



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Mr. Aniket Sagar

erythri

Using NEPAFFENAC $1-1-1$ $1\frac{1}{2}$ ults
for RE.

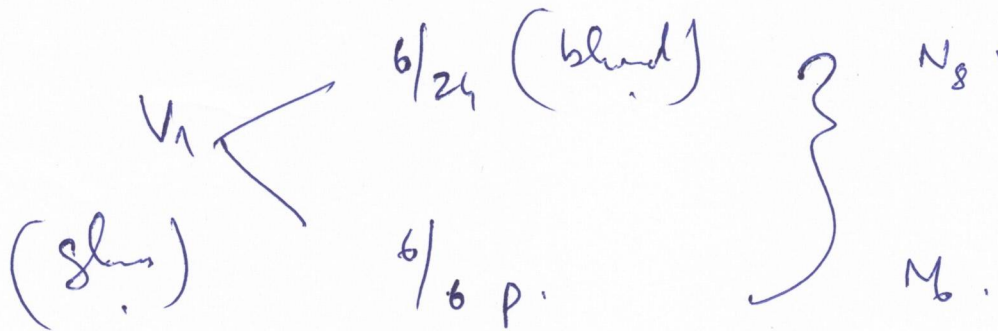
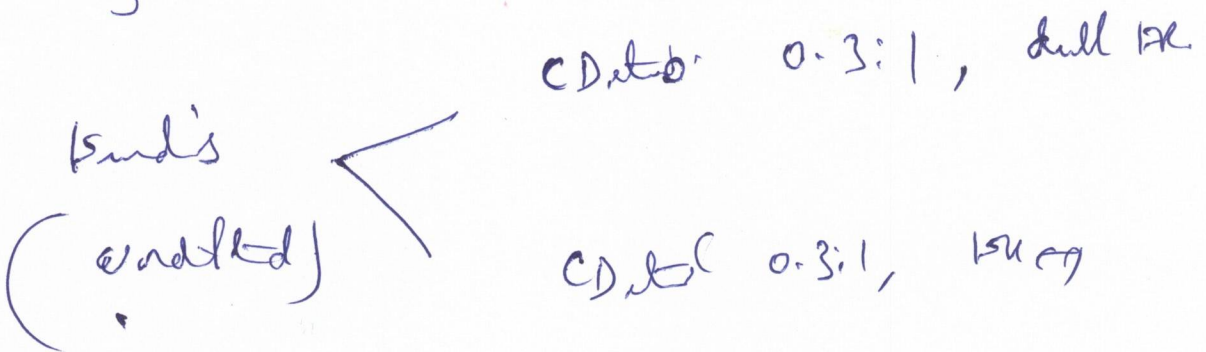


Fig on Nand



Th: RE Dull RE(+)

Adv. Diluted fund's examination of
25/5/24



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Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.ANKIT SAGAR	UHID	: UHJA24001814
Age / Sex	: 41 Years / Male	OP NO/Reg Dt	: 25-05-2024 08:42 AM
Spouse / Father Name	: ARTIKA	Department	:
Address	: SR NAGAR MISSION ROAD BLR, , Bengaluru Urban, Karnataka, INDIA,	Referred By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

HT- 177cm
 wt - 94.2kg
 BP- 118/90
 PR- 86b/m
 SpO2-98%

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

T. Rocavel 10mg

Follow Up Advice :

o-o-1.

Signature of the Doctor

ID: 24001814
Name: MR ANKIT

41 years

1100 Sinus rhythm
9110 ** normal ECG **

ex: M
cm
kg
Birth date: / mmHg

Indication:

Symptoms:

History:

