NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Ms.A RANJITHA	UHID	: UHJA23018758
Age / Sex	: 28 Years / Female	OP NO/Reg Dt	: 20-02-2024 09:02 AM
Spouse / Father Name	: ANJAIAH	Department	:
Address	: # 4th Cross Near Lekhana Proviison Store Kyasandra Tumkur , BANGALORE CITY H	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Investigations:

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

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. A RANJITHA	Order No	: 1000073773
UHID	: UHJA23018758	Registered On	: 20/02/2024 09:02:36 AM
Age/Sex	: 28/Years Female	Collected On	: 20/02/2024 09:31:02 AM
Ward / Bed No	:	Reported On	: 20/02/2024 01:36:34 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023193
Station	: At Hospital	Mobile No	: 9611490968
Payer Name	: Mediwheel	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval
FASTING GLUCOSE (Method: Hexokinase)	105	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	96	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	85.31	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.92	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.16	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	10.88	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)	160	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	83	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	39.4	mg/dL	< 40 - Low ≥ 60 - High

UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. A RANJITHA	Order No	: 1000073773
UHID	: UHJA23018758	Registered On	: 20/02/2024 09:02:36 AM
Age/Sex	: 28/Years Female	Collected On	: 20/02/2024 09:31:02 AM
Ward / Bed No	:	Reported On	: 20/02/2024 01:36:34 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023193
Station	: At Hospital	Mobile No	: 9611490968
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	104	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.0		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.6		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	120.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.0	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	11	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.72	mg/dL	0.6-1.1

LIVER FUNCTION TEST — Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.40	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.05	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.36	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.31	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.88	g/dL	2.3-3.5

UNITED HOSPITAL
Care Par Excellence

ilac-MRA

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. A RANJITHA	Order No	: 1000073773
UHID	: UHJA23018758	Registered On	: 20/02/2024 09:02:36 AM
Age/Sex	: 28/Years Female	Collected On	: 20/02/2024 09:31:02 AM
Ward / Bed No	:	Reported On	: 20/02/2024 01:36:34 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023193
Station	: At Hospital	Mobile No	: 9611490968
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.10		2:1
SERUM SGOT (Method:IFCC without P5P)	21	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	13	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	101	U/L	44-107
GGT (Method:IFCC)	23	U/L	< 38

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. A RANJITHA	Order No	: 1000073773
UHID	: UHJA23018758	Registered On	: 20/02/2024 09:02:36 AM
Age/Sex	: 28/Years Female	Collected On	: 20/02/2024 09:31:02 AM
Ward / Bed No	:	Reported On	: 20/02/2024 01:36:34 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023193
Station	: At Hospital	Mobile No	: 9611490968
Payer Name	: Mediwheel	Report Status	: Final Report

HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	13.03	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	39.5	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7590	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	66.06	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	21.95	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.32	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.35	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.32	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.46	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	88.5	fL	78-100
MCH (Method: Calculated)	29.2	pg	27-31
MCHC (Method: Calculated)	33.0	g/dL	31-37
RDW - CV (Method: Calculated)	14.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.17	Lakhs/Cum	1.5-4.5

UNITED HOSPITAL
Care Par Excellence

ilac-MRA
MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. A RANJITHA	Order No	: 1000073773
UHID	: UHJA23018758	Registered On	: 20/02/2024 09:02:36 AM
Age/Sex	: 28/Years Female	Collected On	: 20/02/2024 09:31:02 AM
Ward / Bed No	:	Reported On	: 20/02/2024 01:36:34 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023193
Station	: At Hospital	Mobile No	: 9611490968
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.73	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	20	mm/hour	1-20

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
ABO Group (Method:Agglutination Gel Method)	A		
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

UNITED HOSPITAL
Care Par Excellence

ilac-MRA

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. A RANJITHA	Order No	: 1000073773
UHID	: UHJA23018758	Registered On	: 20/02/2024 09:02:36 AM
Age/Sex	: 28/Years Female	Collected On	: 20/02/2024 09:31:02 AM
Ward / Bed No	:	Reported On	: 20/02/2024 01:36:34 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023193
Station	: At Hospital	Mobile No	: 9611490968
Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

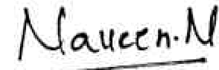
Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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			

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. A RANJITHA	Order No	: 1000073773
UHID	: UHJA23018758	Registered On	: 20/02/2024 09:02:36 AM
Age/Sex	: 28/Years Female	Collected On	: 20/02/2024 09:31:02 AM
Ward / Bed No	:	Reported On	: 20/02/2024 01:36:34 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023193
Station	: At Hospital	Mobile No	: 9611490968
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	4-6	/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		



Verified By
NAGARATNA

---End of Report---

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

ID:18758

Name:Ms.A.Ranjitha

28 years

1100 Sinus rhythm

9110 ** normal ECG **

20-Feb-2024 AM9:41:47

ex:F

Birth date:

cm kg / mmHg

edication:

ymptoms:

istory:

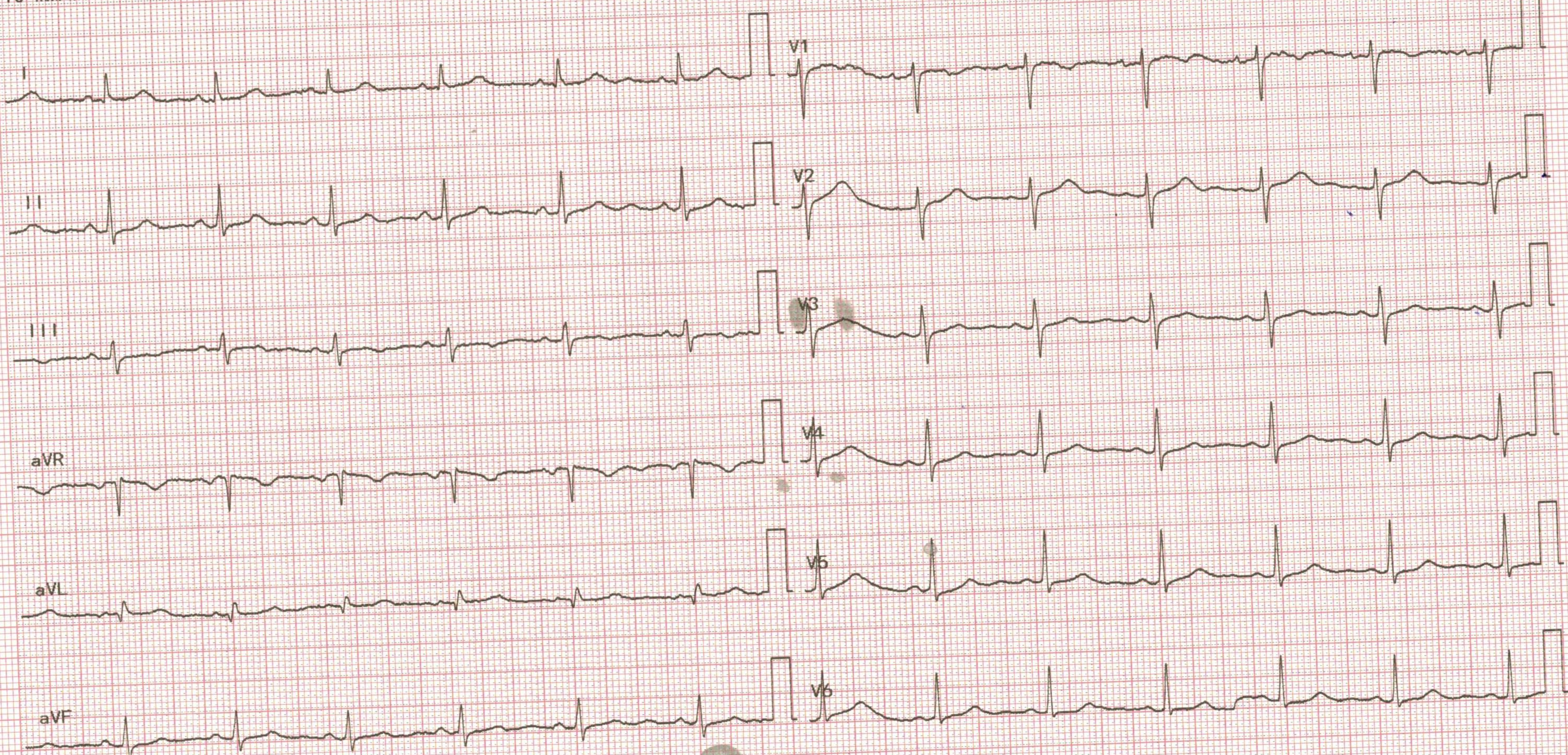
ent. rate	80	bpm
R int	148	ms
RS dur	70	ms
T/QTc(E) int	366/ 402	ms
/QRS/T axis	47/ 50/ 42	°
V5/SV1 amp	0.94/ 0.75	mV
V5+SV1 amp	1.69	mV

Unconfirmed Report

Reviewed by:

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

10 mm/mV



Exam:UNITED HOSPITAL

SCHILLER
Part No.2.157017M CE 0123

NABH NABL No.1

Patient name :	Ms. A RANJITHA	Date :	20/02/24
Age :	28 years GENDER: FEMALE	Patient ID :	18758
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.5 (2.5-3.7)	LVIDD : 3.5 (3.5-5.5)	MV EV : 66.0	AV : 55.8	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 0.2 (2.4-4.2)	AV : 100		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 102		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.9 (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 PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Ms.A RANJITHA**	**UHID**	**: UHJA23018758**
Age / Sex	: 28 Years / Female	OP NO/Reg Dt	: 20-02-2024 09:02 AM
Spouse / Father Name	: ANJAIAH	Department	:
Address	: # 4th Cross Near Lekhana Proviison Store Kyasandra Tumkur , BANGALORE CITY H	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: (Optho)

Complaints / Findings / Observations :

Vn: 6/9, 6/6p } N6.

nil systemic

Screen time 6-8 hrs/day

Investigations:

A/S: OU dryness (+)

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (undilated) OU CD ratio 0.3:1 FR(+)

Follow Up Advice :

Imp: OU dryness (+)

REFRESH TEARS E/D 1-1-1 x 1 month

R/v after 1 month

Signature of the Doctor

Dr Shweta

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	A Ranjitha	**Date**	20/02/24
Age	28 years	**Hospital ID**	UHJA23017858
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and 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 (8.3 x 3.1 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.3 x 3.3 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 7.3 x 2.9 x 3.5 cms. Myometrial and endometrial echoes are normal. Endometrium measures 3.6 mm.
Right ovary is normal in size and echopattern, measures 3.0 cc.
Left ovary is normal in size and echopattern, measures 2.6 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:

- **No definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	A Ranjitha	Date	20/02/24
Age	28 years	Hospital ID	UHJA23017858
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Small nodule measuring 16 x 5 mm is seen in the right upper lung zone.

Rest of the bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **Small nodule in right upper lung zone.** *Suggested follow up in 3-6 months.*
- **No other radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist