NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.HARINI KONETI**	**UHID**	**: UHJA24004876**
Age / Sex	: 41 Years / Female	OP NO/Reg Dt	: 24-08-2024 09:07 AM
Spouse / Father Name	: P V NAGENDRANATH REDDY	Department	:
Address	: 103, PREMNIVAS APRT , 1ST MAIN 1ST CROSS, LAKKASANDRA, , Bengaluru	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

BP- 113 / 70 mm / Hg
PR- 80 b/m
SpO_2 - 99 %.
Ht - 169 cm
Wt - 82.3 kg.

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

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Address	: 103, PREMNIVAS APRT , 1ST MAIN 1ST CROSS, LAKKASANDRA, , Bengaluru	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Vn 6/12 plain
(glaucoma) 6/12 plain

Investigations:

Mj ou Normal

Treatment / Care of Plan / Provisional Diagnosis :

Fundus ou CDR 0.3:1
(withheld) IFA HJ
? Degenerative changes at tele posterpole. 6/12

Follow Up Advice :

If: ou Refraction
(R) - -5.00 DS / -0.75 DC X 90.
(L) - -5.75 DS / -0.75 DC X 130.
6/12

Signature of the Doctor

24/8/24.

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Address	: 103, PREMNIVAS APRT , 1ST MAIN 1ST CROSS, LAKKASANDRA, , Bengaluru	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Dr. Yoga Lakshmi S
MBBS, MS OBG, FMAS
Consultant Obstetrician and Gynecologist, Laparoscopy and IVF Specialist
KMC Reg. No. 93384

Complaints / Findings / Observations :

H/o mastectomy
Ca... 2018
BP - 113/70
PR - 80

Investigations:

H/o chemo ... 6 cycles
... 28 cycles

Treatment / Care of Plan / Provisional Diagnosis :

No h/o DM, HTN, Thy
K/c/o hypothy
P/A - Soft

P2L2
All ...
...
... 5/24

Follow Up Advice :

P/S - ...
No discharge.

Signature of the Doctor

NABH No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Harini Koneti	**Date**	24/08/24
Age	41 years	**Hospital ID**	UHJA24004876
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and ***shows mildly 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 (9.0 x 3.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.4 x 3.8 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 6.5 x 1.8 x 4.3 cms. Endometrium measures 2.3 mm.
Both ovaries appear 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 fatty infiltration of liver (Grade I).**
- **No other definite sonological abnormality detected.**

Dr. Phani Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Patient name :	**Mrs. HARINI KONETI**	**Date :**	**24/08/24**
Age :	**years GENDER: FEMALE**	**Patient ID :**	**24004876**
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 : 0.9	AV : 1.3	MR : TRIVIAL MR
LA : 3.0 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 1.0		AR : MILD + 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 AR
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 : 58%			

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 :

STATUS POST PTCA

NORMAL LV SYSTOLIC FUNCTION EF : 58%
NORMAL LV DIASTOLIC FUNCTION
TRIVIAL MR, TR, PASP- 30mmHg
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

DEPARTMENT OF RADIODIAGNOSIS

Name	Harini Koneti	**Date**	24/08/24
Age	41 years	**Hospital ID**	UHJA24004876
Sex	Female	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

There is a left hilar lymphnode with calcifications.

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **Left hilar lymphnode with calcifications. Patient is a known case of treated mediastinal Hodgkins lymphoma.**
- **No other significant radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Harini Koneti	**Date**	24/08/24
Age	41 years	**Hospital ID**	UHJA24004876
Sex	Female	**Ref.**	Health check

BILATERAL SONOMAMMOGRAPHY

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Homogeneous fatty background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION: *Suboptimal evaluation due to large fatty breasts.*

- **No significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

24-Aug-2024 AM11:52:36

ID:24004876
Name:MRS HARINI

ex:F Birth date: 41 years

cm kg / mmHg

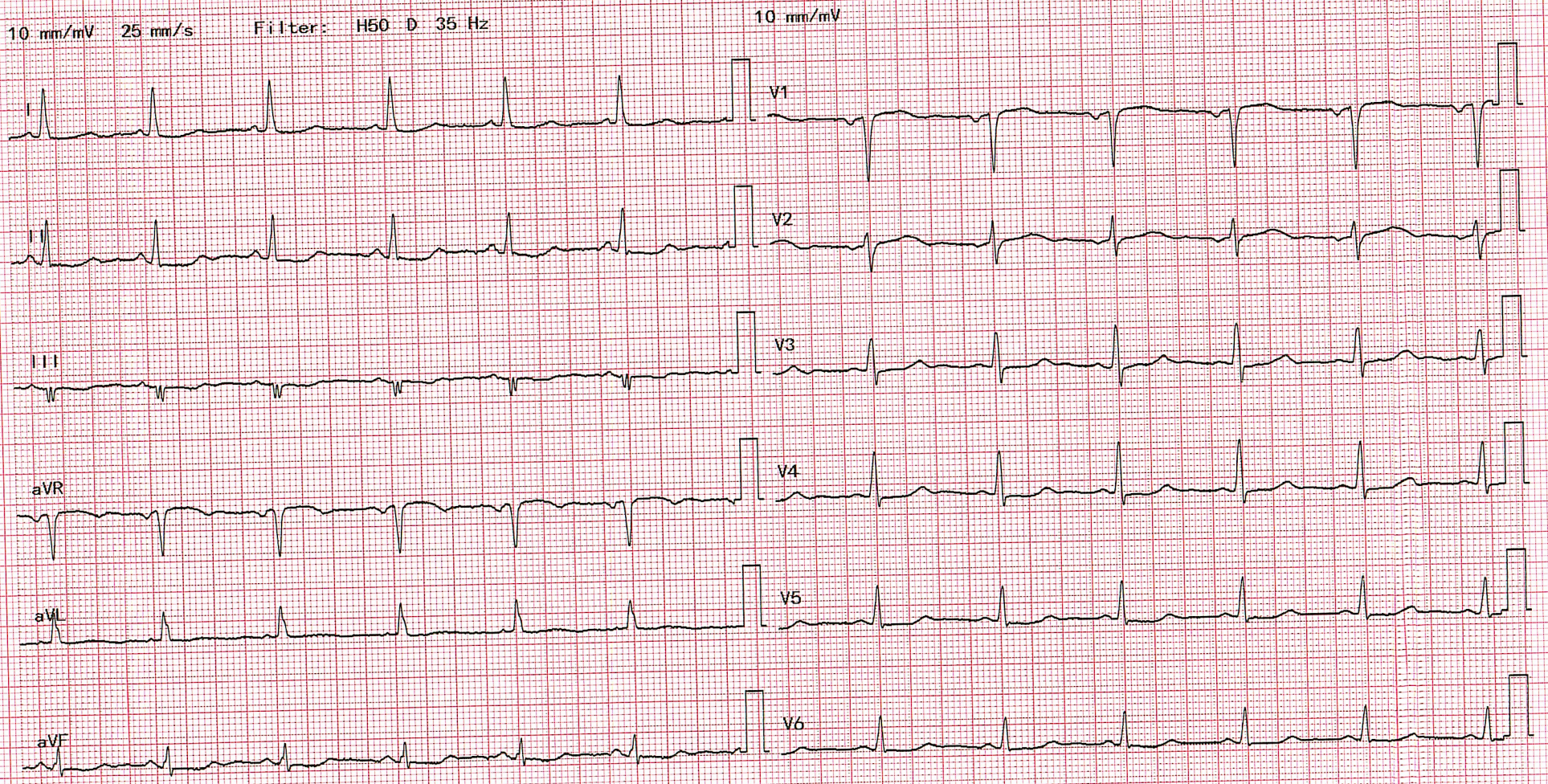
edication:
ymptoms:
istory:

ent. rate	76	bpm
R int	128	ms
RS dur	78	ms
T/QTc(E) int	396/ 426	ms
/QRS/T axis	40/ 17/ 14	°
V5/SV1 amp	0.67/ 1.03	mV
V5+SV1 amp	1.70	mV

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (I, II, aVL)]
9130 ** borderline 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

UNITED HOSPITAL
Care Par Excellence

ilac-MRA

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. HARINI KONETI	Order No	: 1000094262
UHID	: UHJA24004876	Registered On	: 24/08/2024 09:07:34 AM
Age/Sex	: 41/Years Female	Collected On	: 24/08/2024 09:29:36 AM
Ward / Bed No	:	Reported On	: 24/08/2024 03:19:23 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240006746
Station	: At Hospital	Mobile No	: 9901033442
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	91	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	111	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)	1.11	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.52	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	0.25	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)	109	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	156	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	41.9	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	35.9	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	31.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	2.6		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	0.8		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	67.1	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.6	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.59	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.13	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.46	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.7	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.44	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.25	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.96		2:1
SERUM SGOT (Method:IFCC without P5P)	23	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)	59	U/L	46-122
GGT (Method:IFCC)	16	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	22.1	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.86	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	11.62		12¯20 : 1

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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)	11.57	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	36.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6530	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	64.68	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	25.96	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.28	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.71	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.37	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.40	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.7	fL	78-100
MCH (Method: Calculated)	26.3	pg	27-31
MCHC (Method: Calculated)	31.8	g/dL	31-37
RDW - CV (Method: Calculated)	14.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.16	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)	9.27	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	05	mm/hour	1-20

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

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

Interpretation Notes

Note: Both forward and reverse grouping performed

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

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CLINICAL PATHOLOGY

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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	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
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CONSULTANT PATHOLOGIST
KMC:66136