UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. VIJAYA KRISHNA N	Order No	: 1000078394
UHID	: UHJA23020805	Registered On	: 20/03/2024 08:02:11 AM
Age/Sex	: 42/Years Male	Collected On	: 20/03/2024 08:22:15 AM
Ward / Bed No	:	Reported On	: 20/03/2024 12:03:20 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230025733
Station	: At Hospital	Mobile No	: 9980322047
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	93	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	85	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105.40	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.38	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.23	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.79	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	181	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	82	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	33.2	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	131.4	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.39	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.4		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.9		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	147.8	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.8	mg/dL	3.5-7.2
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)	0.90	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	11.1		12˜20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.11	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.21	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.91	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)	4.29	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.91	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.47		2:1
SERUM SGOT (Method:IFCC without P5P)	22	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	18	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	63	U/L	50-116
GGT (Method:IFCC)	14	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	7.35	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)	21.6	mg/dL	17-43

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

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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)	13.46	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	42.8	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4650	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	54.25	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	29.01	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	7.86	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.34	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.54	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle) Remarks: In view of increased RBC count and reduced RBC indices suggest Iron profile and HPLC/HB electrophoresis to rule out Thalassemia trait. Kindly correlate clinically.	5.94	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	72.0	fL	78-100
MCH (Method: Calculated)	22.7	pg	27-31
MCHC (Method: Calculated)	31.4	g/dL	31-37
RDW - CV (Method: Calculated)	18.0	%	11.5-14.5

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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET COUNT (Method:Electrical Impedance)	1.96	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.51	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	28.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

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

ABO Group (Method:Agglutination Gel Method)	A	
Rh Factor (Method:Agglutination Gel Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

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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	6.5		5.0-8.0
SPECIFIC GRAVITY	1.015		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		

Verified By
Rashmita

---End of Report---

Dr. Shobha Emmanuel
CONSULTANT PATHOLOGIST
KMC:66136

*NABL renewal under process.

Patient name :	Mr. VIJAYA KRISHNA N	Date :	20/03/24
Age :	42 years GENDER: MALE	Patient ID :	20805
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.0 (2.5-3.7)	LVIDD : 5.2 (3.5-5.5)	MV EV : 64.0	AV : 57.7	MR : NORMAL
LA : 3.3 (1.9-4.0)	LVIDS : 3.5 (2.4-4.2)	AV : 77.4		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 75.7		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>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, TRIVIAL TR, PASP-20mmHg
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	**: Mr.VIJAYA KRISHNA N**	**UHID**	**: UHJA23020805**
Age / Sex	: 42 Years / Male	OP NO/Reg Dt	: 20-03-2024 08:02 AM
Spouse / Father Name	: NARAYANAPPA	Department	:
Address	: NAGASANDRA , , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha

Complaints / Findings / Observations :

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Vijaya Krishna N	**Date**	20/03/24
Age	42 years	**Hospital ID**	UHJA23020806
Sex	Male	**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 focal lesion.

Right Kidney is normal in size (12 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.1 x 4.9 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 ~ 22 cc.

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
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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Vijaya Krishna N	**Date**	20/03/24
Age	42 years	**Hospital ID**	UHJA23020806
Sex	Male	**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

cm kg / mmHg 42 years

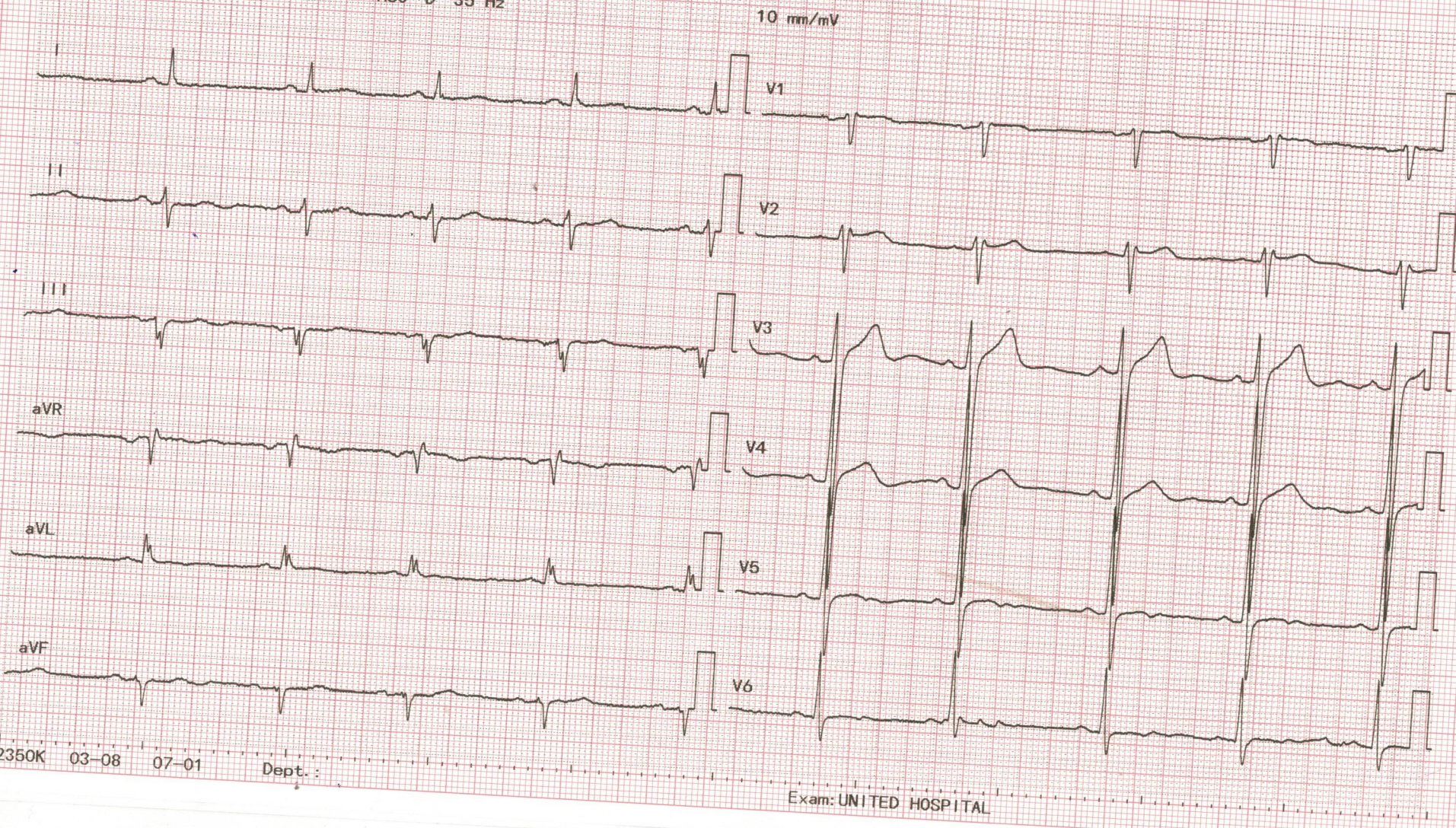
Medication:
Symptoms:
History:

Vent. rate	62	bpm
PR int	160	ms
QRS dur	110	ms
QT/QTc(E) int	412/ 417	ms
P/QRS/T axis	26/ -41/ 60	°
RV5/SV1 amp	2.15/ 0.55	mV
RV5+SV1 amp	2.70	mV

1100 Sinus rhythm
2440 Incomplete right bundle branch block [RSR pattern (V1), 90 ms < QRS dur. < 120 ms, S dur. (V4, V5) >= 39 ms]
4038 Nonspecific ST elevation [ST elevation (V3, V4)]
4048 Nonspecific ST & Twave abnormality [ST abnormality (V3, V4), flat T or negative T (I, V5, V6)]
7200 Abnormal left axis deviation [-90 deg. < QRS axis < -30 deg.]
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

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Address	: NAGASANDRA , , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Ashwitha Padra

Complaints / Findings / Observations :

wt - 82.6
HT - 189
BP - 146/99
SpO2 - 99.%
PR - 60 b/m

Investigations:

PSA - 7.5

Treatment / Care of Plan / Provisional Diagnosis :

To see
Dr. Rajeev Sir please.

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL
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Dr. Rajeev S Bashetty
MBBS, MS, M.Ch (Urology)
KMC Reg. No: 52193
Former Asst. Professor : INU, Bangalore
Former Associate Professor, Vydehi Institute of Medical Science, Bangalore

Lead Consultant Urology & HOD
Director Clinical Excellence

Name : MR. VIJAYA KRISHNA Age/Sex: 42/M PRN No. 23020805 Date. 20/03/24

VITALS : PR : BP : Spo2 : Temp :
Ht : Wt : GRBS :

PAST MEDICAL HISTORY : DM, HTN, Thyroid, IHD, Others

Has done
mri

S. PSA 7.35

for mri

Tab Levoflox 500 mg
OD (after dinner)

Ref Dr. P.S.A. total / after 10 days
P.SA free