

## DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. VISHWANATHA NAIK N	Order No	: 1000097474
UHID	: UHJ A24006012	Registered On	: 28/09/2024 07:51:22 AM
Age/Sex	: 47/Years Male	Collected On	: 28/09/2024 08:21:24 AM
Ward / Bed No	:	Reported On	: 28/09/2024 11:32:22 AM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJ A240008287
Station	: At Hospital	Mobile No	: 9945185857
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	101	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	119	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	5.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
<b>Estimated Average Glucose (eAG)</b> (Method: Calculated)	123	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method: CLIA)	0.78	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method: CLIA)	7.76	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method: CLIA: Ultra-sensitive)	1.73	μIU/mL	0.34-5.60
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method: CHOD-POD)	242	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method: Enzymatic GPO-POD)	154	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method: ENZYMATIC METHOD)	54.1	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	157.10	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	30.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.47		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.90		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	187.90	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	6.8	mg/dL	3.5-7.2
<b>BUN/CREATININE RATIO</b>			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.95	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	9.47		12~20 : 1
<b>LIVER FUNCTION TEST</b>			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.01	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.23	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.78	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.02	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.08	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.31		2:1
SERUM SGOT (Method:IFCC without P5P)	37	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	35	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	55	U/L	50-116
GGT (Method:IFCC)	36	U/L	< 55
<b>PROSTATE SPECIFIC ANTIGEN (PSA)</b> (Method:CLIA)	1.12	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.

<b>UREA</b> (Method:Urease GLDH - Kinetic)	18.5	mg/dL	17-43
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**Dr. Varsha Shree R**  
 M.D(Pathology)  
 CONSULTANT PATHOLOGIST  
 KMC No : 103567

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**HAEMATOLOGY**
**COMPLETE BLOOD COUNT(CBC)**

Sample: Whole blood (EDTA)

<b>HAEMOGLOBIN</b> (Method:Photometric Measurement: Oxyhemoglobin method)	15.07	g/dL	13.5-17.5
<b>PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)</b> (Method: Calculated)	46.0	%	42-52
<b>TOTAL WBC COUNT (TLC)</b> (Method:Coulter Principle)	5330	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> (Method:Optical/Impedance)	56.81	%	40-75
<b>LYMPHOCYTES</b> (Method:Optical/Impedance)	30.69	%	20-45
<b>EOSINOPHILS</b> (Method:Optical/Impedance)	4.06	%	0-6
<b>MONOCYTES</b> (Method:Optical/Impedance)	8.00	%	2-10
<b>BASOPHILS</b> (Method:Optical/Impedance)	0.44	%	0-2
<b>RED BLOOD CORPUSCLES(RBC)</b> (Method:Coulter Principle)	5.30	million/cum	4.5-5.9
<b>MCV</b> (Method:Derived from RBC Histogram)	86.7	fL	78-100
<b>MCH</b> (Method: Calculated)	28.4	pg	27-31
<b>MCHC</b> (Method: Calculated)	32.8	g/dL	31-37
<b>RDW - CV</b> (Method: Calculated)	13.4	%	11.5-14.5
<b>PLATELET COUNT</b> (Method:Electrical Impedance)	2.26	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)	7.96	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.7	fl	9-19
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	06	mm/hour	1-15
<b>BLOOD GROUPING &amp; RH TYPING</b>			Sample: Whole blood (EDTA)
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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CLINICAL PATHOLOGY
**URINE EXAMINATION, ROUTINE**

Sample: Urine

**PHYSICAL EXAMINATION**

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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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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		
<b>URINE SUGAR, FASTING</b> (Method:GOD-POD)	Absent		
<b>URINE SUGAR (POST PRANDIAL)</b>	Absent		

Verified By  
Arpitha S R

---End of Report---



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NON HDL CHOLESTEROL (Method: Calculated)	187.90	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	6.8	mg/dL	3.5-7.2
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AG RATIO (Method: Calculated)	1.31		2:1
SERUM SGOT (Method:IFCC without P5P)	37	U/L	< 50
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<b>UREA</b> (Method:Urease GLDH - Kinetic)	18.5	mg/dL	17-43
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**HAEMATOLOGY**
**COMPLETE BLOOD COUNT(CBC)**

Sample: Whole blood (EDTA)

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<b>PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)</b> (Method: Calculated)	46.0	%	42-52
<b>TOTAL WBC COUNT (TLC)</b> (Method:Coulter Principle)	5330	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> (Method:Optical/Impedance)	56.81	%	40-75
<b>LYMPHOCYTES</b> (Method:Optical/Impedance)	30.69	%	20-45
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<b>MONOCYTES</b> (Method:Optical/Impedance)	8.00	%	2-10
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<b>MCV</b> (Method:Derived from RBC Histogram)	86.7	fL	78-100
<b>MCH</b> (Method: Calculated)	28.4	pg	27-31
<b>MCHC</b> (Method: Calculated)	32.8	g/dL	31-37
<b>RDW - CV</b> (Method: Calculated)	13.4	%	11.5-14.5
<b>PLATELET COUNT</b> (Method:Electrical Impedance)	2.26	Lakhs/Cum	1.5-4.5

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PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.7	fl	9-19
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	06	mm/hour	1-15
<b>BLOOD GROUPING &amp; RH TYPING</b>			Sample: Whole blood (EDTA)
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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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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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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		
<b>URINE SUGAR, FASTING</b> (Method:GOD-POD)	Absent		
<b>URINE SUGAR (POST PRANDIAL)</b>	Absent		

Verified By  
Arpitha S R

---End of Report---



**Dr. Varsha Shree R**  
M.D(Pathology)  
CONSULTANT PATHOLOGIST  
KMC No : 103567



### Out Patient Record

Care Par Excellence  
Jayanagar, Bangalore

NABH No.1  
Patient Name : Mr.VISHWANATHA NAIK N  
Age / Sex : 47 Years / Male  
Spouse / Father Name : ARCHANA V NAIK  
Address : 4TH FLOOR LAKSHMAIAH BLOCK  
GANGA NAGAR, . Bengaluru Urban,

UHID : UHJA24006012  
OP NO/Reg Dt : 28-09-2024 07:51 AM  
Department :  
Referred By :  
Consultant : Dr.Ashmitha Padma MBBS, MD  
(GENERAL MEDICINE), PGDCC,FEM  
KMC No. : 02M1087

#### Complaints / Findings / Observations :

HT: 162cm  
Wt: 71.8 kg  
BP:  
SpO<sub>2</sub>: 98%  
PR 74 bpm

#### Investigations:

#### Treatment / Care of Plan / Provisional Diagnosis :

#### Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL (A Unit of United Brothers Healthcare Services Private Limited)



NABH



No.1

Care Par Excellence  
Jayanagar, Bangalore

PATIENT NAME :	Mr. VISHWANATHA NAIK N	DATE :	28/09/24
AGE :	42 YEARS GENDER : MALE	PATIENT ID :	24006012
REF BY :	CMO	OP/ IP :	HEALTH CHECK

**2D- ECHOCARDIOGRAPHY  
M - MODE AND DOPPLER MEASUREMENTS**

(cm)	(cm)	(cm/sec)	
AO : 2.7 (2.5-3.7)	LVIDD : 3.7 (3.5-5.5)	MV EV: 0.5 AV: 0.8	MR : NORMAL
LA : 2.9 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 1.0	AR : NORMAL
RA : 2.1 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 0.8	PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 0.8 (0.9-1.2)	TV EV : ---- AV : ----	TR : NORMAL
TAPSE : 1.8 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : GRADE I LVDD	
	LVPWS : 0.9 (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 AND COLLAPSING

**IMPRESSION:**

NORMAL CHAMBER DIMENSIONS  
 NORMAL LV SYSTOLIC FUNCTION EF : 60%  
 GRADE I LV DIASTOLIC DYSFUNCTION  
 NO PULMONARY ARTERY HYPERTENSION  
 NO REGIONAL WALL MOTION ABNORMALITIES  
 NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

  
**DR. RAHUL S PATIL**  
 CONSULTANT CARDIOLOGIST

**UNITED HOSPITAL** (A Unit of United Brothers Healthcare Services Private Limited)





N.

No.1

**DEPARTMENT OF RADIODIAGNOSIS**

Name	Vishwanatha Naik N	Date	28/09/24
Age	47 years	Hospital ID	UHJA24006012
Sex	Male	Ref.	Health check

**ULTRASOUND ABDOMEN AND PELVIS**

**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 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 (10.1 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

**Left Kidney** is normal in size (10.3 x 4.0 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 minimally distended.

**Prostate** is normal in echopattern and size, measures ~ 10.2 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. Elluru Santosh Kumar  
Consultant Radiologist



NABH



No.1



## DEPARTMENT OF RADIODIAGNOSIS

<b>Name</b>	Vishwanatha Naik N	<b>Date</b>	28/09/24
<b>Age</b>	47 years	<b>Hospital ID</b>	UHJA24006012
<b>Sex</b>	Male	<b>Ref.</b>	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

ID: 24006012

Name: mr. vishwanatha

Birth date: /

47 years

1100 Sinus rhythm

0102 ARTIFACT PRESENT

9110 \*\* normal ECG \*\*

Sex: M cm kg mmHg

Indication:

Symptoms:

History:

Heart rate 73 bpm

PR interval 134 ms

QRS duration 84 ms

QT/QTc (E) interval 368/394 ms

QT/QTc (T) axis 39/48/40 °

RV5/SV1 amplitude 1.33/0.83 mV

RV5+SV1 amplitude 2.16 mV

Unconfirmed Report

Reviewed by:

10 mm/mV

10 mm/mV 25 mm/s Filter: H50 D 35 Hz

