UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SHAMBHAVI H N	Order No	: 1000086120
UHID	: UHJA24001820	Registered On	: 25/05/2024 11:57:51 AM
Age/Sex	: 35/Years Female	Collected On	: 25/05/2024 01:10:04 PM
Ward / Bed No	:	Reported On	: 25/05/2024 04:44:11 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240002518
Station	: At Hospital	Mobile No	: 9964536065
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	88	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.32	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.29	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.98	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)	203	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	82	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	40.7	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	145.9	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.39	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.98		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.58		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	162.30	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.8	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.52	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.53	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.45	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.22	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.78	g/dL	2.3-3.5

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AG RATIO (Method: Calculated)	1.51		2:1
SERUM SGOT (Method:IFCC without P5P)	25	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	20	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	81	U/L	46-122
GGT (Method:IFCC)	23	U/L	< 38
VITAMIN D (25-OH) (Method:CLIA)	8.7	ng/mL	<20 ng/mL - Deficient 20-29 ng/mL - Insufficient 30-100 ng/mL - Sufficient >100 ng/mL - Toxic

Interpretation Notes

Vitamin D is a lipid-soluble steroid hormone that is produced in the skin through the action of sunlight or is obtained from dietary sources. Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. Less severe vitamin D inadequacy may lead to secondary hyperparathyroidism and subsequently increasing the risk of osteoporosis. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

VITAMIN B12 (Method:CLIA)	132	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.

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Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	13.17	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	40.2	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4820	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	52.51	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	38.04	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.91	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.20	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.34	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.00	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	80.4	fL	78-100
MCH (Method: Calculated)	26.3	pg	27-31
MCHC (Method: Calculated)	32.8	g/dL	31-37
RDW - CV (Method: Calculated)	16.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.85	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.66	fl	9-13

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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	22.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	20	mm/hour	1-20

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

ABO Group (Method:Agglutination Method)	A	
Rh Factor (Method:Agglutination Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
Pavithra M

---End of Report---

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

*NABL renewal under process.

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SHAMBHAVI H N**	**UHID**	**: UHJA24001820**
Age / Sex	: 35 Years / Female	OP NO/Reg Dt	: OP240000002497 / 25-05-2024 11:57 AM
Father Name	:	Department	:
Spouse Name	: SUBRAMANYA C A	Refered By	:
Address	: VAJJARAHALLI BANGALORE, , Bengaluru Urban, Karnataka, INDIA,	Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

HTN — Tab. Arkitel 20

1-0-0

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH NABL No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Mrs Shambhavi

35 yrs/F

HTN – 2yr.

VA (glass) — 6/9, 6/9 } N6.

A/S: OU Normal. (except dryness).

Fundus: OU C/D ratio 0.3:1 FR(+)

RE: – 3.25 DS / – 0.50 DC X 60 6/6P

LE: – 3.25 DS / – 0.75 DC X 150 6/6P

1) 20-20-20 rule

2) REFRESH TEARS E/D 1-1-1 x1 mth.

25/8/24.
Dr Shweta

NABH | NABL | No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SHAMBHAVI H N**	**UHID**	**: UHJA24001820**
Age / Sex	: 35 Years / Female	OP NO/Reg Dt	: OP240000002497 / 25-05-2024 11:57 AM
Father Name	:	Department	:
Spouse Name	: SUBRAMANYA C A	Refered By	:
Address	: VAJJARAHALLI BANGALORE, , Bengaluru Urban, Karnataka, INDIA,	Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and Gynecologist, Laparoscopy and IVF Specialist
KMC Reg. No. 90384

BP - 120/82

For health checkup

[illegible]

Investigations:

W.K.C. HTN,

Treatment / Care of Plan / Provisional Diagnosis :

No h/o DM, Thyroid

No h/o [illegible]

Follow Up Advice :

P/A - [illegible]

P/S - [illegible]

[illegible]

Strict [illegible]

ML - [illegible]
P/4
All LSCS.
Not tubectomised.
Not on any [illegible]
LMP - [illegible]

[illegible]

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Shambhavi H N	**Date**	25/05/24
Age	35 years	**Hospital ID**	UHJA24001820
Sex	Female	**Ref.**	Healthcheck

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Homogeneous fatty background echotexture is seen in both breasts.

There is a well defined cyst measuring 1.2 x 1.0 x 0.9 cms with internal echoes in the subdermal subcutaneous fat of the left inframammary fold.

No focal solid / cystic lesions seen in the breast parenchyma.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **Well defined cyst with internal echoes in the subdermal subcutaneous fat of the left inframammary fold - likely sebaceous cyst.**
- **No other significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Shambhavi H N	**Date**	25/05/24
Age	35 years	**Hospital ID**	UHJA24001820
Sex	Female	**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

Patient name :	Mrs. SHAMBHAVI	Date :	25/05/24
Age :	35 years GENDER: FEMALE	Patient ID :	24001820
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.5 (2.5-3.7)	LVIDD : 4.2 (3.5-5.5)	MV EV : 78.6	AV : 50.9	MR : NORMAL
LA : 3.6 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 115		AR : NORMAL
RA : 2.4 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 73.1		PR : NORMAL
RV : 2.3 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR, PASP-25mmHg
TAPSE: 1.8 (>1.6)	LVPWD : 1.2 (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
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 PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

mrs. Shambhavi. H.N 35/F

BP- 120/82 mm/Hg
PR- 76b/m
SpO2- 99%
Ht - 164 cm
Wt - 86.4 kg.

DEPARTMENT OF RADIODIAGNOSIS

Name	Shambhavi H N	**Date**	25/05/24
Age	35 years	**Hospital ID**	UHJA24001820
Sex	Female	**Ref.**	Healthcheck

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (15.2 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 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 (10.8 x 2.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (11.0 x 4.1 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 distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and normal in size, measures 8.7 x 3.5 x 4.9 cms. Myometrial and endometrial echoes are normal. Endometrium measures 5.8 mm.
Both ovaries ***show polycystic morphology.***
Right ovary measures ***14.0 cc.*** **Left ovary** measures ***13.8 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:

- **Bilateral polycystic ovaries.**
- **Mild hepatomegaly with mild fatty infiltration (Grade I).**

Dr. Elluru Santosh Kumar
Consultant Radiologist

ID:24001820

Name:MRS SHAMBHAVI

25-May-2024 AM9:54:15

ex:F Birth date: 35 years

cm kg / mmHg

edication:

ymptoms:

istory:

ent. rate	60	bpm
R int	132	ms
RS dur	86	ms
T/QTc(E) int	414/ 414	ms
/QRS/T axis	20/ 33/ 12	°
V5/SV1 amp	1.01/ 0.78	mV
V5+SV1 amp	1.79	mV

1100 Sinus rhythm

1102 Sinus arrhythmia [RR int. change over 20%]

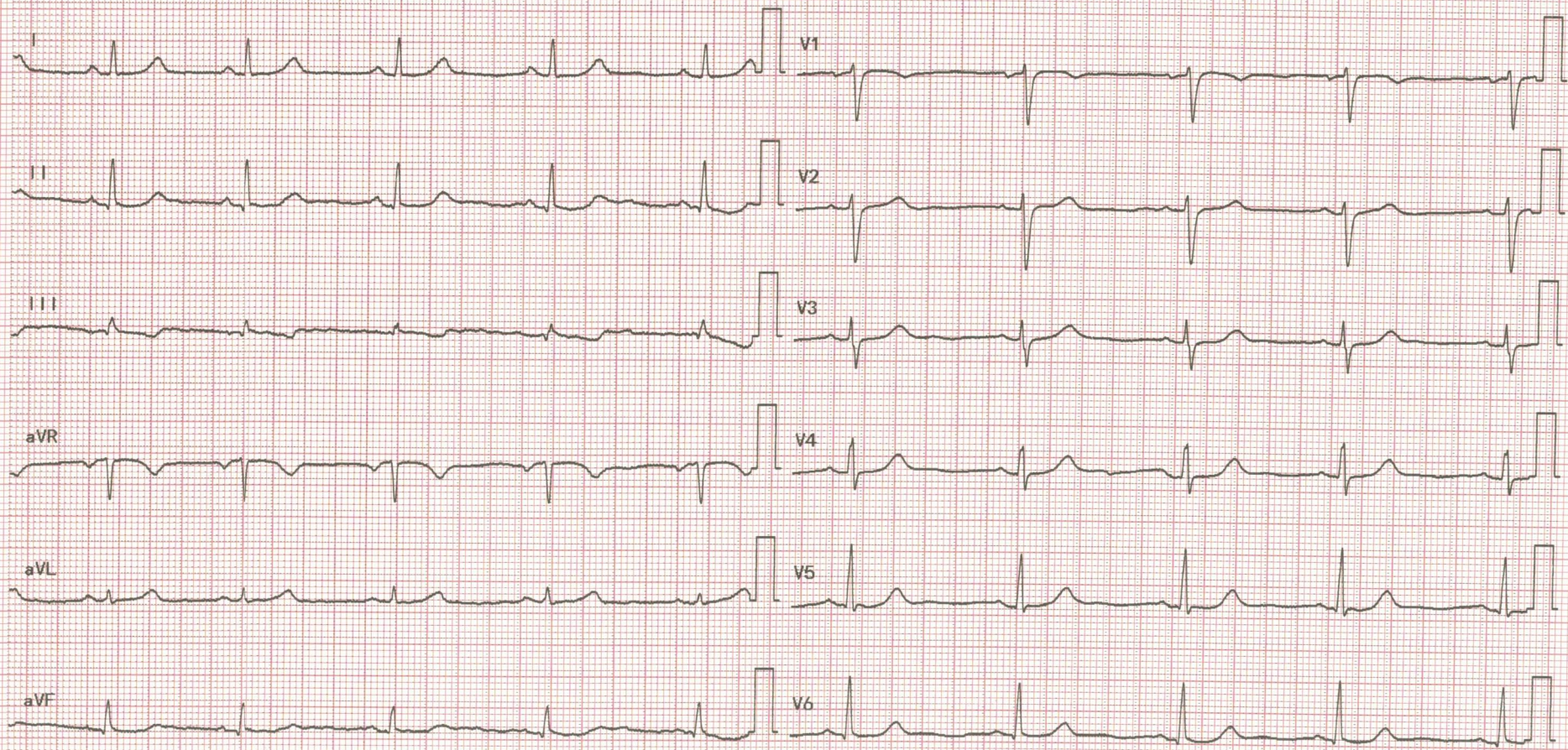
9110 ** normal ECG **

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