Int. rate

R int

RS dur

FT/QTc(E) int

VQRS/T axis

M5/SV1 amp

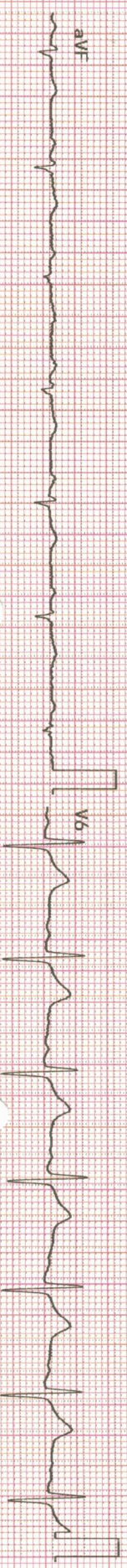
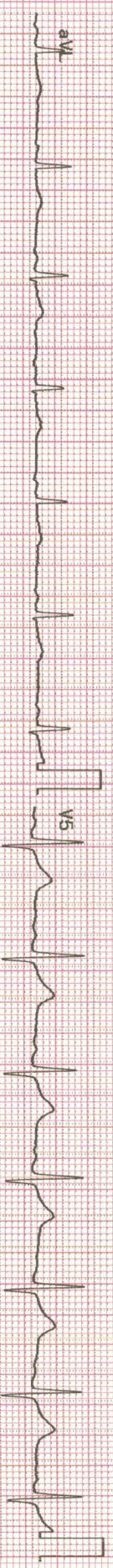
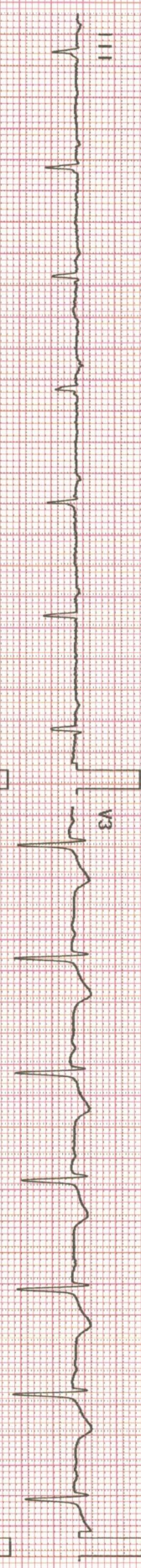
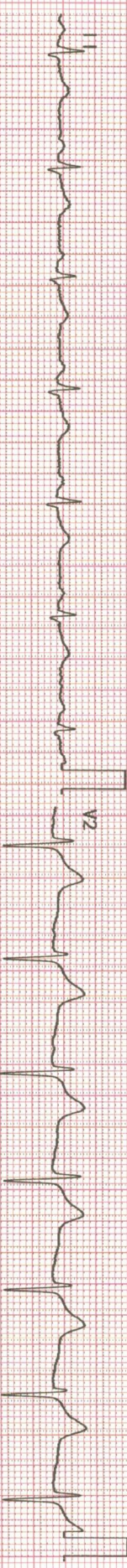
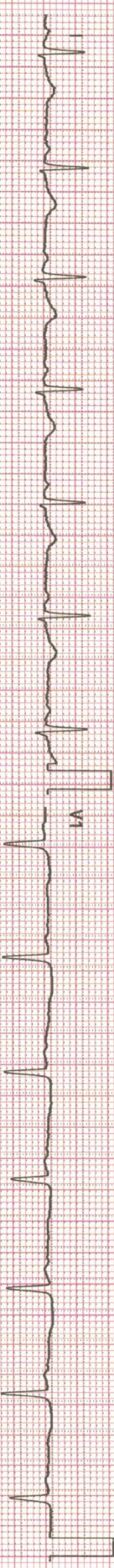
M5+SV1 amp

83	bpm
148	ms
84	ms
364/404	ms
47/-6/27	°
0.85/0.71	mV
1.56	mV

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



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**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore**DEPARTMENT OF RADIODIAGNOSIS**

Name	Ankit Sagar	Date	25/05/24
Age	41 years	Hospital ID	UHJA24001814
Sex	Male	Ref.	Healthcheck

ULTRASOUND ABDOMEN AND PELVIS**FINDINGS:**

Liver is enlarged in size (15 cms) and shows moderate to severe 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 (8.4 x 3.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (11.6 x 4.6 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 ~ 15 cc.

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

IMPRESSION:

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

Dr. Elluru Santosh Kumar
Consultant Radiologist



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DEPARTMENT OF RADIODIAGNOSIS

Name	Ankit Sagar	Date	25/05/24
Age	41 years	Hospital ID	UHJA24001814
Sex	Male	Ref.	Healthcheck

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



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Patient name :	Mr. ANKIT SAGAR	Date :	25/05/24
Age :	41 years GENDER: MALE	Patient ID :	24001814
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY**M – MODE AND DOPPLER MEASUREMENTS**

(c.m)	(c.m)	(cm/sec)		
AO : 3.0 (2.5-3.7)	LVIDD : 4.7 (3.5-5.5)	MV EV : 9.2	AV : 12.9	MR : NORMAL
LA : 3.5 (1.9-4.0)	LVIDS : 3.0 (2.4-4.2)	AV : 76.0		AR : NORMAL
RA : 2.4 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 90.7		PR : NORMAL
RV : 2.7 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : GRADE I 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 AND COLLAPSING

IMPRESSION:

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

DR. RAHUL S PATIL
 CONSULTANT CARDIOLOGIST

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. ANKIT SAGAR	Order No : 1000086029
UHID : UHJ A24001814	Registered On : 25/05/2024 08:42:40 AM
Age/Sex : 41/Years Male	Collected On : 25/05/2024 08:55:16 AM
Ward / Bed No :	Reported On : 25/05/2024 01:05:59 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A240002491
Station : At Hospital	Mobile No : 9619717075
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	93	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	109	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	6.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	128	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.03	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	8.37	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	0.83	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	153	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	84	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	52.0	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	84.2	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	2.94		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.6		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	101.00	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.3	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.99	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	9.0		12~20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.58	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.41	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.7	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.15	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.54	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.62		2:1
SERUM SGOT (Method:IFCC without P5P)	21	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	39	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	39	U/L	50-116
GGT (Method:IFCC)	23	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.72	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)	18.6	mg/dL	17-43
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Dr. Shobha Emmanuel
 MBBS, M.D(Pathology)
 CONSULTANT PATHOLOGIST
 KMC:66136

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Test Name	Result	Unit	Bio. Ref. Interval
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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.53	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	44.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6940	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	68.40	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	23.68	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.46	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.24	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.22	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.33	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	83.9	fL	78-100
MCH (Method: Calculated)	27.3	pg	27-31
MCHC (Method: Calculated)	32.5	g/dL	31-37
RDW - CV (Method: Calculated)	15.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.22	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)	8.31	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	17	mm/hour	1-15
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Gel Method)	A		
Rh Factor (Method:Agglutination Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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Test Name	Result	Unit	Bio. Ref. Interval
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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.5		5.0-8.0
SPECIFIC GRAVITY	1.005		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	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
Rashmita

---End of Report---



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*NABL renewal under process.