

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. G SHIVAMMA	Order No	: 1000088424
UHID	: UHJ A24002691	Registered On	: 22/06/2024 09:27:14 AM
Age/Sex	: 46/Years Female	Collected On	: 22/06/2024 09:38:08 AM
Ward / Bed No	:	Reported On	: 22/06/2024 02:06:57 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A240003740
Station	: At Hospital	Mobile No	: 9741026682
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	111	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	104	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	6.2	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	131	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.17	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.00	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	7.76	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	267	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	208	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.4	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	178.0	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	41.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.63		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.7		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	219.59	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.3	mg/dL	2.6-6.0
LIVER FUNCTION TEST Sample: Serum			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.54	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.46	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.7	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.24	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.45	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.22		2:1
SERUM SGOT (Method:IFCC without P5P)	14	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	19	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	66	U/L	46-122
GGT (Method:IFCC)	18	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	19.5	mg/dL	17-43
BUN/CREATININE RATIO			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.66	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	13.6		12~20 : 1

Sample: Serum



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)	12.75	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	38.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7390	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	58.79	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	28.46	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.94	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.38	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.43	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.38	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	87.6	fL	78-100
MCH (Method: Calculated)	29.1	pg	27-31
MCHC (Method: Calculated)	33.2	g/dL	31-37
RDW - CV (Method: Calculated)	13.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.80	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)	7.11	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.1	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	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	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
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)	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		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
SHAHANAWAZ

---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.G SHIVAMMA

UHID : UHJA24002691

Age / Sex : 46 Years / Female

OP NO/Reg Dt : 22-06-2024 09:27 AM

Spouse / Father Name : ARASAPPA

Department :

Address : HEGGNAHALLI, , Bengaluru Urban,
Karnataka, INDIA,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

no. co. morbs.

HT - 153 cm
wt - 73.1 kg
SPO - 99 %
PR - 93 b/m
BP - 136/94 mmHg

Investigations:

TSH - 4.79
LDL - 178
HbA1c - 6.2 %

Treatment / Care of Plan / Provisional Diagnosis :

Jan
veg thyroid.

Follow Up Advice :

Signature of the Doctor



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Mrs. Shivamma. G 46/F

Dr. Yogalakshmi

22/06/24

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

Re health check

BO-136/95

see up. MRI scan, Jy
an file can

Q2
MRI USG.
related
open
surgery at 37y
concord

Q/A - after
yes - final report

Also G variè
could consider
Dr. G

Dr.
plan for surgery



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Date: 22/06/24

ENT

Mrs. G.A Shivamma
Age. 46y

Came for routine ENT check up.

BL Ears,
Nose,
Oral Cavity,
oropharynx
Neck

Within Normal
limits.

DR. VIGNESH J
MBBS, DLO, DNB, FHNS
ENT, HEAD AND NECK CANCER SURGEON
REG. NO: 92095



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mrs.G SHIVAMMA

UHID : UHJA24002691

Age / Sex : 46 Years / Female

OP NO/Reg Dt : 22-06-2024 09:27 AM

Spouse / Father Name : ARASAPPA

Department : *Ophthalmology*

Address : HEGGNAHALLI, Bengaluru Urban, Karnataka, INDIA,

Referred By :
Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

Investigations:

Vh } *N₁₀* *ret system*
glms }
6/12P
6/18
High over read

Treatment / Care of Plan / Provisional Diagnosis :

Fund's *OU CDt @ 3:1*
(added) *ARFA*

Follow Up Advice :

Ip: OU. RB Emed.
RE: +1.50 DS / +0.50 DC X180. 6/6.
LE: +1.50 DS / +1.00 DC X180 6/6
RE Add. +1.25 DS for near 6.

Signature of the Doctor
[Signature]



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No.1

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

Name	Shivamma G	Date	22/06/24
Age	46 years	Hospital ID	UHJA24002691
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS**FINDINGS:**

Liver is enlarged in size (15.8 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 (9.2 x 3.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (10.1 x 4.4 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 acutely retroflexed and atrophic, measures 8.0 x 2.4 x 4.1 cms. Endometrium could not be distinctly visualized due to acutely retroflexed uterus, grossly measures 5 mm.

Both ovaries could not be visualized - likely atrophic.

Both adnexa: Normal. No mass is seen.

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

IMPRESSION: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Mild hepatomegaly with mild fatty infiltration (Grade I).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist



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No.1



**UNITED
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Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Shivamma G	Date	22/06/24
Age	46 years	Hospital ID	UHJA24002691
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

ID: 24002691

Name: MRS SHIVAMMA

Birth date: / /

46 years

1100 Sinus rhythm
9110 ** normal ECG **

Bx.F cm kg rmmHg

Indication:

Symptoms:

History:

