UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JYOTHI SHIVARAM	Order No	: 1000074594
UHID	: UHJA23019135	Registered On	: 26/02/2024 08:00:11 AM
Age/Sex	: 51/Years Female	Collected On	: 26/02/2024 08:07:59 AM
Ward / Bed No	:	Reported On	: 26/02/2024 01:25:08 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023668
Station	: At Hospital	Mobile No	: 7550057500
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	101	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	124	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.2	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	102.54	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.01	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.4	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.42	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	229	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	157	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	53.3	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	144.3	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	31.39	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.2		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.7		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	175.7	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.7	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.90	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.15	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.75	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.6	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.31	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.29	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.31		2:1
SERUM SGOT (Method:IFCC without P5P)	17	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	13	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	65	U/L	46-122
GGT (Method:IFCC)	21	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	17.9	mg/dL	17-43
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)	0.69	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	11.5		12¯20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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DEPARTMENT OF LABORATORY MEDICINE

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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)	12.20	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	38.3	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4170	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	54.61	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	35.96	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.14	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.19	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.10	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.57	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	83.8	fL	78-100
MCH (Method: Calculated)	26.7	pg	27-31
MCHC (Method: Calculated)	31.9	g/dL	31-37
RDW - CV (Method: Calculated)	13.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.50	Lakhs/Cum	1.5-4.5

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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

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Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023668
Station	: At Hospital	Mobile No	: 7550057500
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.14	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.2	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-30

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

ABO Group (Method:Agglutination Gel Method)	AB		
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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DEPARTMENT OF LABORATORY MEDICINE

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UHID	: UHJA23019135	Registered On	: 26/02/2024 08:00:11 AM
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Station	: At Hospital	Mobile No	: 7550057500
Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			Sample: Urine
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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)	Present (+)		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	2-4	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---

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

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JYOTHI SHIVARAM	Order No	: 1000074597
UHID	: UHJA23019135 \	Registered On	: 26/02/2024 08:00:10 AM
Age/Sex	: 51/Years Female	Collected On	: 26/02/2024 03:30:32 PM
Ward / Bed No	:	Reported On	: 26/02/2024 04:36:46 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023668
Station	: At Hospital	Mobile No	: 7550057500
Payer Name	: Mediwheel	Report Status	: Final Report

Samples

CERVICAL SMEAR - 26/02/2024 03:30 PM

Test Name :PAP SMEAR

NUMBER OF SLIDES RECEIVED: 02
TYPE OF THE SMEAR: Conventional
SOURCE OF THE SMEAR: Ectocervix and endocervix
CLINICAL DETAILS: P1L1
L M P: Postmenopausal status

SPECIMEN ADEQUACY:
Satisfactory for evaluation.
Transformation zone/ Endocervical cell component is present.

MICROSCOPY:
Smears show predominantly intermediate squamous cells along with few parabasal cells.
Background shows dense neutrophilic infiltrate.
No trichomonads, candida, other parasites or non-specific microorganisms are present.

IMPRESSION: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY (NILM)
COMMENTS: INFLAMMATORY SMEAR

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NABH NABL No.1

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Jayanagar, Bangalore

D. Uma (OBG)

Mrs Jyothi
51yr

26/2/24

Routine Health checkup

C/o SUI
5 10-12 years

Not a k/c/o HTN, Tyn / DM

O/H
P4 - LSCS 27years

M/H - Attained Menopause
1yr ago

Past H/O - N.S
Family H/O - No family H/O Cancers
Medical H/O - N.S.

PA - Soft UE - on cough No Urine leak seen
No Prolapse

P/S - Cx vagina Healthy
Ecto cervix Need a touch
PAP smear taken

Ad

R/L c̄ PAP Repair

NABH NABL No.1

UNITED HOSPITA
Care Par Excellen
Jayanagar, Bangalo

Patient name :	Mrs. JYOTHI SHIVARAM	Date :	26/02/24
Age :	51 years GENDER: FEMALE	Patient ID :	19135
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 : 4.2 (3.5-5.5)	MV EV : 63.1	AV : 87.3	MR : NORMAL
LA : 3.4 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 136		AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 98.5		PR : NORMAL
RV : 2.3 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : GRADE 1 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	: SCLEROTIC CHANGES, NON-STENOTIC, JET GRDT-7mmHg
Tricuspid Valve	: NORMAL, TRIVIAL TR, PASP-20mmHg
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

SCLEROTIC AORTIC VALVE
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE 1 LV DIASTOLIC DYSFUNCTION
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

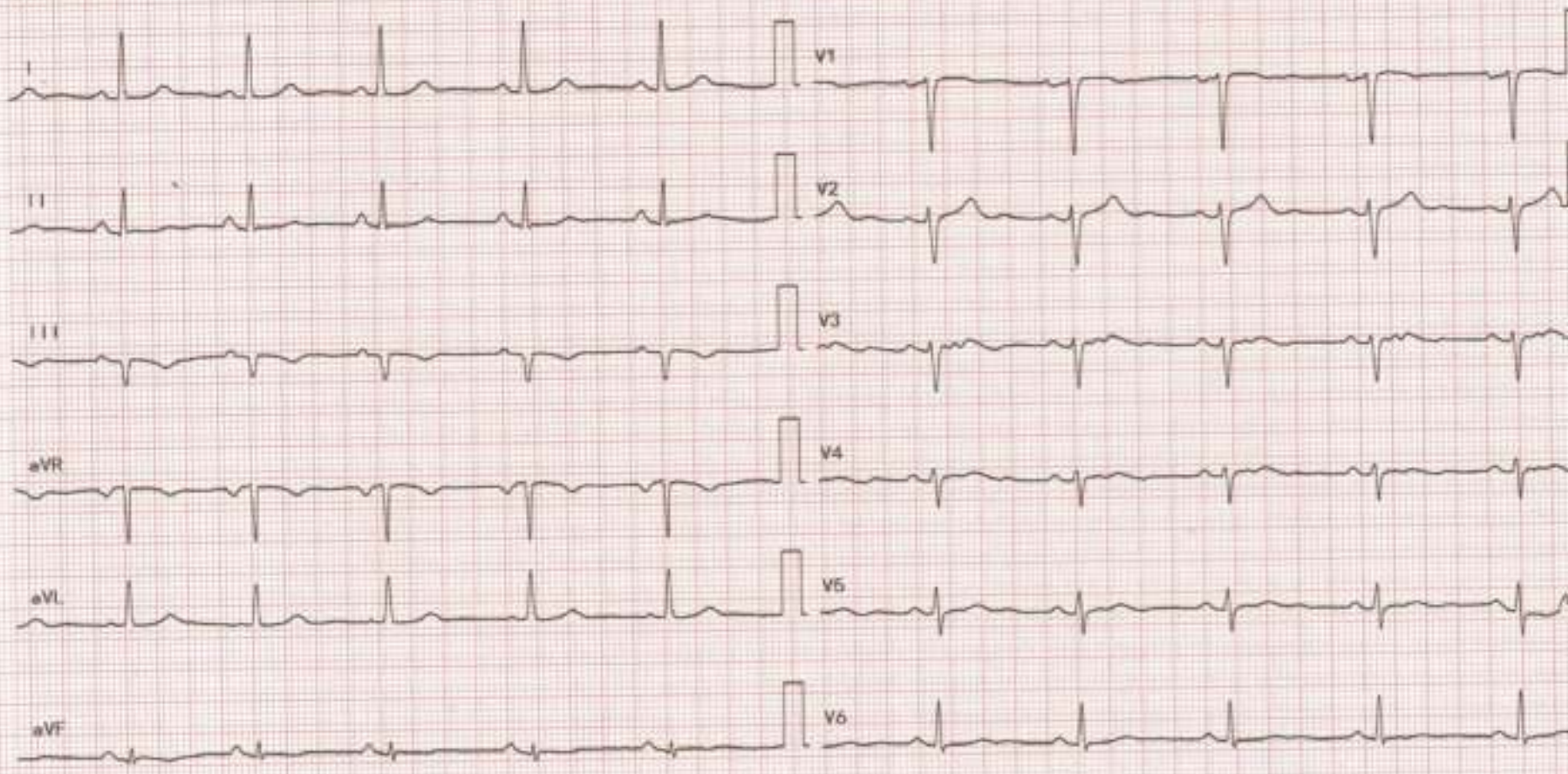
ID:19135
Name:Mr.Jyothi Shivaram
ex:F Birth date: 51 years
cm kg / mmHg
edication:
ymptoms:
istory:

ent. rate	68	bpm
R int	156	ms
RS dur	84	ms
T/QTc(E) int	368/ 385	ms
/QRS/T axis	56/ 7/ 3	°
V5/SV1 amp	0.44/ 1.13	mV
V5+SV1 amp	1.57	mV

1100 Sinus rhythm
3114 Cannot rule out anterior myocardial infarction, age undetermined [R amp. (V4) < 0.2 mV]
9150 ** abnormal 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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UNITED HOSPITAL
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Jayanagar, Bangalore

Out Patient Record

Patient Name	: **Mrs.JYOTHI SHIVARAM**	**UHID**	: **UHJA23019135**
Age / Sex	: 51 Years / Female	OP NO/Reg Dt	: 26-02-2024 08:00 AM
Spouse / Father Name	: SHIVARAM	Department	: Health check
Address	: flot no -1302 tower 10 sattva anugraha apps , , Bengaluru Urban, Karnataka, INDIA,	Refered By	: Corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha

Complaints / Findings / Observations : Ophthomology presciption

Rowin Eye test

Investigations:

VA C 6/24 NVA N10
6/90

Treatment / Care of Plan / Provisional Diagnosis :

ATC ©

Spectacle ©

Follow Up Advice :

Ly: Presbyopia / Astigmia ©

Signature of the Doctor
26/2/24

NSC +2.00
+2.00 } N6

Only reading

R 30/12/14

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Out Patient Record

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Age / Sex	: 51 Years / Female	OP NO/Reg Dt	: 26-02-2024 08:00 AM
Spouse / Father Name	: SHIVARAM	Department	:
Address	: flot no -1302 tower 10 sattva anugraha apps , , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Ashmitha Padma

Complaints / Findings / Observations :

Ht - 156 cm
Wt - 83.6 kg
BP - 130/70
PR - 78 bpm
SPO2 - 97 %
(55-60)

Investigations:

LDL - 144.

Uric acid - 6.7

Treatment / Care of Plan / Provisional Diagnosis :

℞

3 months.

Tab. Rosavel 10mg

0 0 1.

Follow Up Advice :

Adequate hydration.

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Jyothi Shivaram	**Date**	26/02/24
Age	51 years	**Hospital ID**	UHJA23019135
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS (TAS & TVS)

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 contracted. No obvious calculi are seen in the visualized portion of theh lumen. Suggested review scan if any gallbladder pathology is suspected.

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 (9.5 x 3.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.3 x 4.1 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 atrophic, measures 6.1 x 3.1 x 4.7 cms. Endometrium measures 3.5 mm.
Both ovaries appears atrophic.
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. Elluru Santosh Kumar
Consultant Radiologist

NABH NABL No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Jyothi Shivaram	**Date**	26/02/24
Age	51 years	**Hospital ID**	UHJA23019135
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Homogeneous fibroglandular background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

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

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Jyothi Shivaram	**Date**	26/02/24
Age	51 years	**Hospital ID**	UHJA23019135
Sex	Female	**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