



Vasavi Hospitals

LABORATORY

WE CURE WITH CARE
(A Unit of Sree Vasavi Trust)

Patient Name	Mr. GURUPRASAD TODUR	Lab No	56613
UHID	210274	Sample Date	13/03/2023 8:55AM
Age/Gender	34 Yrs/Male	Receiving Date	13/03/2023 9:35AM
Bed No/Ward	OPD	Report Date	13/03/2023 1:39PM
Referred By	Dr. SRIDHAR SRINIVASAN G	Report Status	Final
Bill No.	OPCR/23/7350	Manual No.	

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
Sample: Serum				
BLOOD UREA NITROGEN	9.6	mg/dl	Upto 14 years : 5 - 18 mg/dl Male (above 14 years): 8 - 24 mg/dl Female (above 14 years): 6 - 21 mg/dl Pregnant women : 5 - 12 mg/dl	
SERUM CREATININE	0.75	mg/dl	0.60 - 1.40	
FASTING BLOOD SUGAR	103.6 H	mg/dl	74.00 - 100.00	
GLYCOSYLATED HAEMOGLOBIN (HbA1c)				
HbA1c (GLYCOSYLATED Hb)	5.6	%	4.00 - 6.00	Immunoturbidimetric
MEAN BLOOD GLUCOSE	114.02	mg/dl	70.00 - 140.00	
LIPID PROFILE				
TOTAL CHOLESTEROL	189	mg/dl	0.00 - 200.00	
TRIGLYCERIDES	80.2	mg/dl	0.00 - 200.00	
HDL CHOLESTEROL - DIRECT	44.0	mg/dl	35.00 - 55.00	
LDL CHOLESTEROL - DIRECT	118.2	mg/dl	0.00 - 130.00	
TC/HDL	4.30			
LDL/HDL	2.69			

Sample: Serum

LIVER FUNCTION TEST (LFT)



Verified By
KIRAN KUMAR S

Ravi Shankar K

Ravi Shankar K
Bio Chemist

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Page: 1 Of 5

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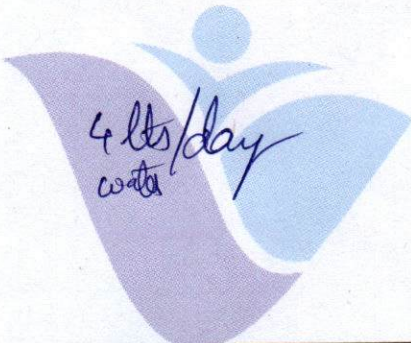
TOTAL BILIRUBIN 0.44 mg/dl Adult - 0.2 - 1.3 mg/ dL

Special condition:

Premature - <2.0 mg/ dL
Full term - <2.0 mg/ dL
0-1 day - Premature- 1.0 - 8.0 mg/ dL
0-1 day - Full term - 2.0 - 6.0 mg/ dL
1 - 2 days Premature - 6.0 - 12.0 mg/ dL
1 - 2 days Full term - 6.0 - 10.0 mg/ dL
3 - 5 days Premature - 10.0 - 14.0 mg/ dL
3 - 5 days Full term - 4.0 - 8.0 mg/ dL

DIRECT BILIRUBIN	0.20	mg/dl	0.00 - 0.30
INDIRECT BILIRUBIN.	0.24	mg/dl	
ASPARATE AMINOTRANSFERASE (SGOT/AST)	19.3	U/L	0.00 - 40.00
ALANINE AMINOTRANSFERASE (SGPT/ALT)	20.7	U/L	0.00 - 40.00
ALKALINE PHOSPHATASE (ALP)	66	IU/L	53.00 - 128.00
TOTAL PROTEIN	6.00	g/dl	6.00 - 8.50
SERUM ALBUMIN	4.16	g/dl	3.50 - 5.20
SERUM GLOBULIN	1.84 L	g/dl	2.30 - 3.50
A/G RATIO	2.26 H	%	1.00 - 1.50
POST PRANDIAL BLOOD GLUCOSE	88.8	mg/dl	70.00 - 140.00
URIC ACID	8.2 H	mg/dl	4.50 - 8.10

--End Of Report--



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Ravi Shankar
Ravi Shankar K
Bio Chemist

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UHID	210274	Sample Date	13/03/2023 8:55AM	
Age/Gender	34 Yrs/Male	Receiving Date	13/03/2023 9:35AM	
Bed No/Ward	OPD	Report Date	13/03/2023 1:05PM	
Referred By	Dr. SRIDHAR SRINIVASAN G	Report Status	Final	
Bill No.	OPCR/23/7350	Manual No.		

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
UIRNE GLUCOSE FASTING				
URINE SUGAR	NIL		NEGATIVE	Sample: Urine
PHYSICAL CHARACTERS				
COLOUR	Pale Yellow			
APPEARANCE	Clear		Clear	
SPECIFIC GRAVITY	1.015			
PH	6.0			
CHEMICAL CONSTITUENTS				
ALBUMIN	Nil			
SUGAR	Nil			
BILE SALTS	Absent			
BILE PIGMENTS	Absent			
KETONE BODIES	NEGATIVE			
BLOOD	Absent			
MICROSCOPY				
PUS CELLS	1-2 /HPF			
R.B.C	Nil			
EPITHELIAL CELLS	0-1 / HPF			
CASTS	Absent			
CRYSTALS	Absent			
BACTERIA	Absent			

--End Of Report--



Verified By
KIRAN KUMAR S

Badarinath S

BADARINATH S
MD (PGI) KMC No 19014
HEMATOPATHOLOGIST / PATHOLOGIST

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Patient Name	Mr. GURUPRASAD TODUR	Lab No	56613	WE CURE WITH CARE (A Unit of Sree Vasavi Trust)
UHID	210274	Sample Date	13/03/2023 8:55AM	
Age/Gender	34 Yrs/Male	Receiving Date	13/03/2023 12:43PM	
Bed No/Ward	OPD	Report Date	13/03/2023 1:05PM	
Referred By	Dr. SRIDHAR SRINIVASAN G	Report Status	Final	
Bill No.	OPCR/23/7350	Manual No.		

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
URINE GLUCOSE-POST PRANDIAL				
URINE SUGAR	NIL		NEGATIVE	

--End Of Report--



Verified By
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Ravi Shankar K
Ravi Shankar K
Bio Chemist

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UHID	210274	Sample Date	13/03/2023 8:55AM	
Age/Gender	34 Yrs/Male	Receiving Date	13/03/2023 9:35AM	
Bed No/Ward	OPD	Report Date	13/03/2023 11:52AM	
Referred By	Dr. SRIDHAR SRINIVASAN G	Report Status	Final	
Bill No.	OPCR/23/7350	Manual No.		

HAEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD GROUP	"A"			
RH TYPE	POSITIVE			
			Sample: Blood	
HAEMOGLOBIN	14.5	gm/dl	14.00 - 18.00	
TOTAL COUNT	13170 H	cells/cumm	4500.00 - 11000.00	
DLC				
NEUTROPHILS	67 H	%	35.00 - 66.00	
LYMPHOCYTES	26	%	24.00 - 44.00	
MONOCYTES	06	%	4.00 - 10.00	
EOSINOPHILS	01	%	1.00 - 6.00	
BASOPHILS	00	%	0.00 - 1.00	
R.B.C COUNT	4.95	mill/cumm	4.50 - 5.90	
PACKED CELL VOLUME (PCV)	41.7	%	40.00 - 50.00	
PLATELET COUNT	4.13	lakh/cumm	1.50 - 4.50	
M.C.V	84.3	fL	80.00 - 100.00	
M.C.H	29.3	pg	26.00 - 34.00	
M.C.H.C	34.8	%	32.00 - 36.00	
ESR (ERYTHROCYTE SEDIMENTATION RATE)	20 H	mm/hr	0.00 - 10.00	