R int 76 bpm

RS dur 136 ms

T/QTc(E) int 80 ms

V/QRS/T axis 364/394 ms

V5/SV1 amp 53/ -6/ 14 °

V5+SV1 amp 0.97/ 0.66 mV

1.64 mV

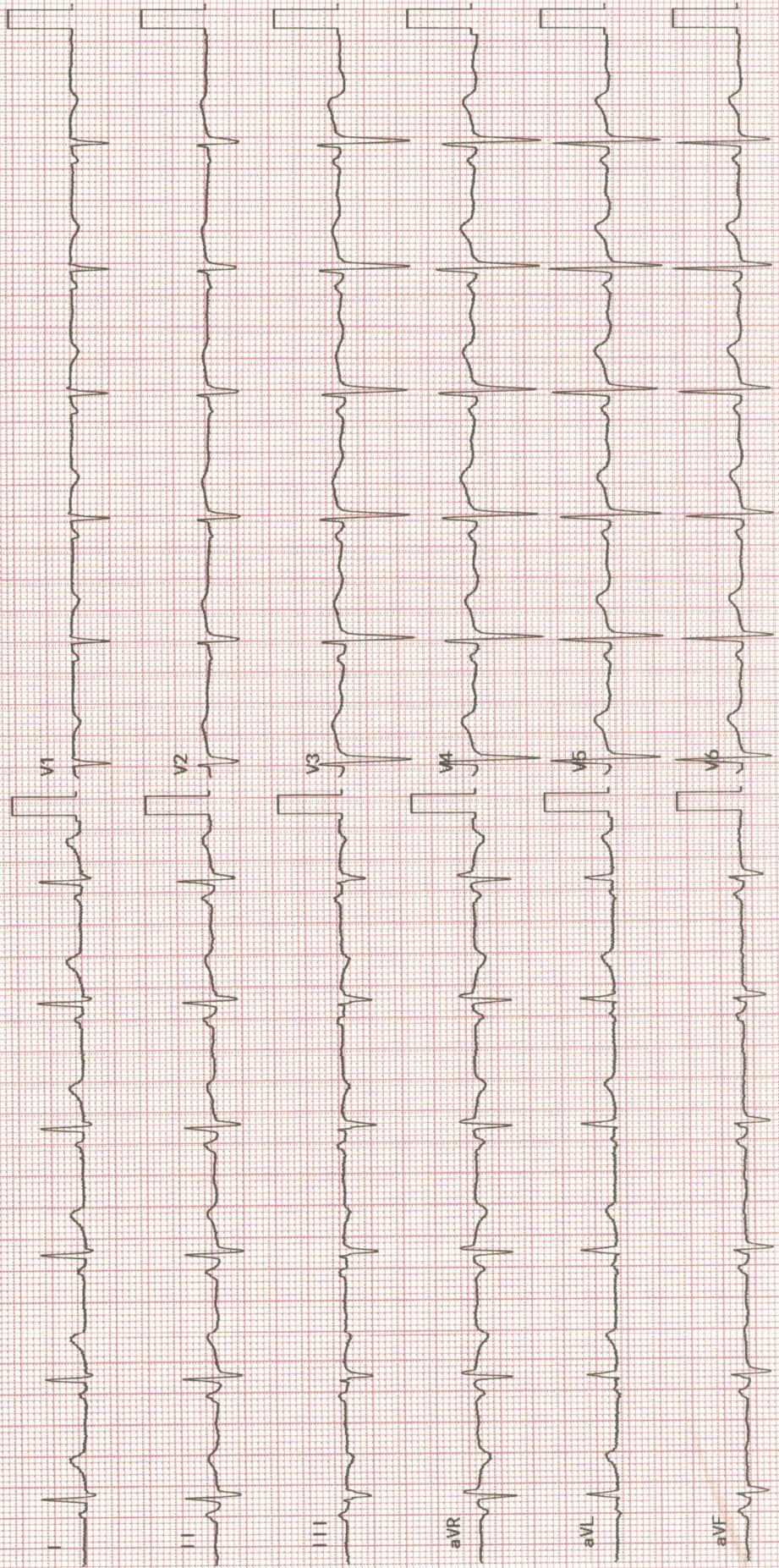
Unconfirmed Report

Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s



EXERCISE STRESS TEST REPORT

Patient Name: MRS. G SHIVAMMA,
Patient ID: 24022691
Height: 153 cm
Weight: 73.1 kg

DOB: 20.01.1978
Age: 46yrs
Gender: Female
Race: Indian

Study Date: 22.06.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: DR. RAHUL PATIL
Attending Physician: DR. RAHUL PATIL
Technician: YAMINI/THABITHA

Medications:

--

Medical History:

NO H/O DM & HTN

Reason for Exercise Test:

Screening for CAD

Exercise Test Summary

Case Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:04	0.00	0.00	85	130/80	
	STANDING	00:03	0.00	0.00	86	130/80	
	HYPERV.	00:02	0.00	0.00	86	130/80	
	WARM-UP	00:07	0.00	0.00	87	130/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	129	130/80	
	STAGE 2	02:54	2.50	12.00	146	140/90	
RECOVERY		06:05	0.00	0.00	96	140/90	

The patient exercised according to the BRUCE for 5:54 min:s, achieving a work level of Max. METS: 7.00. The resting heart rate of 84 bpm rose to a maximal heart rate of 148 bpm. This value represents 85 % of the maximal, age-predicted heart rate. The resting blood pressure of 130/80 mmHg, rose to a maximum blood pressure of 140/90 mmHg. The exercise test was stopped due to Patient unable to walk on treadmill.

Interpretation

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: appropriate.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: none.

Overall impression: Normal stress test.

Conclusions

MODERATE EFFORT TOLERANCE

NORMAL HR AND BP RESPONSE

NO ANGINA OR ARRHYTHMIAS NOTED

NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician _____

Technician _____

Meds:

Test Reason: Screening for CAD
Medical History: NO H/O DM & HTN

Ref: MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL
Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test
Comment:

BRUCE: Total Exercise Time 05:54
Max HR: 148 bpm 85% of max predicted 174 bpm HR at rest: 84
Max BP: 140/90 mmHg BP at rest: 130/80 Max RPP: 20440 mmHg*bpm
Maximum Workload: 7.00 METS
Max. ST: -0.10 mm, 0.00 mV/s in I; RECOVERY 02:50
Arrhythmia: A:21, PVC:8, PSVC:3

Reasons for Termination: Patient unable to walk on treadmill
Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall Impression: Normal stress test.

BASELINE EXERCISE	MAX. ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY	BASELINE EXERCISE	MAX. ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
30/80 mmHg 77 bpm 0.05 mm 0.41 mV/s	90 bpm -0.10 0.48	146 bpm 140/90 mmHg 5:54 0.20 0.97	95 bpm 140/90 mmHg 5:50 -0.05 0.42	87 bpm 130/80 mmHg 0:01	90 bpm 2:50	146 bpm 140/90 mmHg 5:54 -0.10 -1.26	95 bpm 140/90 mmHg 5:50 0.15 -0.30
I 0.50 0.55 0.65	I 0.65 0.60 0.76	I 0.20 0.97	I -0.05 0.42	V1 0.10 -0.48	V1 0.10 -0.89	V1 -0.10 -1.26	V1 0.15 -0.30
II 0.50 0.55 0.65	II 0.60 0.60 0.76	II 0.70 2.63	II 0.35 0.35	V2 0.30 0.17	V2 0.20 0.12	V2 0.30 -0.16	V2 0.15 0.17
III 0.50 0.14	III 0.65 0.11	III 0.50 1.73	III 0.45 -0.18	V3 0.45 0.01	V3 0.60 -0.20	V3 0.40 0.79	V3 0.40 -0.14
aVR -0.30 -0.80	aVR -0.30 -1.34	aVR -0.40 -2.37	aVR -0.10 -0.72	V4 0.50 0.30	V4 0.65 0.30	V4 0.70 1.54	V4 0.40 0.28
aVL -0.15 -0.04	aVL -0.35 0.03	aVL -0.15 -0.36	aVL -0.30 -0.01	V5 0.45 0.39	V5 0.50 0.41	V5 0.65 1.84	V5 0.30 0.24
aVF 0.55 0.46	aVF 0.65 0.48	aVF 0.60 2.16	aVF 0.35 0.12	V6 0.35 0.32	V6 0.35 0.34	V6 0.75 2.40	V6 0.15 0.13

Unconfirmed

DR. G SHIVAMMA,

Patient ID 24022691

2.06.2024

Female 153 cm 73.1 kg

1:47:00am 46yrs Indian

Meds:

Test Reason: Screening for CAD

Medical History: NO H/O DM & HTN

Ref. MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL

Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test

Comment:

BRUCE: Total Exercise Time 05:54

Max HR: 148 bpm 85% of max predicted 174 bpm HR at rest: 84

Max BP: 140/90 mmHg BP at rest: 130/80 Max RPP: 20440 mmHg* bpm

Maximum Workload: 7.00 METS

Max ST: -0.10 mm, PVC:8, PSVC:3

Arrhythmia: A:21, PVC:8, PSVC:3

Reasons for Termination: Patient unable to walk on treadmill

Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to

Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate

response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall

Impression: Normal stress test.

Conclusion: MODERATE EFFORT TOLERANCE

NORMAL HR AND BP RESPONSE

NO ANGINA OR ARRHYTHMIAS NOTED

NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND

RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Location Number: * 0 *

GE CASE V6.73 (2)

Unconfirmed

Attending MD: DR. RAHUL PATIL

Page 2

MRS. G. SHIVAMMA
Patient ID: 240022691
22.06.2024
11:44:09am

89 bpm
130/90 mmHg

PRETEST
STANDING
00:37

BRUCE
0.0 mph
0.0 %

LINKED MEDIANS

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J

*I
0.20
0.36

*aVR
-0.50
-1.08

*V1
0.00
-0.67

*V4
0.45
0.23

*II
0.80
1.00

*aVL
-0.25
-0.32

*V2
0.25
-0.11

*V5
0.45
0.32

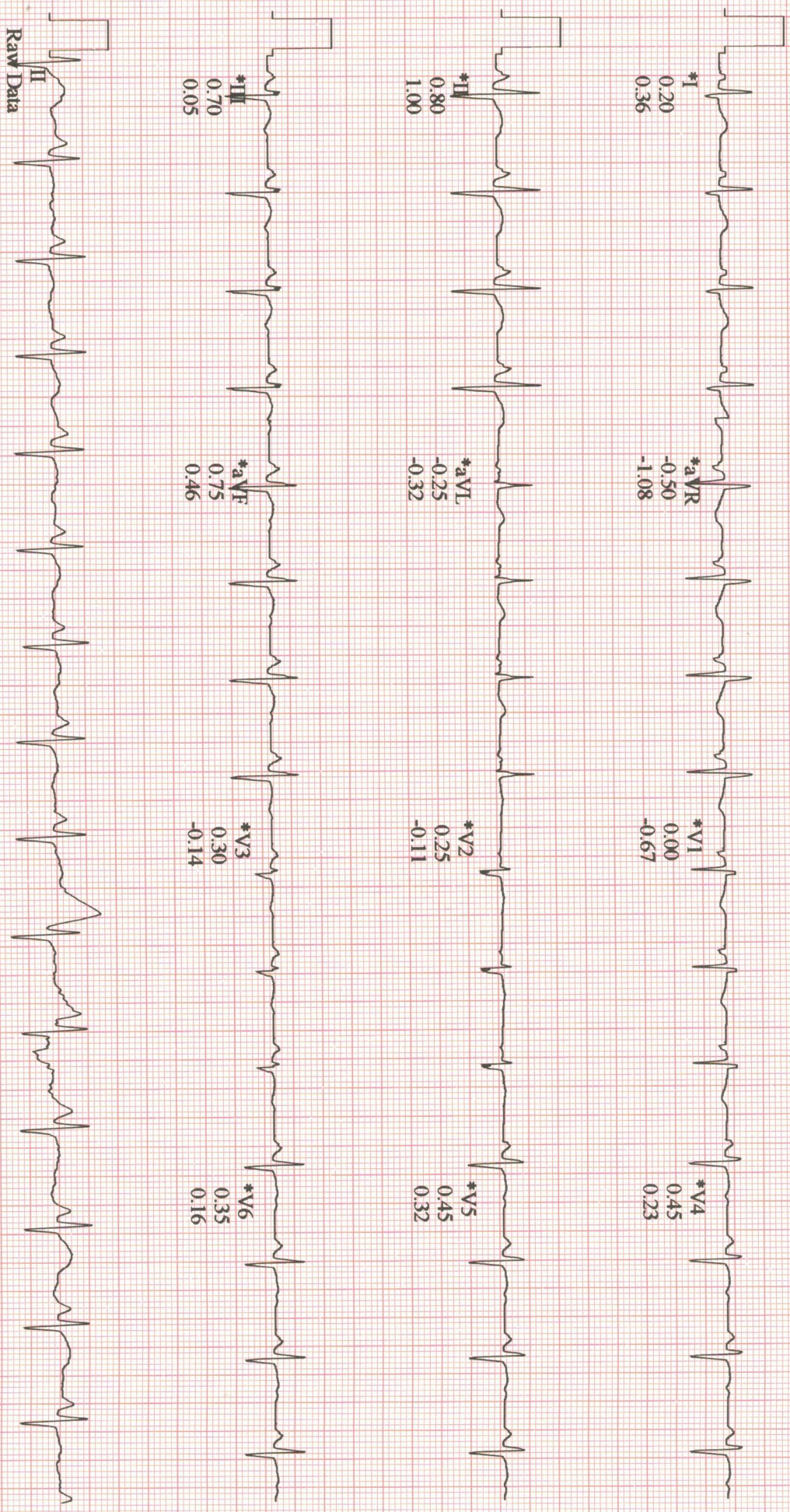
*III
0.70
0.05

*aVF
0.75
0.46

*V3
0.30
-0.14

*V6
0.35
0.16

Raw Data



*Computer Synthesized Rhythms

MRS. G. SHIVAMMA
Patient ID: 240022691
22.06.2024
11:44:31am

95 bpm
130/90 mmHg

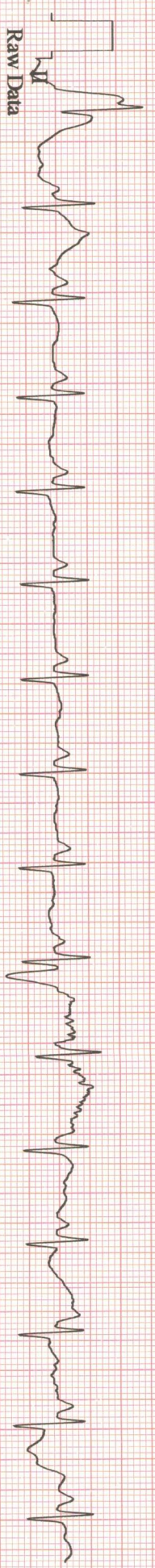
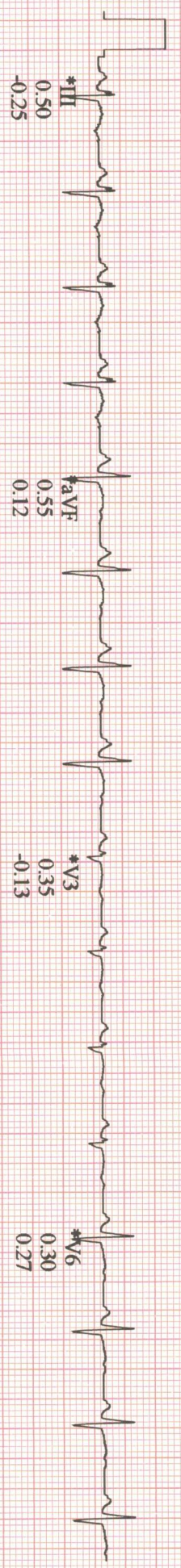
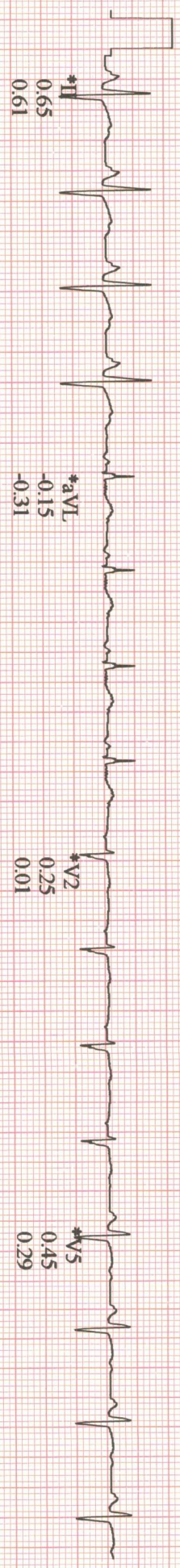
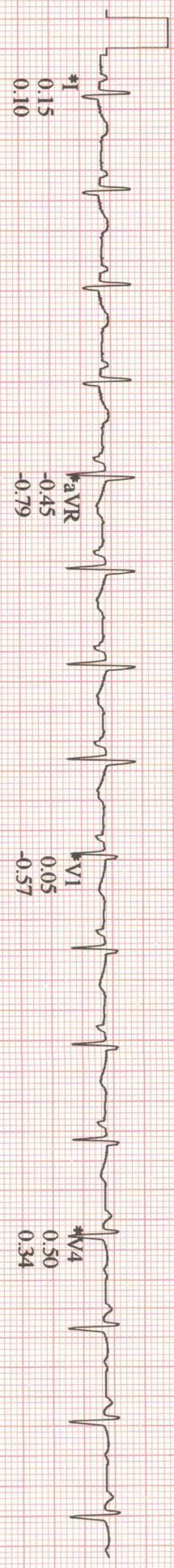
LINKED MEDIANS
PRETEST
WARM-UP
00:59

BRUCE
0.0 mph
0.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



*Computer Synthesized Rhythms

129 bpm
130/80 mmHg

EXERCISE
STAGE 1
02:39

BRUCE
1.7 mph
10.0%

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)

