No Intra Cardiac Thrombus, Tumour or Vegetation

CARDIOLOGY

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COLOUR DOPPLER STUDY

VALVES	VELOCITY	GRADIENT	REGURGITATION	OTHERS
PV	0.71m/s		NO PR	
MV	E: 0.95m/s A: 0.68m/s		NO MR	
AV	1.11m/s		NO AR	
TV	E: 0.60m/s A: 0.40m/s		TRIVIAL TR	
OTHERS				

SUMMARY FINDINGS:

NORMAL CARDIAC CHAMBERS

NO REGIONAL WALL MOTION ABNORMALITY AT REST

NORMAL LV SYSTOLIC FUNCTION (EF-65%)

NORMAL LV DIASTOLIC FUNCTION

NO CLOT / PE / VEGETATION/PAH

Dr. PRANEETHSCONSULTANT
CARDIOLOGIST

Mr. Thirumalivasan G

CARDIOLOGY

UHID / IP NO	224724 (2567)	RISNo./Status:	109378/
Patient Name:	Mrs. VIJAYALAXMI PULLELA	Age/Gender:	38 Y/F
Referred By:	Dr. CMO	Ward/Bed No:	OPD
Bill Date/No:	13/01/2024 9:25AM/ OPCR/24/6849	Scan Date :	
Report Date :	13/01/2024 10:52AM	Company Name:	Final



Patient Name	Mrs. VIJAYALAXMI PULLELA	Lab No	109378
UHID	224724	Sample Date	13/01/2024 9:25AM
Age/Gender	38 Yrs/Female	Receiving Date	13/01/2024 9:48AM
Bed No/Ward	OPD	Report Date	13/01/2024 2:09PM
Referred By	Dr. CMO	Report Status	Final
Bill No.	OPCR/24/6849	Manual No.	

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
			Sample: Serum	
BLOOD UREA NITROGEN	10.4	mg/dl	Upto 14 years: 5 - 18 mg/dl Male (above 14 years): 8 - 24 mg/dl Female (above 14 years): 6 - 21 mg/dl Pregnant women: 5 - 12 mg/dl	
SERUM CREATININE	0.63	mg/dl	0.60 - 1.40	
FASTING BLOOD SUGAR	97	mg/dl	74.00 - 100.00	
GLYCOSYLATED HAEMOGLOBIN	(HbA1c)			
HbA1c (GLYCOSYLATED Hb)	5.7	%	4.00 - 6.00	Immunoturbidimetric
MEAN BLOOD GLUCOSE	116.89	mg/dl	70.00 - 140.00	
LIPID PROFILE				
TOTAL CHOLESTEROL	125	mg/dl	0.00 - 200.00	
TRIGLYCERIDES	115.4	mg/dl	0.00 - 200.00	
HDL CHOLESTEROL - DIRECT	43.1	mg/dl	35.00 - 55.00	
LDL CHOLESTROL - CALCULATED	58.82	mg/dl	0 - 130	
TC/HDL	2.90			
LDL/HDL	1.36			
			Sample: Serum	

LIVER FUNCTION TEST (LFT)

Verified By Ravi Shankar K

Kani Stantar

Shashi Kumar G

Bio Chemist

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Patient Name	Mrs. VIJAYALAXMI PULLELA	Lab No	109378
UHID	224724	Sample Date	13/01/2024 9:25AM
Age/Gender	38 Yrs/Female	Receiving Date	13/01/2024 9:48AM
Bed No/Ward	OPD	Report Date	13/01/2024 2:09PM
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TOTAL BILIRUBIN	0.69	ma/dl	Adult - 0.2 - 1.3 mg/ dL

Special condition:

Premature - <2.0 mg/dL
Full term - <2.0 mg/dL
0-1 day - Premature1.0 - 8.0 mg/dL
0-1 day - Full term 2.0 - 6.0 mg/dL
1 - 2 days Premature 6.0 - 12.0 mg/dL
1 - 2 days Full term 6.0 - 10.0 mg/dL
3 - 5 days Premature 10.0 - 14.0 mg/dL
3 - 5 days Full term -

3 - 5 days Premature 10.0 - 14.0 mg/ dL 3 - 5 days Full term -4.0 - 8.0 mg/ dL 0.00 - 0.30

DIRECT BILIRUBIN	0.30	mg/dl	0.00 - 0.30
INDIRECT BILIRUBIN.	0.39	mg/dl	
ASPARATE AMINOTRANSFERASE (SGOT/AST)	12.0	U/L	0.00 - 40.00
ALANINE AMINOTRANSFERASE (SGPT/ALT)	16.1	U/L	0.00 - 40.00
ALKALINE PHOSPHATASE (ALP)	65	IU/L	42.00 - 98.00
TOTAL PROTEIN	6.44	g/dl	6.00 - 8.50
SERUM ALBUMIN	4.09	g/dl	3.50 - 5.20
SERUM GLOBULIN	2.35	g/dl	2.30 - 3.50
A/G RATIO	1.74	%	1.00 - 2.00
URIC ACID	5.6	mg/dl	3.20 - 6.40
	E,	d Of Donort	

--End Of Report--

Verified By Shashi Kumar G Ravi Shankar K

Kavi Startar

Bio Chemist

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378 **UHID** 224724 **Sample Date** 13/01/2024 9:25AM 38 Yrs/Female 13/01/2024 1:29PM Age/Gender **Receiving Date** 13/01/2024 2:09PM Bed No/Ward OPD **Report Date** Final **Referred By** Dr. CMO **Report Status** OPCR/24/6849 Bill No. Manual No.

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
POST PRANDIAL BLOOD GLUCOSE	124.5	mg/dl	70.00 - 140.00	

-- End Of Report--

Verified By

Shashi Kumar G

BADARINATH S

MD (PGI) KMC No 19014 HEMATOPATHOLOGIST / PATHOLOGIST

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378 **UHID** 224724 **Sample Date** 13/01/2024 9:25AM 38 Yrs/Female 13/01/2024 1:29PM Age/Gender **Receiving Date** 13/01/2024 2:09PM Bed No/Ward OPD **Report Date** Final **Referred By** Dr. CMO **Report Status** OPCR/24/6849 Bill No.

Manual No.

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Method Ref. Range	
UIRNE GLUCOSE FASTING				
URINE SUGAR	NIL		NEGATIVE	
			Sample: Urine	
PHYSICAL CHARACTERS				
COLOUR	Pale Yellow			
APPEARANCE	Clear		Clear	
SPECIFIC GRAVITY	1.015			
PH	6.0			
CHEMICAL CONSTITUENTS				
ALBUMIN	Nil			
SUGAR	Nil			
BILE SALTS	Absent			
BILE PIGMENTS	Absent			
KETONE BODIES	NEGATIVE			
BLOOD	Absent			
MICROSCOPY				
PUS CELLS	3-4/HPF			
R.B.C	Nil			
EPITHELIAL CELLS	1-2 /HPF			
CASTS	Nil			
CRYSTALS	Nil			
BACTERIA	Absent			
URINE GLUCOSE-POST PRAN	DIAL			
URINE SUGAR	NIL		NEGATIVE	

Verified By Shashi Kumar G **BADARINATH S**

MD (PGI) KMC No 19014 HEMATOPATHOLOGIST / PATHOLOGIST

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378

UHID 224724 **Sample Date** 13/01/2024 9:25AM

Age/Gender38 Yrs/FemaleReceiving DateBed No/WardOPDReport Date

Referred By Dr. CMO Report Status Final

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378 **UHID** 224724 **Sample Date** 13/01/2024 9:25AM 38 Yrs/Female 13/01/2024 9:48AM Age/Gender **Receiving Date** 13/01/2024 12:48PM Bed No/Ward OPD **Report Date** Final **Referred By** Dr. CMO **Report Status** Bill No. OPCR/24/6849 Manual No.

HAEMATOLOGY

	1 14	ALMAIOLOG) I	
Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD GROUP	" B "			
RH TYPE	POSITIVE			
			Sample: Blood	
HAEMOGLOBIN	12.9	gm/dl	12.00 - 16.00	
TOTAL COUNT	6780	cells/cumm	4500.00 - 11000.00	
DLC				
NEUTROPHILS	58	%	35.00 - 66.00	
LYMPHOCYTES	33	%	24.00 - 44.00	
MONOCYTES	05	%	4.00 - 10.00	
EOSINOPHILS	04	%	1.00 - 6.00	
BASOPHILS	00	%	0.00 - 1.00	
R.B.C COUNT	4.23	mill/cumm	4.00 - 5.20	
PACKED CELL VOLUME (PCV)	37.1	%	36.00 - 46.00	
PLATELET COUNT	2.51	lakh/cumm	1.50 - 4.50	
M.C.V	87.7	fL	80.00 - 100.00	
M.C.H	30.5	pg	26.00 - 34.00	
M.C.H.C	34.8	%	32.00 - 36.00	
ESR (ERYTHROCYTE SEDIMENTATION RATE)	16	mm/hr	0.00 - 20.00	

--End Of Report--

Verified By Shashi Kumar G **BADARINATH S**

MD (PGI) KMC No 19014 HEMATOPATHOLOGIST / PATHOLOGIST

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378

UHID 224724 **Sample Date** 13/01/2024 9:25AM

Age/Gender38 Yrs/FemaleReceiving DateBed No/WardOPDReport Date

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HISTOPATHOLOGY

PAP SMEAR

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Mrs. VIJAYALAXMI PULLELA 109378 **Patient Name** Lab No **UHID** 224724 **Sample Date** 13/01/2024 9:25AM 15/01/2024 7:05AM Age/Gender 38 Yrs/Female **Receiving Date Bed No/Ward** OPD **Report Date** 17/01/2024 9:46AM Final **Referred By** Dr. CMO **Report Status** Bill No. OPCR/24/6849 Manual No.

PAP SMEAR

SPECIMEN TYPE: Received LBP.

CLINICAL DETAILS: Master health check up.

PAP Smear Cytology No: C12/2024

No. of slides-One

SPECIMEN ADEQUACY: Adequate for evaluation.

