UNITED HOSPITAL
Care For Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. CHETHAN KUMAR V	Order No	: 1000102698
UHID	: UHJA24007781	Registered On	: 09/11/2024 08:20:16 AM
Age/Sex	: 38/Years Male	Collected On	: 09/11/2024 08:33:25 AM
Ward / Bed No	:	Reported On	: 09/11/2024 01:05:18 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240010508
Station	: At Hospital	Mobile No	: 7348843967
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	95	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	118	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	108	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.24	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.29	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.78	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	169	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	134	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	34.7	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	107.50	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	26.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.87		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.10		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	134.30	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.3	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.85	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.74	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.38	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.36	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.89	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.11	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.57		2:1

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	72	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	109	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	61	U/L	50-116
GGT (Method:IFCC)	117	U/L	< 55

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

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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)	13.40	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.8	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4250	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	51.91	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	37.56	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.23	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.94	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.36	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	6.28	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram) Remarks: In view of low RBC indices and increased RBC counts, kindly evaluate for iron deficiency/hemoglobinopathy. Kindly correlate with clinical findings	69.8	fL	78-100
MCH (Method: Calculated)	21.3	pg	27-31
MCHC (Method: Calculated)	30.6	g/dL	31-37
RDW - CV (Method: Calculated)	18.0	%	11.5-14.5

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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET COUNT (Method:Electrical Impedance)	2.19	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.27	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	32.7	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	2210	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	140	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1600	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	290	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	05	mm/hour	1-15

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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CLINICAL PATHOLOGY

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	25	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)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	0-2	/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. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

NABH No.1

(6)

UNITED HOSPITAL
Care For Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.CHETHAN KUMAR V	UHID	: UHJA24007781
Age / Sex	: 38 Years / Male	OP ND/Reg Dt	: 09-11-2024 08:20 AM
Spouse / Father Name	: VENKATRAJU	Department	:
Address	: Bengaluru Urban, Karnataka, INDIA.	Refered By	:
		Consultant	: Dr Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC FEM
		KMC No	: 02M4087

Complaints / Findings / Observations :

HT - 165cm
WT - 78.2kg
SPO2 - 99%
PR - 83 b/m
BP - 110/76

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

Patient name :	**Mr. CHETHAN KUMAR V**	**Date :**	**09/11/24**
Age :	**38 years GENDER: MALE**	**Patient ID :**	**24007781**
Ref by :	**CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 4.8 (3.5-5.5)	MV EV : 1.0	AV : 0.8	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 3.2 (2.4-4.2)	AV : 1.1		AR : NORMAL
RA : 1.9 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 0.7		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ------	AV : ------	TR : TRIVIAL TR, PASP-28pmmHg
TAPSE: 1.8 (>1.6)	LVPWD 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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 For Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Chethan Kumar V	**Date**	09/11/24
Age	38 years	**Hospital ID**	UHJA24007781
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.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Chethan Kumar V	**Date**	09/11/24
Age	38 years	**Hospital ID**	UHJA24007781
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (17.9 cms) and shows mild 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 ***shows a small polyp measuring 2.6 mm in the body region.*** There is no 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 mildly enlarged in size (15 cms)***, normal in shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (9.9 x 3.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (10.0 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.

Prostate is normal in echopattern and size, measures ~ 11.2 cc.

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

IMPRESSION:

- **Small gall bladder polyp.**
- **Mild splenomegaly.**
- **Mild hepatomegaly with mild fatty infiltration (Grade I).**

Dr. Elluru Santosh Kumar
Consultant Radiologist

ID: 24007781
Name: MR CHETHAN KUMAR

9-Nov-2024 AM8:43:01

ex: M Birth date: / mm/dd 38 years

cm kg

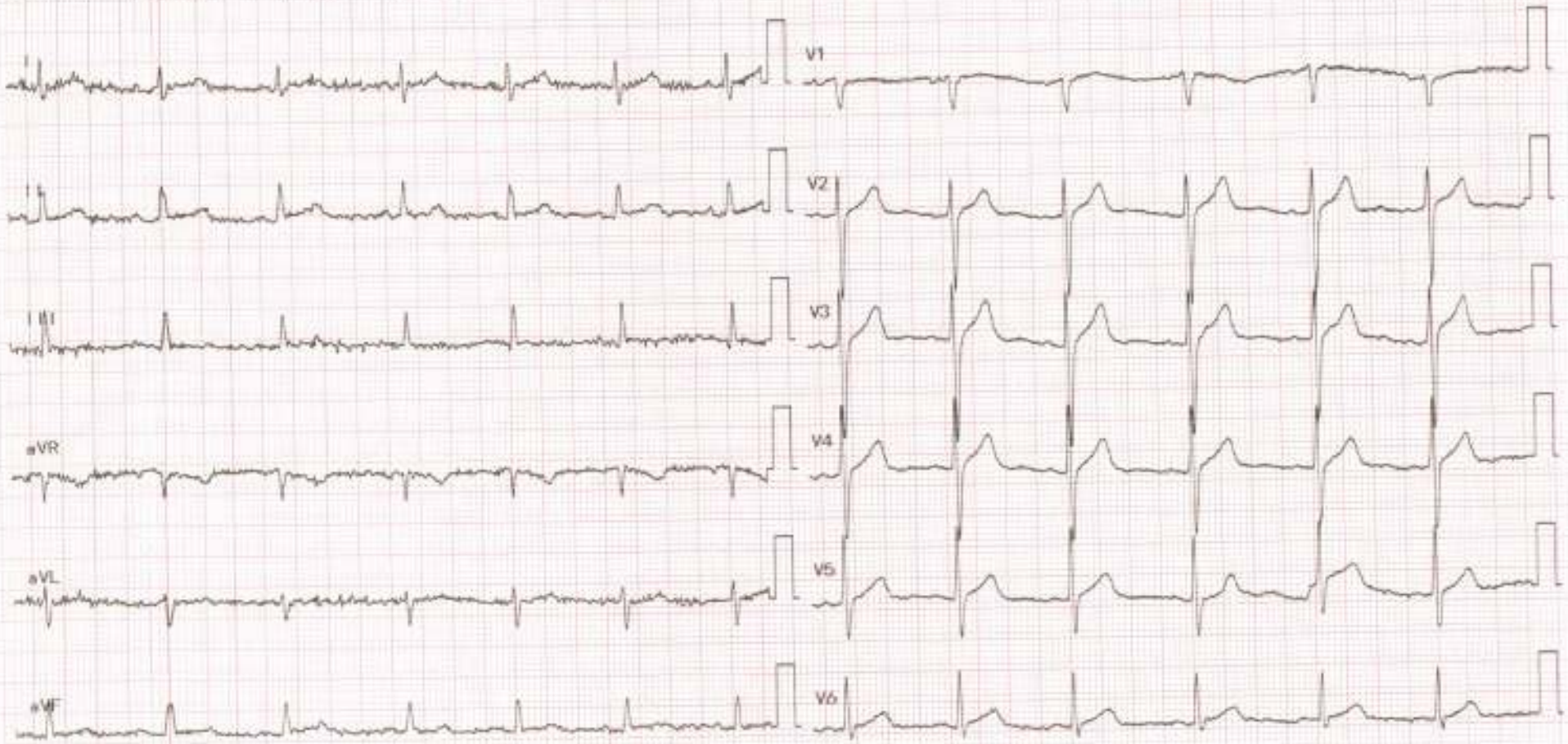
edication:
ymptoms:
istory:

ent. rate	80	bpm
R int	136	ms
RS dur	92	ms
T/QTc(E) int	356/ 392	ms
/QRS/T axis	57/ 63/ 22	°
V5/SV1 amp	1.22/ 0.49	mV
V5+SV1 amp	1.72	mV

1100 Sinus rhythm
40303 Early repolarization [ST elevation (I, II, V3, V4, V5, V6)]
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