*I
0.40
0.94

*aVR
-0.65
-2.11

*V1
0.20
-1.20

*V4
0.60
0.51

*II
0.80
1.89

*aVL
-0.05
-0.24

*V2
0.30
-0.56

*V5
0.45
0.48

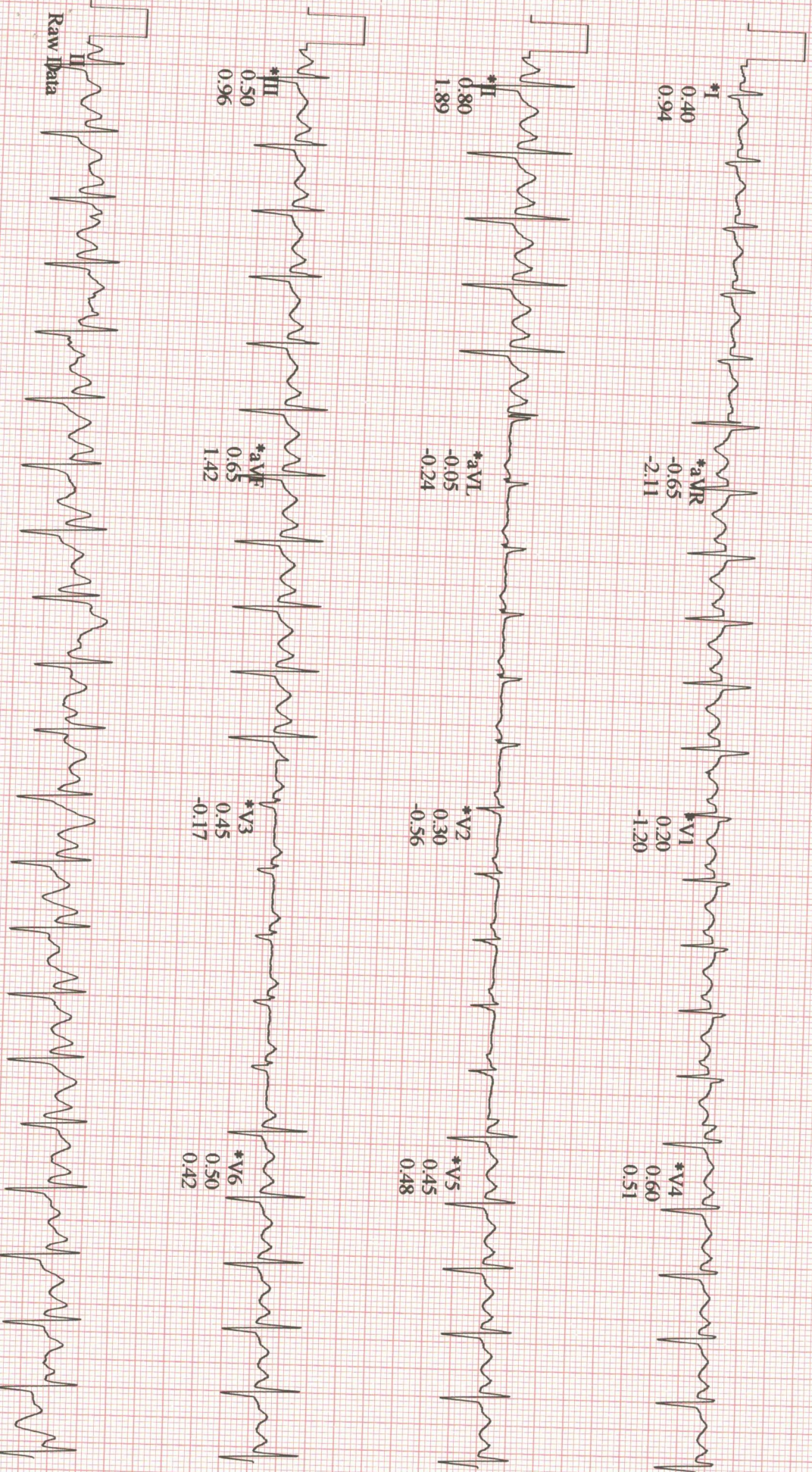
*III
0.50
0.96

*aVF
0.65
1.42

*V3
0.45
-0.17

*V6
0.50
0.42

Raw Data



*Computer Synthesized Rhythms

MRS. G SHIVANMA
PatientID: 24022691
22.06.2024
11:52:54am

LINKED MEDIANS

UNITED HOSPITAL

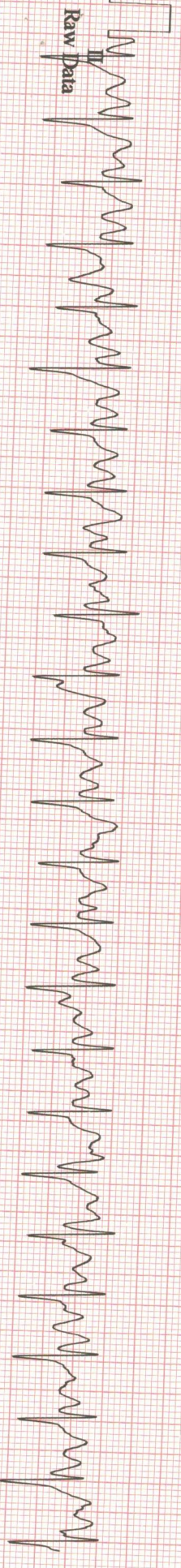
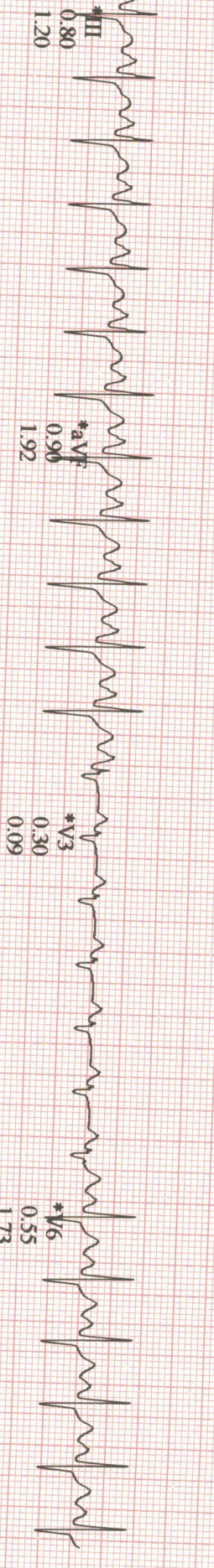
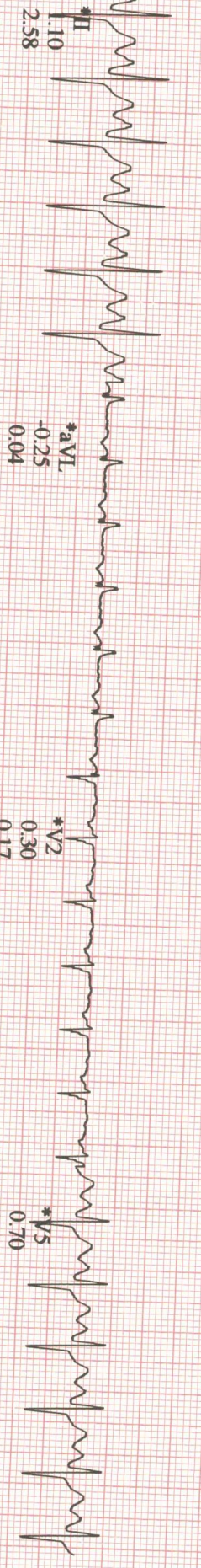
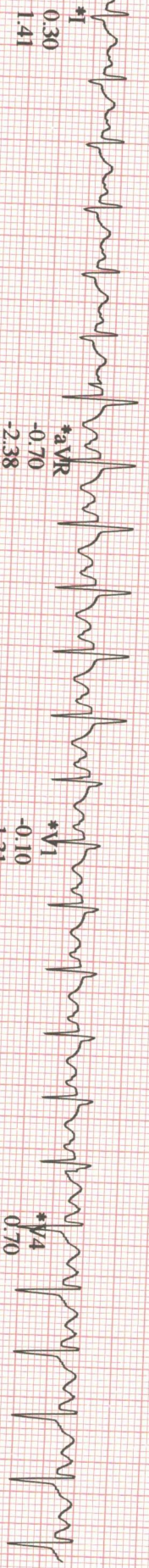
146 bpm
140/90 mmHg

EXERCISE
STAGE 2
05:40

BRUCE
2.5 mph
12.0%

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)



ASF V6 73

25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(H)W CE

*Computer Synthesized Rhythms

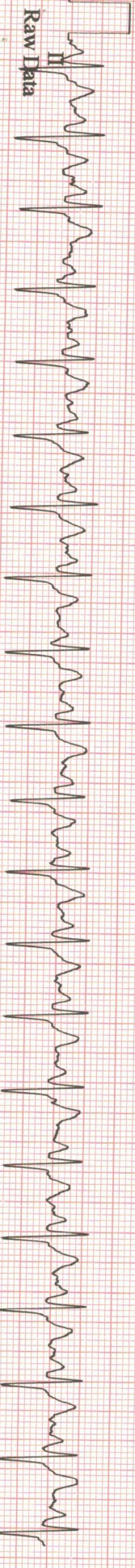
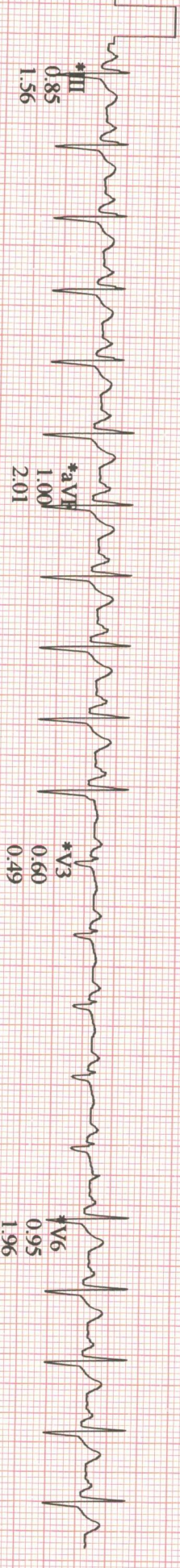
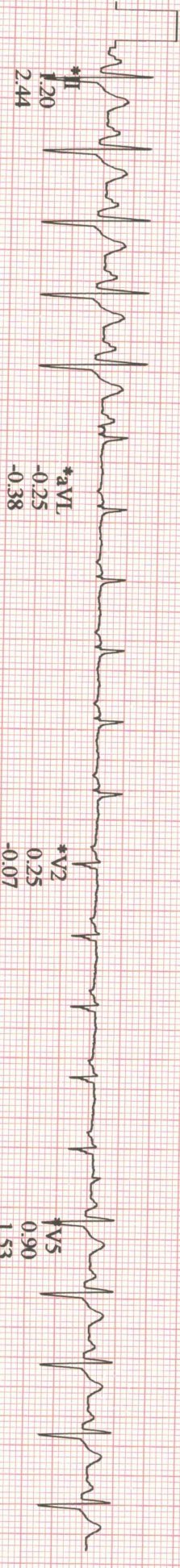
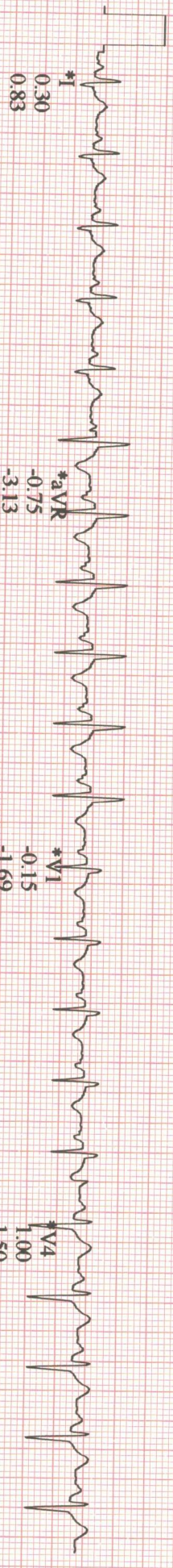
126 bpm
140/90 mmHg

RECOVERY
#1
00:30

BRUCE
0.0 mph
0.0 %

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



*Computer Synthesized Rhythms

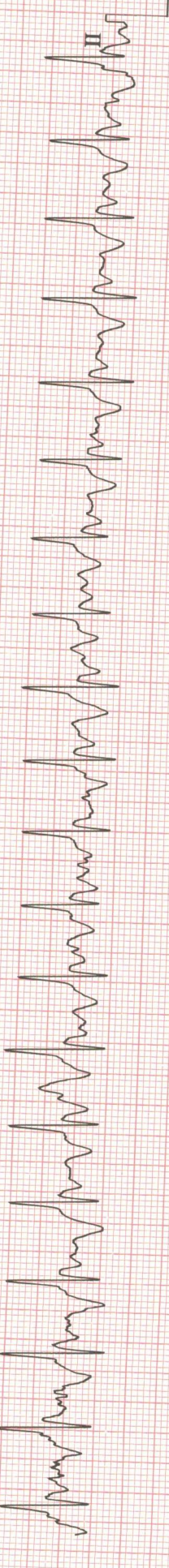
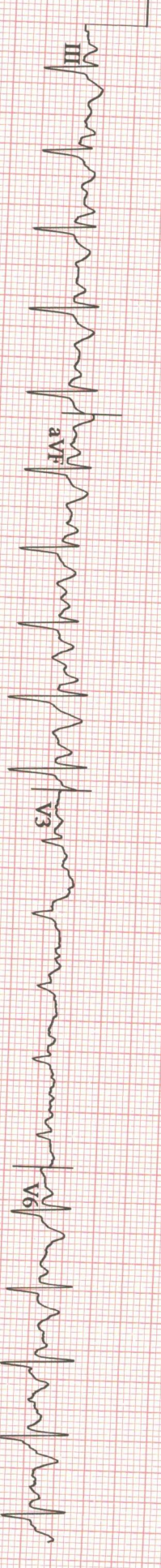
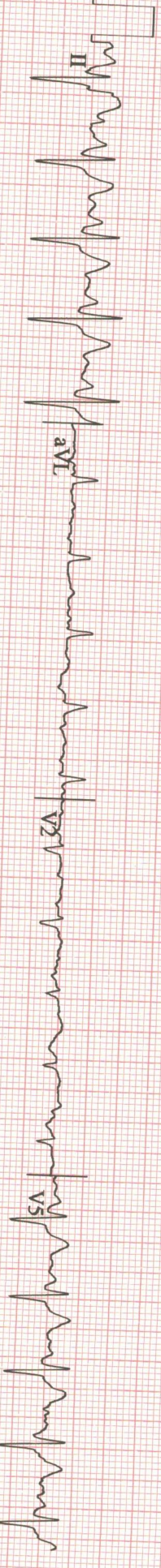
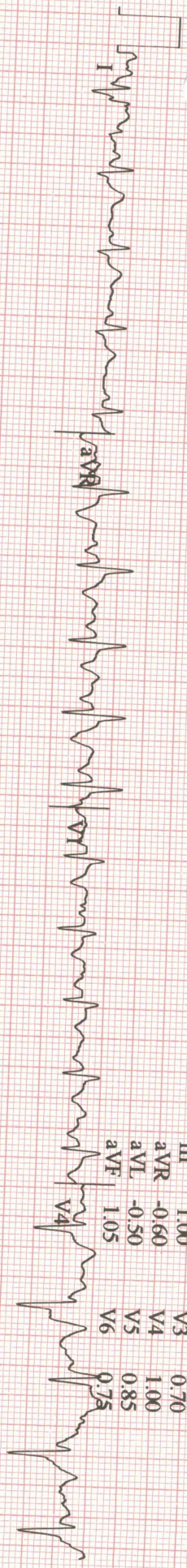
MRS. G. SHIVAMMA
Patient ID: 24022691
22.06.2024
11:53:57am

12-LEAD REPORT

116 bpm
RECOVERY #1
00:50
BRUCE
0.0 mph
0.0%

UNITED HOSPITAL
Measured at 60ms Post J (10mm/mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.10	V1	-0.20
II	1.10	V2	0.25
III	1.00	V3	0.70
aVR	-0.60	V4	1.00
aVL	-0.50	V5	0.85
aVF	1.05	V6	0.75

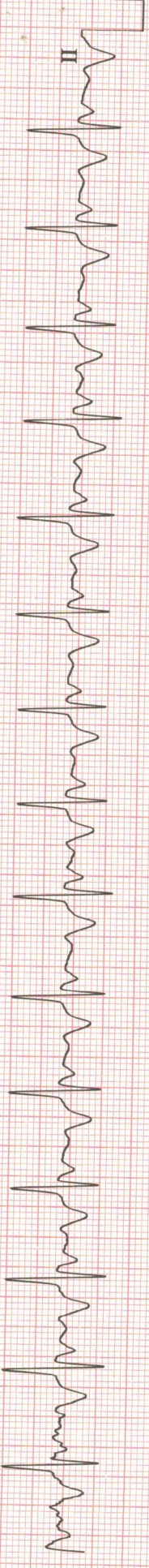
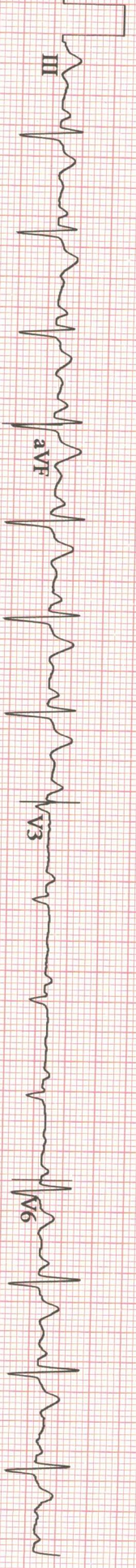
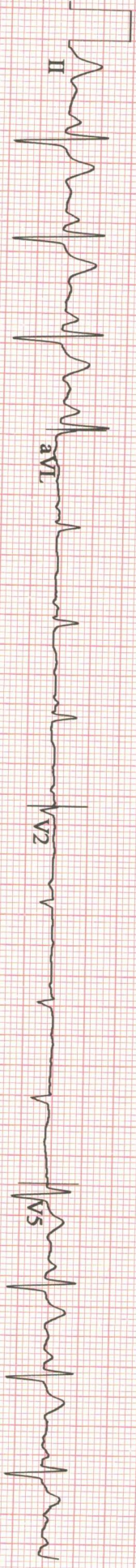
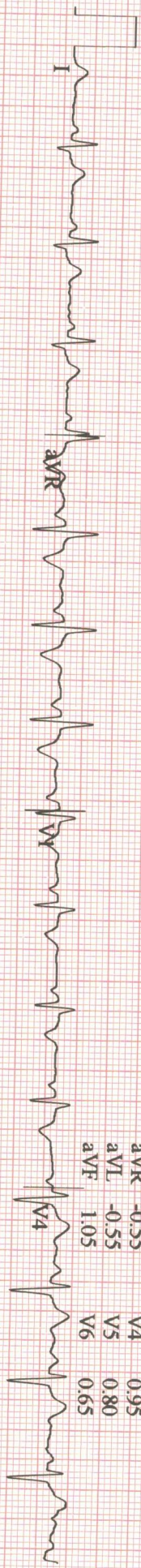


12-LEAD REPORT

95 bpm
 140/90 mmHg
 RECOVERY #1
 01:50
 BRUCE
 0.0 mph
 0.0 %

UNITED HOSPITAL
 Measured at 60ms Post J (10mm/mV)
 Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	0.05	V1	0.00
II	1.05	V2	0.25
III	1.00	V3	0.70
aVR	-0.55	V4	0.95
aVL	-0.55	V5	0.80
aVF	1.05	V6	0.65



MRS. G. SHIVANMA
Patient ID: 24022691
22.06.2024
11:55:57am

90 bpm

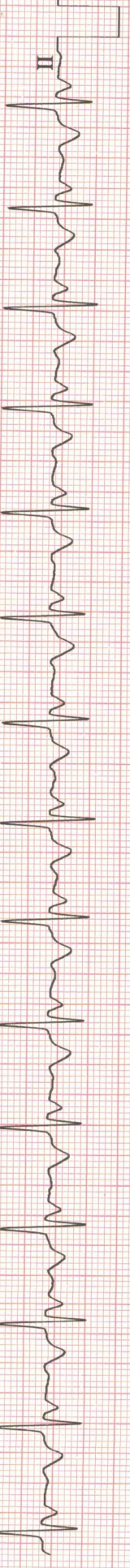
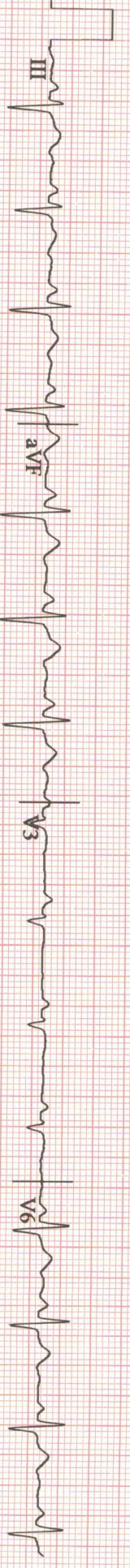
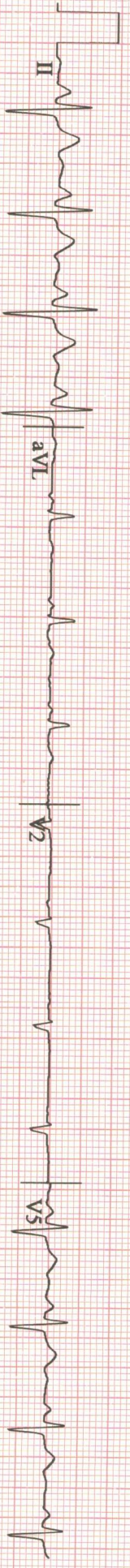
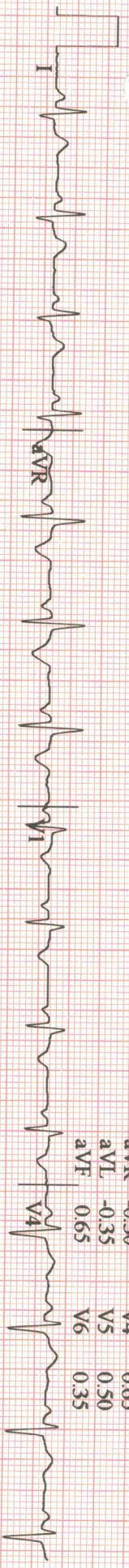
12-LEAD REPORT

RECOVERY
#1
02:50

BRUCE
0.0 mph
0.0%

UNITED HOSPITAL
Measured at 60ms Post J (10mm/mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	-0.10	V1	0.10
II	0.60	V2	0.20
III	0.65	V3	0.60
aVR	-0.30	V4	0.65
aVL	-0.35	V5	0.50
aVF	0.65	V6	0.35



12-LEAD REPORT

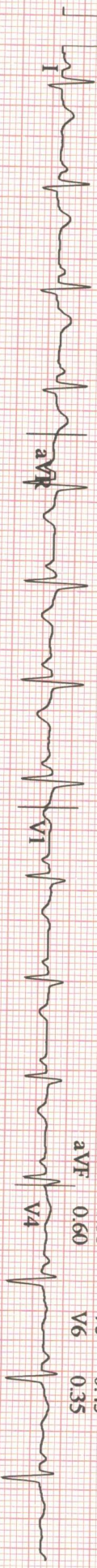
90 bpm

RECOVERY #1
 03:50

BRUCE
 0.0 mph
 0.0 %

UNITED HOSPITAL
 Measured at 60ms Post J (10mm/mV)
 Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	-0.10	V1	0.10
II	0.50	V2	0.10
III	0.65	V3	0.55
aVR	-0.25	V4	0.55
aVL	-0.35	V5	0.45
aVF	0.60	V6	0.35



MRS. G. SHIVAMMA
Patient ID: 24022691
22.06.2024
11:57:57am

12-LEAD REPORT

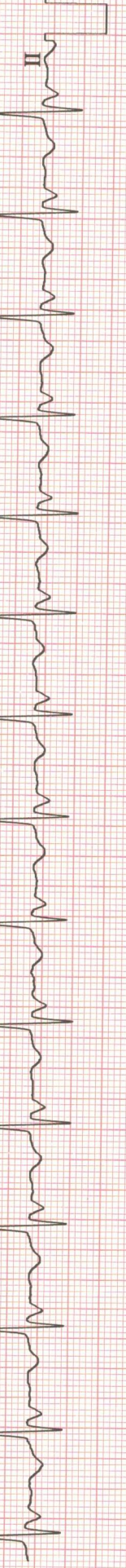
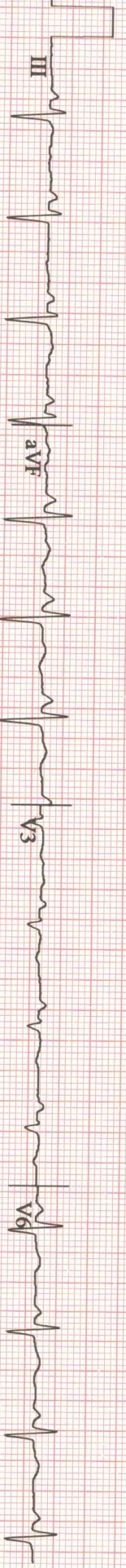
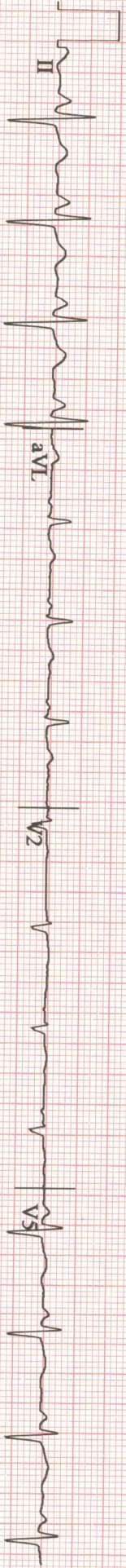
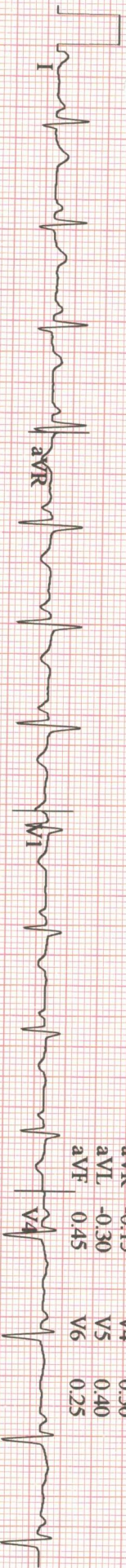
90 bpm

RECOVERY
#1
04:50

BRUCE
0.0 mph
0.0%

UNITED HOSPITAL
Measured at 60ms Post J (10mm/mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	-0.10	V1	0.15
II	0.35	V2	0.15
III	0.50	V3	0.45
aVR	-0.15	V4	0.50
aVL	-0.30	V5	0.40
aVF	0.45	V6	0.25



GE

CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+HR(QI, V5) CE

Start of Test: 11:47:00am

12-LEAD REPORT

95 bpm
140/90 mmHg

RECOVERY #1
05:50

BRUCE
0.0 mph
0.0%

UNITED HOSPITAL
Measured at 60ms Post J (10mm/mV)
Auto Points

Lead	ST(mm)	Lead	ST(mm)
I	-0.05	V1	0.15
II	0.35	V2	0.15
III	0.45	V3	0.40
aVR	-0.10	V4	0.40
aVL	-0.30	V5	0.30
aVF	0.35	V6	0.15