GENERAL CATEGORIZATION

Superficial cells: Present

Intermediate cells: Present

Parabasal cells: Absent

Metaplastic cells: Absent

Endocervical cells: Absent

Endometrial cells: Absent

Non Neoplastic findings: Mild neutrophilic inflammatory cell infiltrate.

Organisms: Nil.

EPITHELIAL CELL ABNORMALITIES: Absent

Interpretation: Negative for intraepithelial lesion or malignancy.

-- End Of Report--

Verified By

Shashi Kumar G

Dr. Sunitha N

MBBS DNB(PATHOLOGY) CHIEF HISTOPATHOLÓGIST

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378 **UHID** 224724 **Sample Date** 13/01/2024 9:25AM Age/Gender 38 Yrs/Female **Receiving Date** 13/01/2024 9:48AM Bed No/Ward 13/01/2024 11:52AM OPD **Report Date** Final **Referred By** Dr. CMO **Report Status** Bill No. OPCR/24/6849 Manual No.

HORMONES

Test Name	Result	Unit	Biological Ref. Range	Method			
THYROID PROFILE (T3, T4, TSH)						
TOTAL TRIIODOTHYRONINE (T3)	1.45	ng/mL	0.59 - 2.15				
TOTAL THYROXINE (T4)	77.8	ng/mL	52.00 - 127.00				
TSH (THYROID STIMULATING HORMONE)	2.44	uIU/ml	0.30 - 4.50				

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Cari Startar

Bio Chemist

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378

UHID 224724 **Sample Date** 13/01/2024 9:25AM

Age/Gender38 Yrs/FemaleReceiving DateBed No/WardOPDReport Date

Referred By Dr. CMO Report Status Final

Bill No. OPCR/24/6849 Manual No.

USG

ABDOMEN & PELVIS (USG)

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Mrs. VIJAYALAXMI PULLELA 109378 **Patient Name** Lab No **UHID** 224724 **Sample Date** 13/01/2024 9:25AM 13/01/2024 12:50PM Age/Gender 38 Yrs/Female Receiving Date 13/01/2024 1:17PM Bed No/Ward **OPD Report Date** Final **Referred By** Dr. CMO **Report Status**

Bill No. OPCR/24/6849 Manual No.

LIVER: Liver is 13.6 cm in size, both lobes of liver are normal in size with homogeneous echotexture. No evidence of any focal lesion / intrahepatic billiary dilatation noted. CBD and Portal vein normal in size and echotexture.

GALL BLADDER: Well distended, gall bladder wall thickness is normal. Contents are clear. No evidence of gall stones /cholecystitis.

PANCREAS: Head and body appears normal. Uncinate process and tail could not be assessed due to bowel gas. MPD is normal.

SPLEEN: Normal in size measuring 10 cms with normal echotexture.

KIDNEYS: Both kidneys are normal in size, shape, contour & position. Cortico medullary differentiation is well maintained. No evidence of any hydroureteronephrosis / calculus.

Note - Subcentimeteric calculus cannot be detected in ultrasound.

Right Kidney measures $: 9.2 \times 4.0 \text{ cms.}$ Parenchymal thickness 1.1 cms. Left Kidney measures $: 9.6 \times 4.2 \text{ cms.}$ Parenchymal thickness 1.4 cms.

URINARY BLADDER: Well distended with clear contents. Wall thickness is normal.

UTERUS: Normal in size and echotexture, measuring 9.2 x 3.6 x 5.3 cms. Myometrial echoes appear normal. Endometrium appears normal, measures 5.3 mm.

OVARIES: Both ovaries are normal in size and echotexture. Right ovary: 3.0 x 1.6 cms. Left ovary: 2.6 x 1.5 cms.

No obvious free fluid in the peritoneal cavity / pleural collection.

IMPRESSION: NO SONOLOGICAL ABNORMALITY DETECTED.

** Note: All abnormalities cannot be detected by Ultrasound scan due to technical limitation, obesity and other factors. Scan findings to be correlated with old reports or other investigations.

--End Of Report--

Verified By

Shashi Kumar G

Dr. NAVEEN SUBBAIAH

MBBS, MD -RADIO DIAGNOSIS

Visiting Consultant

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Patient Name Mrs. VIJAYALAXMI PULLELA Lab No 109378 **UHID** 224724 **Sample Date** 13/01/2024 9:25AM 13/01/2024 10:21AM Age/Gender 38 Yrs/Female Receiving Date **Bed No/Ward** OPD **Report Date** 13/01/2024 1:05PM Final **Referred By** Dr. CMO **Report Status**

X-RAY

Manual No.

CHEST PA VIEW (X RAY)

FINDINGS:

Bill No.

The lungs on the either side show equal translucency.

OPCR/24/6849

Cardiac size and ventricular configuration are normal.

Both hilar region appear normal.

Both C P angles appear clear.

Both domes of diaphragm appear normal.

Bony cage and soft tissue appear normal.

IMPRESSION: ESSENTIALLY NORMAL STUDY.

-- End Of Report--

Verified By Shashi Kumar G Dr. NAVEEN SUBBAIAH MBBS, MD -RADIO DIAGNOSIS Visiting Consultant

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