UNITED HOSPITAL
Care Par Excellence

ilac-MRA

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SELVADURAI S	Order No	: 1000092994
UHID	: UHJA24004416	Registered On	: 10/08/2024 08:20:08 AM
Age/Sex	: 44/Years Male	Collected On	: 10/08/2024 08:38:27 AM
Ward / Bed No	:	Reported On	: 10/08/2024 03:29:08 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240006162
Station	: At Hospital	Mobile No	: 9480434856
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	102	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	232	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	6.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	143	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.61	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.28	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.95	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	126	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	99	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	32.4	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	73.8	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	19.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.8		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)	93.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.6	mg/dL	3.5-7.2

BUN/CREATININE RATIO — Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	6	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.9	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	7.0		12¯20 : 1

LIVER FUNCTION TEST — Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.59	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.14	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.45	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.5	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.66	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.84	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.64		2:1
SERUM SGOT (Method:IFCC without P5P)	20	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	19	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	60	U/L	50-116
GGT (Method:IFCC)	28	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.53	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)	12.9	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)	14.17	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	42.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7540	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	47.35	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	40.06	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.53	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.73	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.33	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.14	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	83.0	fL	78-100
MCH (Method: Calculated)	27.6	pg	27-31
MCHC (Method: Calculated)	33.2	g/dL	31-37
RDW - CV (Method: Calculated)	14.4	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.32	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.31	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.8	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	05	mm/hour	1-15

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

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

Interpretation Notes

Note: Both forward and reverse grouping performed

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Payer Name	: Mediwheel	Report Status	: Final Report

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	5.0		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)	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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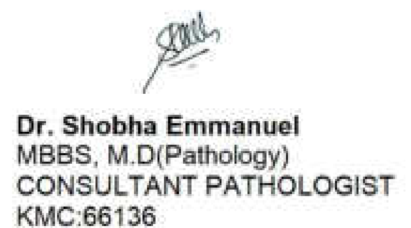
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	NIL		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Arpitha S R

---End of Report---



Dr. Shobha Emmanuel
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CONSULTANT PATHOLOGIST
KMC:66136

NABH NABL No.1

(4)

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.SELVADURAI S	UHID	: UHJA24004416
Age / Sex	: 44 Years / Male	OP NO/Reg Dt	: 10-08-2024 08:20 AM
Spouse / Father Name	: .	Department	: opthal
Address	: siddaya road , kr bank of baroda, , Bengaluru Urban, Karnataka, INDIA,	Refered By	: Mediwheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shweta

Complaints / Findings / Observations :

Investigations:

VA (glass) 6/6P, 6/6 } N6

FBS - 132
PPBS - 159.

Fundus Exam (3 with bad)

Treatment / Care of Plan / Provisional Diagnosis :

A/S OU Normal

Fundus OU CD ratio 0.3:1 (R=L) (undilated)

Follow Up Advice :

Imp: OU Ref Error

Signature of the Doctor

Dr. Shweta

NABH No.1

Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.SELVADURAI S	UHID	: UHJA24004416
Age / Sex	: 44 Years / Male	OP NO/Reg Dt	: 10-08-2024 08:20 AM
Spouse / Father Name	: .	Department	:
Address	: siddaya road , kr bank of baroda, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

No current complains

K/c/o HTN, DM type 2, dyslipidemia on regular Rx.

BP - 120/90 mmHg
SpO2 - 99 %
P - 85 b/mt
Ht - 170 cm
wt - 109 kg

Investigations:

Reports Noted

FBS/PPBS 102/232
HBA1C 6.6

Treatment / Care of Plan / Provisional Diagnosis :

