UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. VANITHA N	Order No	: 1000094258
UHID	: UHJA24004875	Registered On	: 24/08/2024 09:04:15 AM
Age/Sex	: 57/Years Female	Collected On	: 24/08/2024 09:21:49 AM
Ward / Bed No	:	Reported On	: 24/08/2024 05:26:26 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240006745
Station	: At Hospital	Mobile No	: 9483504905
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	130	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	255	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	6.8	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	148	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.79	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.47	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.42	ı IU/mL	0.38-5.33
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	252	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	133	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	53.2	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	172.2	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	26.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.73		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.2		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	198.80	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.1	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	7	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.69	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.18	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.20	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.98	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.9	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.34	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.56	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.69		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	29	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	45	U/L	46-122
GGT (Method:IFCC)	30	U/L	< 38
VITAMIN D (25-OH) (Method:CLIA)	16.8	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)	303	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)	13.92	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	42.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6077	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	56.88	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	29.85	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.91	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.95	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.41	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.93	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	88.0	fL	78-100
MCH (Method: Calculated)	28.6	pg	27-31
MCHC (Method: Calculated)	32.4	g/dL	31-37
RDW - CV (Method: Calculated)	13.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.28	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.81	fl	9-13

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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	35	mm/hour	1-30

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

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

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	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Sridhar Kandukuri

---End of Report---

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

NABH

No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs. VANITHA N	UHID	: UHJA24004875
Age / Sex	: 57 Years / Female	OP NO/Reg Dt	: 24-08-2024 09:04 AM
Spouse / Father Name	: PRASANNA	Department	:
Address	: GIRINAGAR BANGALORE, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Ht: 151 Cm
Wt: 65 kg
Spo2: 98 %
PR: 77 bpm
Bp: 170 / 90 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mrs. Vanitha**	**Date :**	**24/08/24**
Age :	57 years GENDER: FEMALE	Patient ID :	24004875
Ref by :	DR.CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV : 0.6	AV : 0.9	MR : NORMAL
LA : 3.0 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 1.0		AR : TRIVIAL AR
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.8		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : TRIVIAL TR
TAPSE: 2.0 (>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

IMPRESSION :

NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE I LV DIASTOLIC DYSFUNCTION
TRIVIAL AR, TR, PASP-23mmHg
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

DEPARTMENT OF RADIODIAGNOSIS

Name	Vanitha N	**Date**	24/08/24
Age	57 years	**Hospital ID**	UHJA24004875
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

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Vanitha N	**Date**	24/08/24
Age	57 years	**Hospital ID**	UHJA24004875
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS (TAS & TVS)

FINDINGS:

Liver ***is enlarged in size (15.0 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 (9.7 x 2.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.3 x 4.2 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 atrophic, measures 6.6 x 4.8 x 3.7 cms. Endometrium is thin. ***Intrauterine device is seen in situ in the upper uterine cavity. There is left lateral wall subserosal fibroid measuring 2.2 x 1.9 x 1.8 cms.***
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:

- **Small uterine fibroid.**
- **Intrauterine device in situ in the upper uterine cavity.**
- **Mild hepatomegaly with mild fatty infiltration (Grade I).**

Dr. Elluru Santosh Kumar
Consultant Radiologist

ID:24004875
Name:MRS VANITHA

24-Aug-2024 AM11:09:44

ex:F Birth date: 57 years

cm kg / mmHg

edication:

ymptoms:

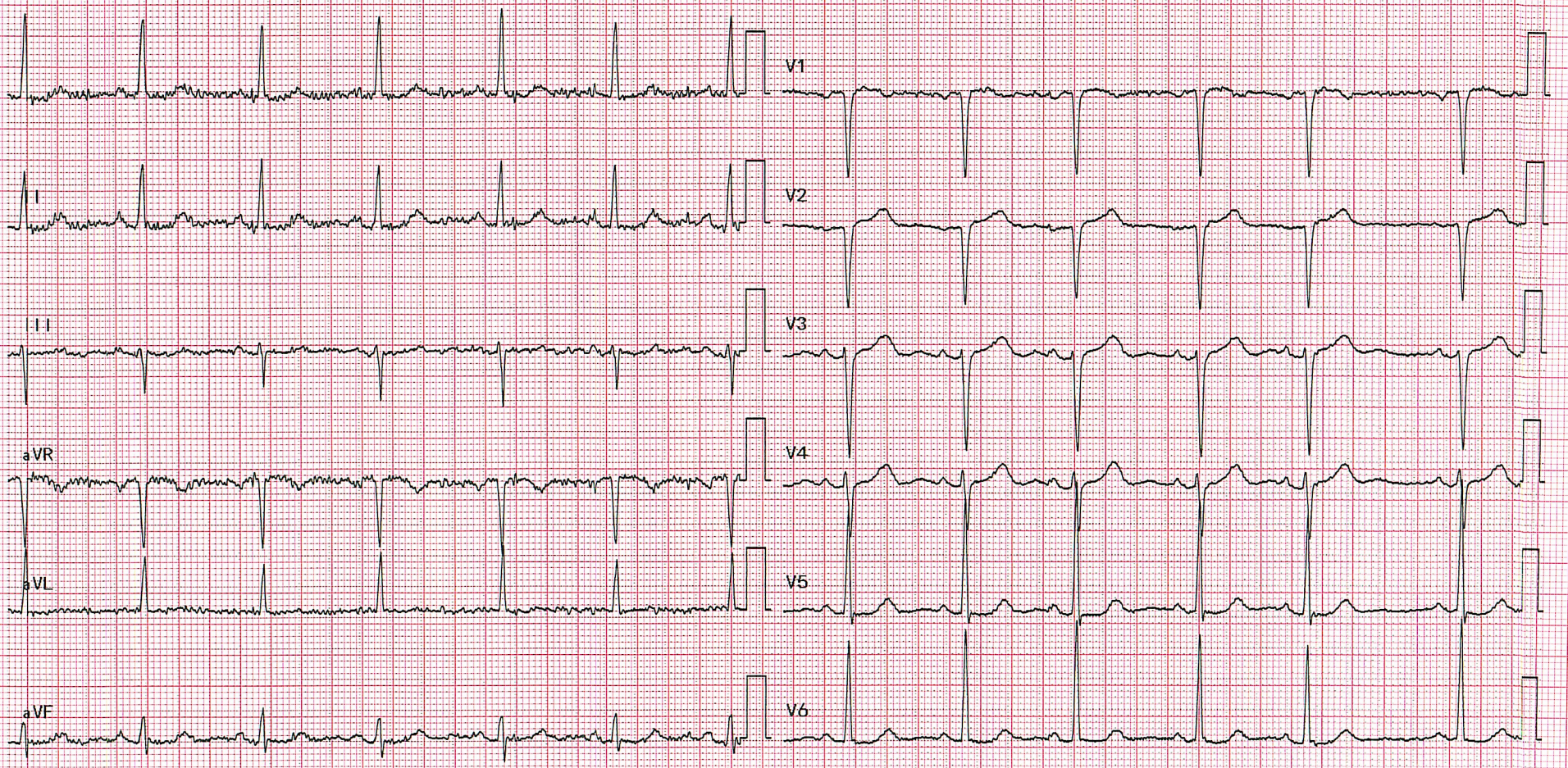
istory:

ent. rate	77	bpm
R int	158	ms
RS dur	76	ms
T/QTc(E) int	364/ 396	ms
/QRS/T axis	26/ 20/ 51	°
V5/SV1 amp	2.04/ 1.47	mV
V5+SV1 amp	3.51	mV

1100 Sinus rhythm
1102 Sinus arrhythmia [RR int. change over 20%]
0102 ARTIFACT PRESENT
9110 ** normal ECG **

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH No.1

Out Patient Record

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Jayanagar, Bangalore

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Age / Sex	: 57 Years / Female	OP NO/Reg Dt	: 24-08-2024 09:04 AM
Spouse / Father Name	: PRASANNA	Department	: Opthal
Address	: GIRINAGAR BANGALORE, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Investigations:

V/A (glass) 6/9, 6/6p } N

DM - 2yrs.
HTN - 15 yrs

NG ov Nad

Treatment / Care of Plan / Provisional Diagnosis :

Fundi ov CD ratio 0.3:1 FR (+)
(multiple)

If: ov Rf End

Follow Up Advice :

Continue same glass.

Annually - dilated fundis Examination.

Signature of the Doctor
24/8/24.