UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. C PAUL WILSON	Order No	: 1000072397
UHID	: UHJA23018099	Registered On	: 10/02/2024 09:53:29 AM
Age/Sex	: 48/Years Male	Collected On	: 10/02/2024 10:01:22 AM
Ward / Bed No	:	Reported On	: 10/02/2024 02:53:31 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022390
Station	: At Hospital	Mobile No	: 9008778397
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	233	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	356	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	9.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	228.81	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.78	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	6.86	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	4.15	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	253	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	384	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	54.6	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	121.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	76.79	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.6		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.2		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	198.4	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.4	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.80	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	10		12¯20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.50	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.42	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.43	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.77	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.59		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	21	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	91	U/L	50-116
GGT (Method:IFCC)	59	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.35	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	17.1	mg/dL	17-43

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	13.89	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	41.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5320	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	54.53	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.24	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.34	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.59	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.30	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.50	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	92.7	fL	78-100
MCH (Method: Calculated)	30.9	pg	27-31
MCHC (Method: Calculated)	33.3	g/dL	31-37
RDW - CV (Method: Calculated)	13.3	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.45	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.45	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-15

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

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

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		5.0-8.0
SPECIFIC GRAVITY	1.025		1.005-1.030

CHEMICAL EXAMINATION

PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Present (1.5%)		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
Parameshwar B

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.C PAUL WILSON**	**UHID**	**: UHJA23018099**
Age / Sex	: 48 Years / Male	OP NO/Reg Dt	: 10-02-2024 09:53 AM
Spouse / Father Name	: SWARNA R	Department	: (Optho)
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 :

Routine Eye exam

Investigations:

VA < 6/18 N < N10

AS < ⊘

Treatment / Care of Plan / Provisional Diagnosis : fundus < ⊘

Imp! Refractive error c̄ presbyopia

Follow Up Advice :

Adv! yearly review

Signature of the Doctor

10/2/24

United Hospital
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NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mr. C PAUL WILSON**	**Date :**	**10/02/24**
Age :	**48 years GENDER: MALE**	**Patient ID :**	**18099**
Ref by :	**DR.CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.9 (2.5-3.7)	LVIDD : 4.2 (3.5-5.5)	MV EV : 72.4	AV : 63.4	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.6 (2.4-4.2)	AV :84.7		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 62.9		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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

ID: 23018099
Name: Mr. C. Paul Wilson

10-Feb-2024 AM11:11:02

ex: M Birth date: 48 years

cm kg / mmHg

edication:
ymptoms:
istory:

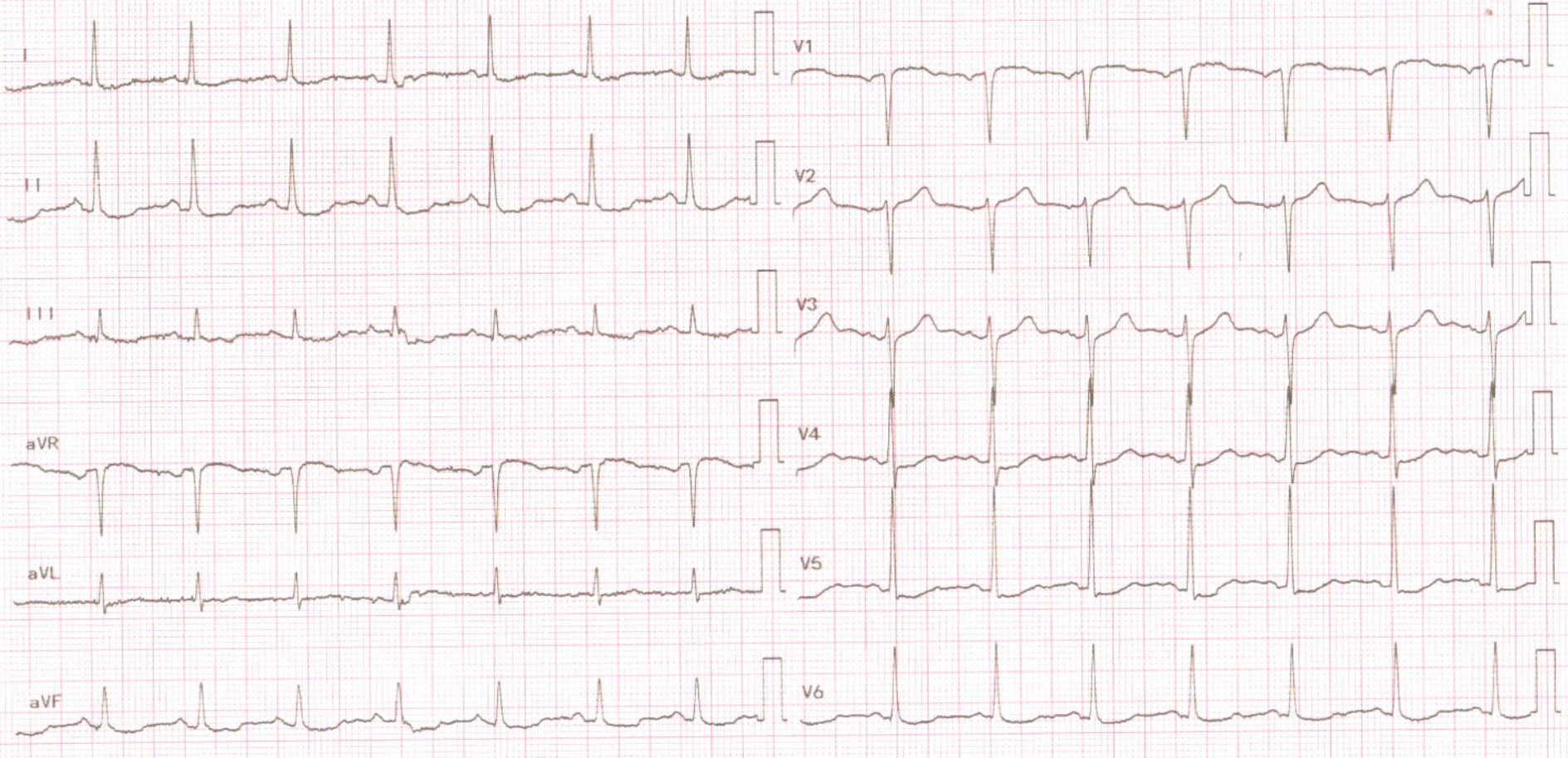
ent. rate	93	bpm
R int	150	ms
RS dur	80	ms
T/QTc(E) int	352/ 403	ms
/QRS/T axis	58/ 37/ 262	°
V5/SV1 amp	1.85/ 1.26	mV
V5+SV1 amp	3.11	mV

1100 Sinus rhythm
4012 Moderate ST depression [0.05+ mV ST depression (I, II, aVF, V4, V5, V6)]
4564 Twave abnormality, possible lateral ischemia [negative T (V5, V6)]
4664 Twave abnormality, possible inferior ischemia [negative T (II, aVF)]
9150 ** abnormal 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

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	C Paul Wilson	**Date**	10/02/24
Age	48 years	**Hospital ID**	UHJA23018099
Sex	Male	**Ref.**	Healthcheck

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (16.8 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 focal lesion.

Right Kidney is normal in size (10.8 x 4.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.1 x 5.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus 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, mass or mural lesion.

Prostate is normal in echopattern and size, measures ~ 11.9 cc.

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

IMPRESSION:

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

Dr. Elluru Santosh Kumar
Consultant Radiologist

Please bring this report during your visit to the Hospital / ಆಸ್ಪತ್ರೆಗೆ ಬರುವಾಗ ಈ ರಿಪೋರ್ಟನ್ನು ತನ್ನಿ

"Please turnover for disclaimers of Radiology scans and procedures"

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	C Paul Wilson	**Date**	10/02/24
Age	48 years	**Hospital ID**	UHJA23018099
Sex	Male	**Ref.**	Healthcheck

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

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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 :

SIB physician Team

Reports Revived.

Ht - 163 cm
Wt - 74.7 kg.
BP - 158/100 mm Hg
PR - 92 b/m
SPO2 - 98%

Investigations:

Newly detected T2DM

Lipid Profile - deranged.

Treatment / Care of Plan / Provisional Diagnosis :

HbA1C - 9.6%.

Adv: Dietary changes
Lifestyle modification

Follow Up Advice :

℞
TAB GLYCOMET GP2 1-0-1 X 3 Months (BF)
TAB ROSEDAY 10mg 0-0-1 X 3 Months (AF)

FBS, PPBS, HbA1C
Lipid Profile after 3 months & Review

Signature of the Doctor

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