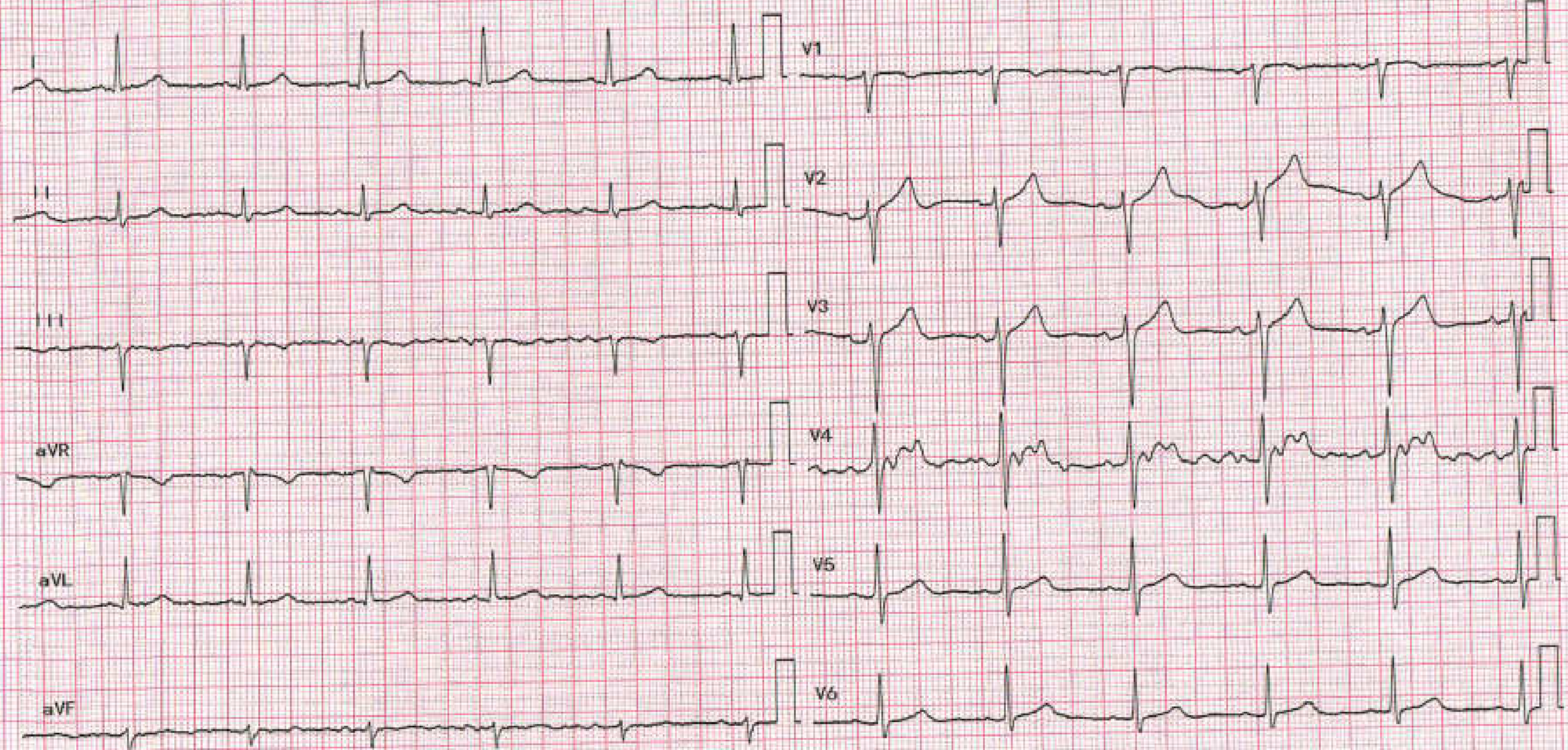
Systemic Exam:
Normal findings Noted.

Tab. GEPRIDE M1
0-0-1 → 1-0-1 (B/F) x 1 month

Follow Up Advice : If symptoms of hypoglycemia occur stop medication & Review in OPD.

10/8/24

Signature of the Doctor



Part No.2.157017M
10-Aug-2024 AM9:11:02
SCHILLER
Birth date:
kg
/ mmHg
44 years
1100 Sinus rhythm
9110 ** normal ECG **
72 bpm
150 ms
86 ms
382/ 407 ms
30/ -3/ 17 °
V5/SV1 amp 0.96/ 0.63 mV
V5+SV1 amp 1.60 mV
Unconfirmed Report
Reviewed by:
10 mm/mV 25 mm/s Filter: H50 D 35 Hz
10 mm/mV
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
2350K 03-08 07-01 Dept.:
Exam: UNITED HOSPITAL

(a)

NABH No.1

Out Patient Record

Patient Name	: Mr.SELVADURAI S	UHID	: UHJA2400-1116
Age / Sex	: 44 Years / Male	OP NO/Reg Dt	: 10-08-2024 08:20 AM
Spouse / Father Name	: .	Department	:
Address	: siddaya road , kr bank of baroda, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

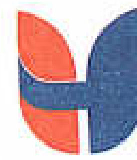
BP - 120/90 mmHg
SpO2 - 99 %
P - 85 b/mt
Ht - 170 cm
wt 109 kg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor



UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME :	Mr. SELVADURAI S	DATE :	10/08/24
AGE :	44 YEARS GENDER : MALE	PATIENT ID :	24004416
REF BY :	CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M - MODE AND DOPPLER MEASUREMENTS

(cm)	(cm)	(cm/sec)		
AO : 3.1 (2.5-3.7)	LVIDD : 4.9 (3.5-5.5)	MV EV : 1.0	AV : 0.7	MR : TRIVIAL MR
LA : 3.8 (1.9-4.0)	LVIDS : 3.2 (2.4-4.2)	AV : 1.2		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 0.9		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.3 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.0 (>1.6)	LVPWD : 1.3 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: MILD CONCENTRIC LVH
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:

MILD CONCENTRIC LV HYPERTROPHY
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

NABH No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Selvadurai S	Date	10/08/24
Age	44 years	Hospital ID	UHJA24004416
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. Manu Srinivas H, MD, RD
Consultant Radiologist

NABH No.1

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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Selvadurai S	Date	10/08/24
Age	44 years	Hospital ID	UHJA24004416
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size (14.0 cms) 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 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 (11.8 cms), shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (9.9 x 5.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (9.8 x 4.7 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.

Prostate is normal in echopattern and size, measures ~ 20 cc.

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

IMPRESSION:

- **Mild fatty infiltration of liver (Grade I).**
- **No other definite sonological abnormality detected.**

Dr. Manu Srinivas H, MD, RD.
Consultant Radiologist