UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. RITU CHOWDHARY	Order No	: 1000074206
UHID	: UHJA23018947	Registered On	: 23/02/2024 10:56:20 AM
Age/Sex	: 36/Years Female	Collected On	: 23/02/2024 11:13:05 AM
Ward / Bed No	:	Reported On	: 23/02/2024 02:41:52 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023422
Station	: At Hospital	Mobile No	: 9831945865
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	83	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	92	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	99.66	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.93	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	7.51	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.34	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)	177	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	64	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	56.6	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	107.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	12.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.1		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.9		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	120.4	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.0	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.64	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.50	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.41	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.10	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.00	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.36		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	14	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	81	U/L	46-122
GGT (Method:IFCC)	21	U/L	< 38

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	10.94	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	34.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6190	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	53.33	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.42	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.86	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.25	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.14	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.13	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.3	fL	78-100
MCH (Method: Calculated)	26.5	pg	27-31
MCHC (Method: Calculated)	32.2	g/dL	31-37
RDW - CV (Method: Calculated)	14.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.06	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)	9.41	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	22.1	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	19	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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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Turbid		
PH	5.0		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)	Present (+)		Negative
BLOOD (Method:Peroxidase Reaction)	Present (+)		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	4-6	/HPF	0-5
PUS CELLS	8-10	/HPF	0-5
RBCs	4-6	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
PRAVEEN T

---End of Report---

Naveen.M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. RITU CHOWDHARY	Order No	: 1000074209
UHID	: UHJA23018947 \	Registered On	: 23/02/2024 10:56:19 AM
Age/Sex	: 36/Years Female	Collected On	: 23/02/2024 04:06:33 PM
Ward / Bed No	:	Reported On	: 23/02/2024 05:12:07 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023422
Station	: At Hospital	Mobile No	: 9831945865
Payer Name	: Mediwheel	Report Status	: Final Report

Samples

CERVICAL SMEAR - 23/02/2024 04:06 PM

Test Name :PAP SMEAR

NUMBER OF SLIDES RECEIVED: 02
TYPE OF THE SMEAR: Conventional
SOURCE OF THE SMEAR: Ectocervix and endocervix
CLINICAL DETAILS: P1L1
L M P: 17/02/2024

SPECIMEN ADEQUACY:
Satisfactory for evaluation.
Transformation zone/ Endocervical cell component is absent.

MICROSCOPY:
Smears show predominantly superficial and intermediate squamous cells.
Background shows dense neutrophilic infiltrate.
No trichomonads, candida, other parasites or non-specific microorganisms are present.

IMPRESSION: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY (NILM)
COMMENTS: INFLAMMATORY SMEAR

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NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: **Mrs.RITU CHOWDHARY**	**UHID**	: **UHJA23018947**
Age / Sex	: 36 Years / Female	OP NO/Reg Dt	: 23-02-2024 10:56 AM
Spouse / Father Name	: SANDIP JAISWAL	Department	:
Address	: # Flat 627 Sowparnika Swastika Appartment Attibele Bidarguppe ,	Refered By	: Dr- Shwetha.
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: (Optho)

Complaints / Findings / Observations :

VA < 6/12 6/12 P N6.

Investigations:

Dg Am.

M's OU Normal

RE: +1.00/-2.50 x 115

LE: +0.75/-1.75 68.

Fundus OU CD:0.3:1

Treatment / Care of Plan / Provisional Diagnosis :

(Advised) AM(+)

If: Ref Enclosed

Follow Up Advice :

RE: -1.50 DC x 110 6/6

LE: -1.75 DC x 70 6/6.

Signature of the Doctor

23/2/24.

DEPARTMENT OF RADIODIAGNOSIS

Name	Ritu Chowdhary	**Date**	23/02/24
Age	36 years	**Hospital ID**	UHJA23018947
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

23-Feb-2024 PM12:22:11

ID:23018947
Name:mrs.ritu chowdhary

ex:F Birth date: 36 years

cm kg / mmHg

edication:
ymptoms:
istory:

ent. rate	81	bpm
R int	136	ms
RS dur	78	ms
T/QTc(E) int	340/ 377	ms
/QRS/T axis	43/ -18/ 15	°
V5/SV1 amp	0.67/ 0.85	mV
V5+SV1 amp	1.52	mV

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (I, II, aVL)]
0102 ARTIFACT PRESENT
9130 ** borderline ECG **

Unconfirmed Report
Reviewed by:

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

10 mm/mV

I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6

Exam:UNITED HOSPITAL

2350K 03-08 07-01 Dept.:

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. RITU CHOWDHARY	Date :	23/02/24
Age :	36 years GENDER: FEMALE	Patient ID :	18947
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 : 3.7 (3.5-5.5)	MV EV : 80.5	AV : 60.6	MR : NORMAL
LA : 3.0 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV: 82.8		AR : NORMAL
RA : 2.1 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 87.8		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.7 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.9 (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, PASP-15mmHg
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

DEPARTMENT OF RADIODIAGNOSIS

Name	Ritu Chowdhary	**Date**	23/02/24
Age	36 years	**Hospital ID**	UHJA23018947
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and 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 (9.1 x 4.1 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.3 x 4.0 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 well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus is anteverted and normal in size, measures 7.4 x 4.4 x 3.0 cms. Myometrial and endometrial echoes are normal. Endometrium measures 3.2 mm.
Right ovary is normal in size and echopattern, measures 3.9 cc.
Left ovary is normal in size and echopattern, measures 2.2 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:

- **No definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

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