

DEPARTMENT OF RADIO DIAGNOSIS

Name	Kancherla Kondal Rao	Date	10/02/24
Age	39 years	Hospital ID	UHJA23018089
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

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

ID: 23018089

Name: Mr. Kondalarao

Birth date: / /

kg mmHg

39 years

1100 Sinus rhythm
9110 ** normal ECG **

Indication:

Symptoms:

History:

Heart rate

69 bpm

RR interval

142 ms

RS duration

88 ms

PR/QTc(E) interval

372/392 ms

QRS/T axis

41/1/-6

M5/SV1 amp

1.14/0.30 mV

M5+SV1 amp

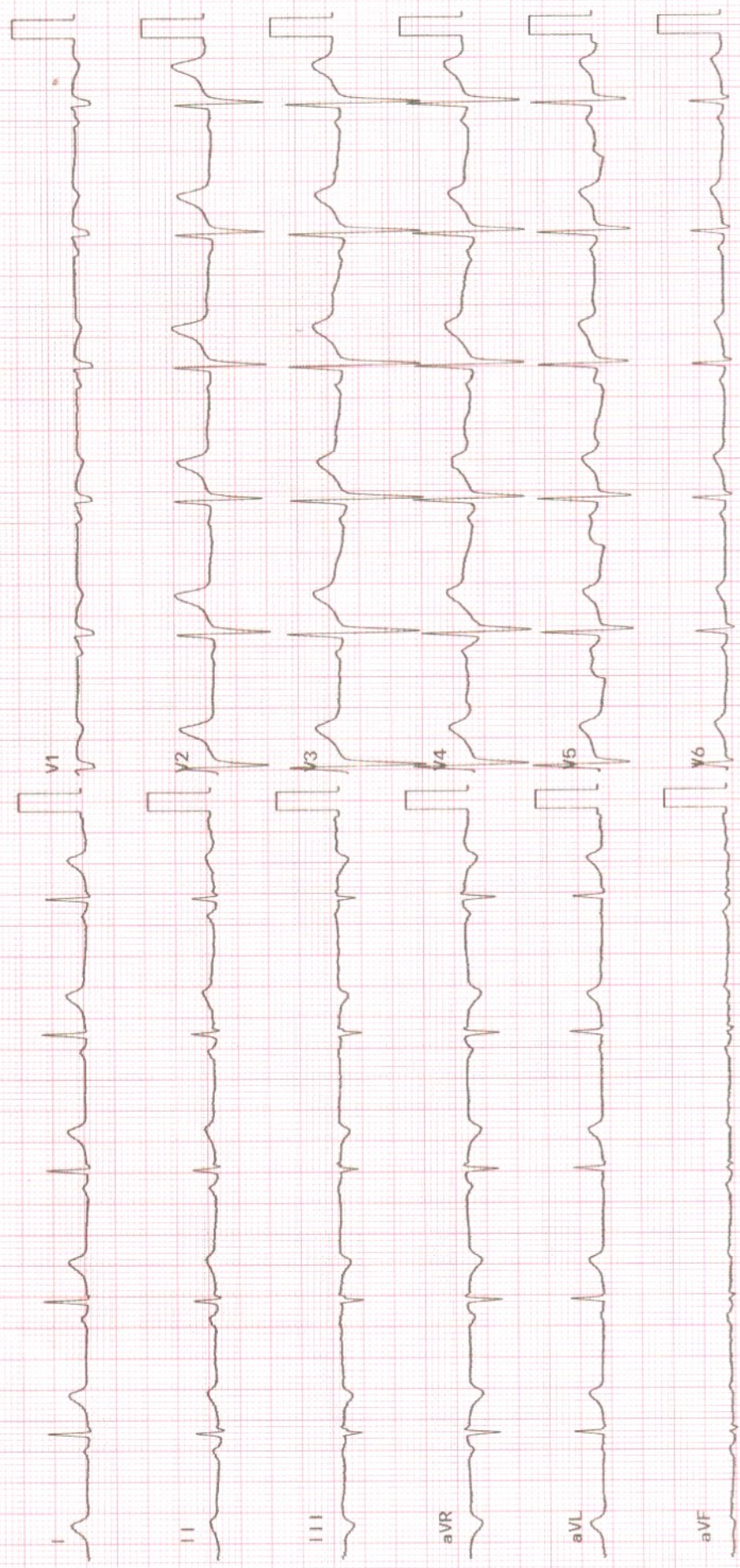
1.44 mV

Unconfirmed Report
Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s





NABH



NABL



No.1

Patient name :	Mr. KANCHERLA KONDALARAO	Date :	10/02/24
Age :	39 years GENDER: MALE	Patient ID :	18089
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

DEPARTMENT OF RADIODIAGNOSIS

Name	Kancherla Kondalarao	Date	10/02/24
Age	39 years	Hospital ID	UHJA23018089
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 (9.8 x 4.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (9.6 x 4.6 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 ~ 14 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

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KANCHERLA KONDALARAO	Order No	: 1000072357
UHID	: UHJ A23018089	Registered On	: 10/02/2024 09:06:58 AM
Age/Sex	: 39/Years Male	Collected On	: 10/02/2024 09:17:43 AM
Ward / Bed No	:	Reported On	: 10/02/2024 02:10:54 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230022377
Station	: At Hospital	Mobile No	: 9989994142
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	98	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	116	mg/dL	70-140
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.24	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.99	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.11	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	170	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	91	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	28.6	mg/dL	< 40 - Low ≥ 60 - High
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	123.2	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	18.19	mg/dL	< 30

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TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.9		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	4.3		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	141.4	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.2	mg/dL	3.5-7.2
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.54	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.44	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.18	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.22	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.29		2:1
SERUM SGOT (Method:IFCC without P5P)	35	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	35	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	113	U/L	50-116

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Test Name	Result	Unit	Bio. Ref. Interval
GGT (Method:IFCC)	21	U/L	< 55
CREATININE (Method:Modified Jaffe, Kinetic)	1.05	mg/dL	0.9-1.3



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)	11.68	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	36.6	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5720	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	51.15	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	35.88	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.69	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.95	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.33	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.41	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	67.6	fL	78-100
MCH (Method: Calculated)	21.6	pg	27-31
MCHC (Method: Calculated)	31.9	g/dL	31-37
RDW - CV (Method: Calculated)	18.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.28	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME (MPV) (Method: Derived from PLT Histogram)	8.83	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	37.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE (ESR) (Method: Modified Westergren Method)	22	mm/hour	1-15
BLOOD GROUPING & RH TYPING			
Sample: Whole blood (EDTA)			
ABO Group (Method: Agglutination Gel Method)	AB		
Rh Factor (Method: Agglutination Gel Method)	Negative		

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

PHYSICAL EXAMINATION

VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.030		1.005-1.030

CHEMICAL EXAMINATION

PROTEIN (Method:Protein Error of pH Indicator)	Trace		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	6-8	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
Parameshwar B

---End of Report---

Naveen M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418