

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. MN KRUPAKAR	Order No : 1000100827
UHID : UHJA24007147	Registered On : 26/10/2024 08:42:56 AM
Age/Sex : 57/Years Male	Collected On : 26/10/2024 08:46:39 AM
Ward / Bed No :	Reported On : 26/10/2024 12:26:53 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJA240009731
Station : Corp	Mobile No : 9845213008
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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BIOCHEMISTRY

FASTING GLUCOSE (Method: Hexokinase)	102	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
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POST PRANDIAL GLUCOSE (Method: Hexokinase)	157	mg/dL	70-140
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GLYCOSYLATED HAEMOGLOBIN (HBA1C) Sample: Whole blood (EDTA)

HBA1C (Method: HPLC)	6.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
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Estimated Average Glucose (eAG) (Method: Calculated)	140	mg/dL	
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THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH) Sample: Serum

TOTAL T3 (Method: CLIA)	0.98	ng/mL	0.87-1.78
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TOTAL T4 (Method: CLIA)	11.11	µg/dL	5.1-14.1
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THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	1.58	µIU/mL	0.38-5.33
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LIPID PROFILE Sample: Serum

TOTAL CHOLESTEROL (Method: CHOD-POD)	176	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
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TRIGLYCERIDES (Method: Enzymatic GPO-POD)	87	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
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HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	40.5	mg/dL	< 40 - Low ≥ 60 - High
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LDL CHOLESTEROL (Method: Calculated)	118.10	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	17.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.35		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.92		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	135.50	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.0	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	7	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.73	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	9.5		12–20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.64	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.53	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)	4.71	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.39	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.97		2:1
SERUM SGOT (Method:IFCC without P5P)	26	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	36	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	82	U/L	50-116
GGT (Method:IFCC)	40	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	3.59	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)	14.2	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)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.32	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	47.0	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5150	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	48.28	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.58	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	8.68	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.24	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.22	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.47	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	85.9	fL	78-100
MCH (Method: Calculated)	28.0	pg	27-31
MCHC (Method: Calculated)	32.6	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.65	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) <small>(Method:Derived from PLT Histogram)</small>	7.35	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) <small>(Method: Calculated)</small>	18.6	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) <small>(Method: Calculated)</small>	2490	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) <small>(Method: Calculated)</small>	450	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) <small>(Method: Calculated)</small>	1880	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) <small>(Method: Calculated)</small>	320	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) <small>(Method: Calculated)</small>	10	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) <small>(Method:Modified Westergren Method)</small>	14	mm/hour	1-20

BLOOD GROUPING & RH TYPING

ABO Group <small>(Method:Agglutination Method)</small>	A
Rh Factor <small>(Method:Agglutination Method)</small>	Positive

Interpretation Notes

Note: Both forward and reverse grouping performed

Sample: Whole blood (EDTA)

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CLINICAL PATHOLOGY

**URINE EXAMINATION, ROUTINE
PHYSICAL EXAMINATION**

Sample: Urine

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.010		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	2-4	/HPF	0-5
PUS CELLS	4-6	/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
G Mahesh kumar

---End of Report---



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



Out Patient Record

NABH

No.1

Patient Name : Mr.MNKRUPAKAR
 Age / Sex : 57 Years / Male
 Spouse / Father Name : S J SREEVALLI
 Address : padmanabha nagar ... Bengaluru Urban,
 Karnataka, INDIA,

UHID : UHJA24007147
 OP NO/Reg Dt : 26-10-2024 08:42 AM
 Department :
 Referred By :
 Consultant : Dr.Ashmitha Padma MBBS, MD
 (GENERAL MEDICINE), PGDCC,FEM
 : 02M1087
 KMC No. :

Complaints / Findings / Observations :

HTN - 1. Amlong.
img

HT - 175 cm
 wt - 79.9 kg.
 BP - 152/92.
 PR - 76b/min
 SpO2 - 98%

Investigations:

HbA1c - 6.5%.

Treatment / Care of Plan / Provisional Diagnosis :

After 2 month.
 Repeat HbA1c.

Follow Up Advice :

1. Glyconil ER
 100

1 0 0

Signature of the Doctor



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

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Age / Sex : 57 Years / Male

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(GENERAL MEDICINE), PGDCC,FEM

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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)



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

NABH

No.1

PATIENT NAME :	Mr. M N KRUPAKAR	DATE :	26/10/24
AGE :	57 YEARS GENDER : MALE	PATIENT ID :	24007147
REF BY :	CMO	OP/ IP :	HEALTH CHECK

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

(cm)	(cm)	(cm/sec)		
AO : 2.3 (2.5-3.7)	LVIDD : 5.0 (3.5-5.5)	MV EV: 0.9	AV: 0.9	MR : TRIVIAL MR
LA : 3.5 (1.9-4.0)	LVIDS : 3.2 (2.4-4.2)	AV : 1.2		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 0.8		PR : NORMAL
RV : 1.6 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR, PASP-32mmHg
TAPSE : 1.8 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : GRADE II LVDD		
	LVPWS : 1.0 (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 II 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)



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	MN Krupakar	Date	26/10/24
Age	57 years	Hospital ID	UHJA24007147
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

57 years

1100 Sinus rhythm
0102 ARTIFACT PRESENT
9110 ** normal ECG **

ex: M cm kg Birth date: / mnh/g

Indication:

Symptoms:

History:

ent. rate

R int

RS dur

II/OTc(E) int

VQRS/T axis

V5/SV1 amp

V5+SV1 amp

74 bpm
154 ms
92 ms
384/411 ms
71/28/46 ms
1.44/0.93 mV
2.37 mV

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

10 mm/mV

Unconfirmed Report
Reviewed by:

