UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. MURUGESH P	Order No	: 1000074719
UHID	: UHJA23019195	Registered On	: 27/02/2024 08:47:36 AM
Age/Sex	: 53/Years Male	Collected On	: 27/02/2024 08:55:09 AM
Ward / Bed No	:	Reported On	: 27/02/2024 03:31:38 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023745
Station	: At Hospital	Mobile No	: 9611579898
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)	86	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	93.92	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.20	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.48	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.21	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	258	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	164	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	43.2	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	182.0	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	32.79	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.9		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	4.2		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	214.8	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	8.0	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	1.11	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	11.7		12˜20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.96	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.15	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.81	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.13	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.07	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.34		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	14	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	49	U/L	50-116
GGT (Method:IFCC)	15	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.25	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)	27.0	mg/dL	17-43

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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Test Name	Result	Unit	Bio. Ref. Interval
HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.30	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.4	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4510	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	56.13	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	26.50	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	7.62	%	0-6
MONOCYTES (Method:Optical/Impedance)	9.24	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.51	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.18	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	87.6	fL	78-100
MCH (Method: Calculated)	29.5	pg	27-31
MCHC (Method: Calculated)	33.7	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.87	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)	6.95	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	8	mm/hour	1-20

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

ABO Group (Method:Agglutination Gel Method)	B	
Rh Factor (Method:Agglutination Gel Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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Station	: At Hospital	Mobile No	: 9611579898
Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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)	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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Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023745
Station	: At Hospital	Mobile No	: 9611579898
Payer Name	: Mediwheel	Report Status	: Final Report

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)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

UNITED HOSPITAL
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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. MURUGESH P	Order No	: 1000074722
UHID	: UHJA23019195	Registered On	: 27/02/2024 08:51:13 AM
Age/Sex	: 53/Years Male	Collected On	: 27/02/2024 08:55:33 AM
Ward / Bed No	:	Reported On	: 27/02/2024 11:18:00 AM
Reference	:	Bill No	: OOBJA23008268
Station	: At Hospital	Mobile No	: 9611579898
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
VITAMIN B12 (Method:CLIA)	407	pg/mL	75-807

Interpretation Notes

Vitamin B12 or Cobalamin assay helps to diagnose the cause of anemia or neuropathy; to evaluate nutritional status in some patients; to monitor effectiveness of treatment for B12 deficiency. Vitamin B12 is necessary for normal RBC formation, tissue and cellular repair, and DNA synthesis. Vitamin B12 is also important for nerve health; a deficiency in either B12 or Folate can lead to macrocytic anemia. Interpretation of the result should be considered in relation to clinical circumstances. The concentration of Vitamin B12 obtained with different assay methods cannot be used interchangeably due to differences in assay methods and reagent specificity.

Verified By
PRAVEEN T

---End of Report---

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

NABH NABL No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Patient name :	Mr. MURUGESH P	Date :	27/02/24
Age :	53 years GENDER: MALE	Patient ID :	19195
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 4.4 (3.5-5.5)	MV EV : 76.6	AV : 53.4	MR : NORMAL
LA : 3.0 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 103		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 93.1		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>1.6)	LVPWD : 0.9 (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, TRIVIAL TR
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

ex:M Birth date: 53 years

cm kg / mmHg

edication:

ymptoms:

istory:

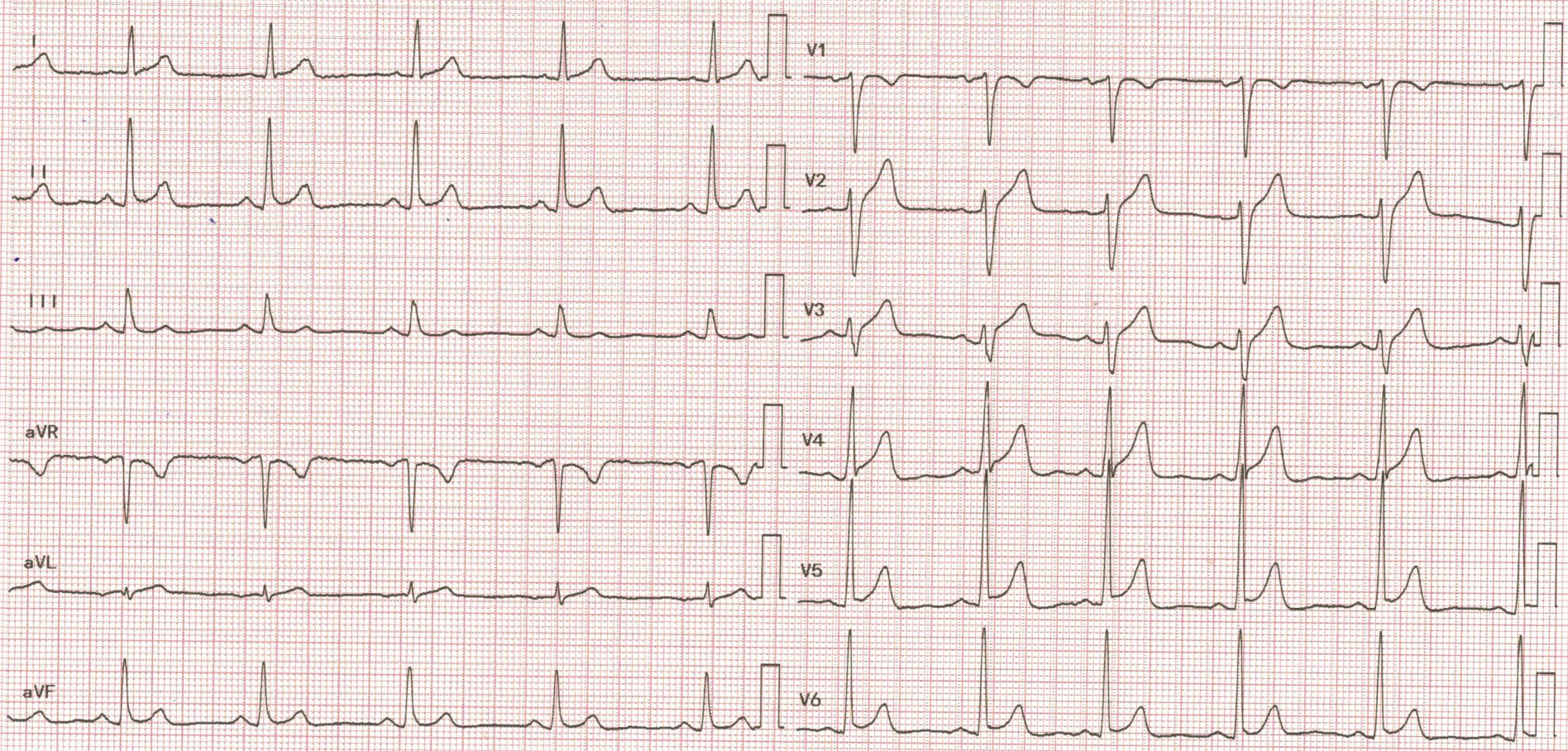
ent. rate	66	bpm
R int	154	ms
RS dur	104	ms
T/QTc(E) int	366/ 380	ms
P/QRS/T axis	68/ 51/ 37	°
V5/SV1 amp	2.30/ 1.20	mV
V5+SV1 amp	3.50	mV

1100 Sinus rhythm
40303 Early repolarization [ST elevation (I, II, aVF, V2, V3, V4, V5, V6)]
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 NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.MURUGESH P**	**UHID**	**: UHJA23019195**
Age / Sex	: 53 Years / Male	OP NO/Reg Dt	: 27-02-2024 08:47 AM
Spouse / Father Name	: PACHAPPAN M	Department	:
Address	: no 12 1st a main 2nd cross cholur palya magadi road , , Bengaluru Urban, Karnataka,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha [Opthal].

Complaints / Findings / Observations :

HTN - 4yrs

Vn: 6/9 PH 6/6 / 6/9 PH 6/6 N6 N6 with +2.25DS

Investigations:

A/S OU Nml

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (undilated) OU CDR 0.3:1 KMC(+)

Follow Up Advice :

Imp: OU Ref Error.

+2.25DS for near. Rx:

Signature of the Doctor

NABH NABL No.1

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Age / Sex	: 53 Years / Male	OP NO/Reg Dt	: 27-02-2024 08:47 AM
Spouse / Father Name	: PACHAPPAN M	Department	:
Address	: no 12 1st a main 2nd cross cholur palya magadi road , , Bengaluru Urban, Karnataka,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Ashwitha Padma

Complaints / Findings / Observations :

CVA - 2019 } T. Telma H 40. T. Moxorac 0.2 1 01.
HTN

WT - 79.3.
HT - 173.
BP - 135/92
SpO2 - 99%
PR - 84b/

LDL - 182.

Investigations:

Uric acid - 8

Clopidrogrel 75 0-0-1.

↓ Water intake.

Treatment / Care of Plan / Provisional Diagnosis :

℞

Tab. Rosavel AP 75/10.
0-0-1.

Follow Up Advice :

Adequate hydration.

Signature of the Doctor

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Murugesh P	**Date**	27/02/24
Age	53 years	**Hospital ID**	UHJA23019195
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and ***shows mildly 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 (9.9 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (9.6 x 3.8 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, mass or mural lesion.

Prostate is normal in echopattern and size, measures ~ 10.9 cc.

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

IMPRESSION:

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

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Murugesh P	**Date**	27/02/24
Age	53 years	**Hospital ID**	UHJA23019195
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. *Minimal scoliosis of the dorsal spine with convexity towards right.*

IMPRESSION:

- **No significant radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist