NABH

NABL

No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs.SWARNA R	UHID	: UHJA23018100
Age / Sex	: 39 Years / Female	OP NO/Reg Dt	: 10-02-2024 09:55 AM
Spouse / Father Name	: .	Department	:
Address	: # 59,6th Cross Jai Jaavan Nagar Banglroe Banaswadi Post , BANGALORE CITY H O,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

S/B physician Team

Reports reviewed

Investigations:

Newly Detected T2DM.

Lipid Profile - deranged.

Treatment / Care of Plan / Provisional Diagnosis :

HbA1c - 8.1%

Dietary changes

Lifestyle modifications.

Adv: T. EVION 400mg 1-0-0 x 1month (AF).

T. GYLOCOMET GP1 1-0-1 x 3months (BF)

T. ROSEDAY 10mg 0-0-1 x 3months (AF

Follow Up Advice :

FBS, PPBS, HbA1c

Lipid Profile after 3months

Signature of the Doctor

ID: 23018100

Name: Mrs. Swarna. R

10-Feb-2024 AM11:36:23

SCHILLER

lex: F

Birth date:

39 years

cm kg / mmHg

ledication:

lymptoms:

listory:

lent. rate	105	bpm
IR int	156	ms
IRS dur	88	ms
IT/QTc(E) int	328/ 389	ms
I/QRS/T axis	60/ 39/ 30	°
IV5/SV1 amp	0.85/ 0.90	mV
IV5+SV1 amp	1.76	mV

1120 Sinus tac.ycardia [vent. rate >= 100 bpm]

4068 Nonspecific Twave abnormality [flat T or negative T (aVF, V4, V5)]

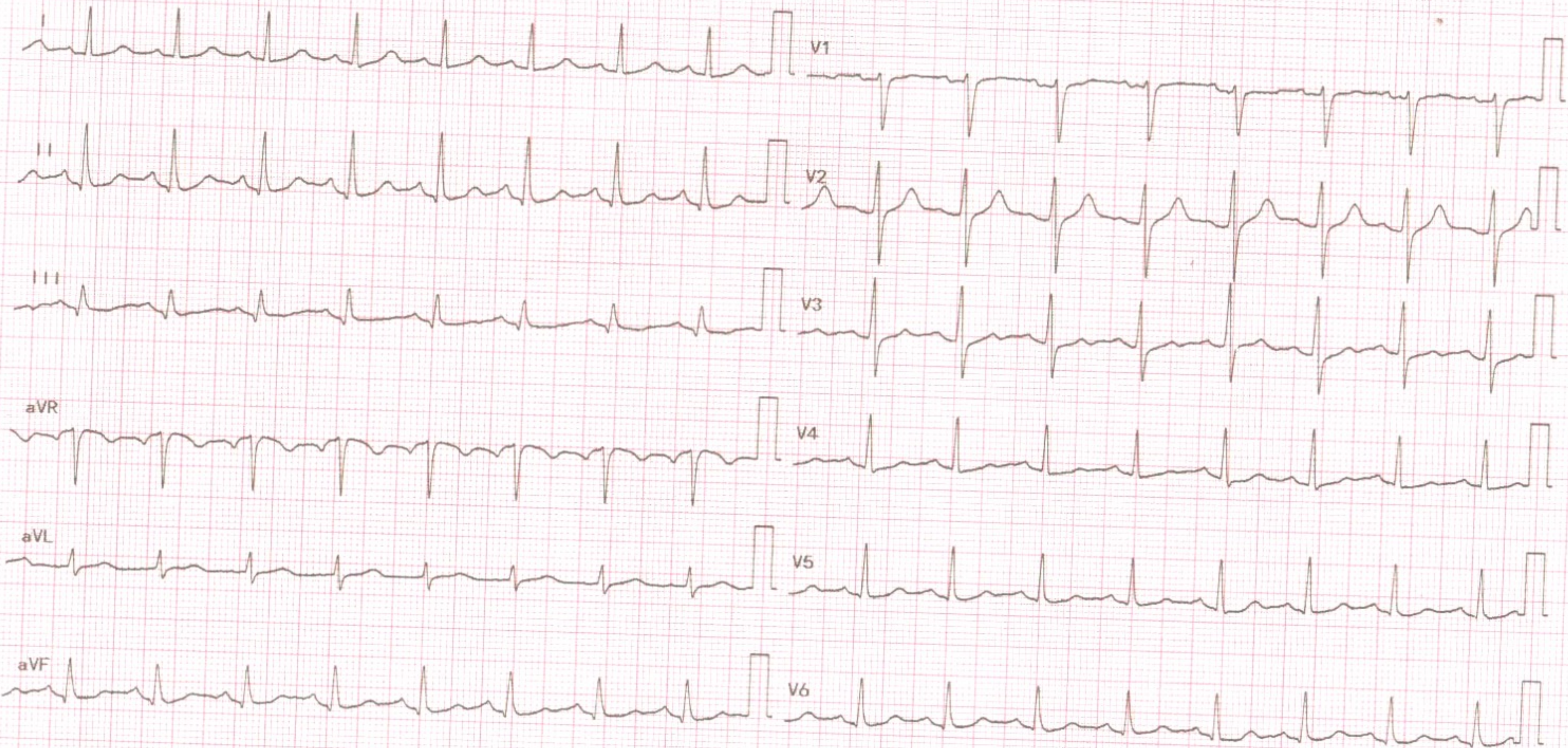
9140 ** abnormal rhythm ECG **

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

Part No.2.157017M

NABH NABL No.1

Patient name :	Mrs. SWARNA R	Date :	10/02/24
Age :	39 years GENDER: FEMALE	Patient ID :	18100
Ref by :	DR.CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 3.9 (3.5-5.5)	MV EV : 76.3	AV : 84.7	MR : NORMAL
LA : 3.4 (1.9-4.0)	LVIDS : 3.2 (2.4-4.2)	AV : 100		AR : NORMAL
RA :2.4 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 97.5		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.9 (>1.6)	LVPWD : 1.1 (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

IMPRESSION :

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

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

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		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

for health check.

Ht - 159cm
Wt - 69.3kg
PR - 114b/m
SpO2 - 98%
BP - 110/78.

Investigations:

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Ob[illegible] [illegible]
Gynecologist, [illegible] [illegible] and
and IVF Spe[illegible] [illegible]scopy
KMC Reg. No. 90384

Treatment / Care of Plan / Provisional Diagnosis :

ML - 10y
Nullgravid
Can't [illegible]
[illegible]
[illegible] - 14/1/24
[illegible]

K/c/o Hypothy
No h/o Any HTN
H/o stent 2022
No h/o any [illegible] Ca
No h/o [illegible]

Follow Up Advice :

Signature of the Doctor

P/A - Sft.

P/R - C/T Very well

C/O Anal pain - Anal tag inflamed
- fissure

Adv [crossed out] Diet - loads Stg roach

- Anorelief - 5d
1-0-1

- T. Augmentin 625mg - 5d
1-0-1

- C. pantocid - 5d
1-0-1

- T. Enzyme - 5d
1-0-1
A/C

- T. Sobon - 5d
0-1

- Sitzbath 1-0-1

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		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Routine Eye test

Investigations:

VA < 6/6 (BE)

A&L Conj congestion

Treatment / Care of Plan / Provisional Diagnosis :

Fundus LO

Follow Up Advice : Dx: Allergic conjunctivitis (BE)

Rx:

Lubrex Eye drops
1-0-1 x 1 month

Signature of the Doctor
10/2/24

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DEPARTMENT OF RADIODIAGNOSIS

Name	Swarna R	Date	10/02/24
Age	39 years	Hospital ID	UHJA23018100
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and ***shows moderate 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 (9.8 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (11.0 x 4.4 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 well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus is anteverted and normal in size, measures 8.7 x 3.2 x 4.5 cms. Myometrial and endometrial echoes are normal. Endometrium measures 8.2 mm.
Both ovaries *show polycystic morphology.*
Right ovary measures 6.5 cc. **Left ovary** measures 11.6 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: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Moderate fatty infiltration of liver (Grade II).**
- **Bilateral polycystic ovaries.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

UNITED HOSPITAL
Care Par Excellence

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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SWARNA R	Order No	: 1000072400
UHID	: UHJA23018100	Registered On	: 10/02/2024 09:55:32 AM
Age/Sex	: 39/Years Female	Collected On	: 10/02/2024 10:05:37 AM
Ward / Bed No	:	Reported On	: 10/02/2024 02:26:16 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022391
Station	: At Hospital	Mobile No	: 8147791841
Payer Name	: Mediwheel	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval
FASTING GLUCOSE (Method: Hexokinase)	170	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	267	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	8.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	185.76	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.97	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.73	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.11	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)	289	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	783	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.0	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	167.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	156.59	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	6.15		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.56		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	242	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.5	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)	0.64	mg/dL	0.6-1.1

LIVER FUNCTION TEST — Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.69	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.08	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.61	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.9	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.38	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.52	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.24		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	18	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	80	U/L	46-122
GGT (Method:IFCC)	16	U/L	< 38

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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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)	12.91	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	40.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9060	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	55.86	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	37.80	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.54	%	0-6
MONOCYTES (Method:Optical/Impedance)	4.64	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.16	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.11	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	78.5	fL	78-100
MCH (Method: Calculated)	25.3	pg	27-31
MCHC (Method: Calculated)	32.2	g/dL	31-37
RDW - CV (Method: Calculated)	15.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.37	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)	7.83	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	22.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	22	mm/hour	1-20

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
ABO Group (Method:Agglutination Gel Method)	B
Rh Factor (Method:Agglutination Gel Method)	Positive

Interpretation Notes

Note: Both forward and reverse grouping performed

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
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		

Verified By
PREETHI R

---End of Report---

Naveen.N
Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418