--End Of Report--



Verified By
KIRAN KUMAR S

Badarinath S

BADARINATH S
MD (PGI) KMC No 19014
HEMATOPATHOLOGIST / PATHOLOGIST

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Vasavi Hospitals

DEPARTMENT OF RADIOLOGY & IMAGING

Patient Name	Mr. GURUPRASAD TODUR	RIS No	56613	WE CURE WITH CARE (A Unit of Sree Vasavi Trust)
UHID	210274	Order Date	13/03/2023 8:55AM	
Age/Gender	34 Yrs/Male	Receiving Date	13/03/2023 11:18AM	
Bed No/Ward	OPD	Report Date	13/03/2023 11:21AM	
Referred By	Dr. SRIDHAR SRINIVASAN G	Report Status	Final	
Bill No.	OPCR/23/7350	Manual No.	25400	

USG

LIVER: Liver is 14.8 cm in size, both lobes of liver are normal in size with homogeneous echotexture. No evidence of any focal lesion / intrahepatic biliary dilatation noted. CBD and Portal vein normal in size and echotexture.

GALL BLADDER: Well distended, gall bladder wall thickness is normal. Contents are clear. No evidence of gall stones / cholecystitis.

PANCREAS: Head and body appears normal. Uncinate process and tail could not be assessed due to bowel gas. MPD is normal.

SPLEEN: Normal in size measuring 10.3 cms with normal echotexture.

KIDNEYS: Both Kidneys are normal in size, shape, contour & position. Cortico medullary differentiation is well maintained. No evidence of any hydronephrosis / hydroureter.

Right Kidney measures : 11.7 x 4.4 cms. Parenchymal thickness 1.8 cms.

Left Kidney measures : 11.3 x 5.1 cms. Parenchymal thickness 1.9 cms.

URINARY BLADDER: Well distended with clear contents. Wall thickness is normal.

PROSTATE: Normal in size and echotexture. Vol: 9.5 cc.

No focal lesion seen. Both seminal vesicles appear normal.

No obvious free fluid in the peritoneal cavity.

IMPRESSION: NO SONOLOGICAL ABNORMALITY DETECTED.

**** Note: All abnormalities cannot be detected by Ultrasound scan due to technical limitation, obesity and other factors. Scan findings to be correlated with old reports or other investigations.**

--End Of Report--

Verified By
Ms Hemalatha K R

Dr. KIRUTHIKA SELVARAJ
MBBS, DMRD
CONSULTANT RADIOLOGIST

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24/7 Radiology Services (Digital X-Ray, Ultrasound, Computed Tomography (CT))



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DEPARTMENT OF RADIOLOGY & IMAGING

Patient Name	Mr. GURUPRASAD TODUR	RIS No	56613
UHID	210274	Order Date	13/03/2023 8:55AM
Age/Gender	34 Yrs/Male	Receiving Date	13/03/2023 9:13AM
Bed No/Ward	OPD	Report Date	13/03/2023 3:27PM
Referred By	Dr. SRIDHAR SRINIVASAN G	Report Status	Final
Bill No.	OPCR/23/7350	Manual No.	46594

X-RAY

CHEST PA VIEW (X RAY)

FINDINGS:

The lungs on the either side show equal translucency.

Cardiac size and ventricular configuration are normal.

Both hilar region appear normal.

Both C P angles appear clear.

Both domes of diaphragm appear normal.

Bony cage and soft tissue appear normal.

IMPRESSION: ESSENTIALLY NORMAL STUDY.

--End Of Report--



Verified By

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DIET SHEET

Name: Ma Gunderand Tothua Age: 34 / 04 Sex: M/F

Height: 176 Cms Weight: 77 Kgs IBW: 76

Total Calories: 1800 kcal

Morning: Coffee / Tea / Milk 1 cup (with Skimmed milk) / Green Tea 1 cup

Breakfast: 8 am - 9 am

Idly 4 / Dosa 3 / Roti (millets) / Pulkas 3 / Upma / Pongal / Rice 2 cup /

Brown Bread / White Bread Slices 4 / Oats / Muesli / Cornflakes 1 cup +

Vegetable Salad 1 cup / Sprouts 1 cup / Fruit - 1 bowl / Egg - 1

Sambar 1 cup / Chutney 1 tsp

Mid morning: 11 am - 11.30 am

Fruit 1 no / Buttermilk 1 glass / Fruit juice 1 glass / Soup 1 glass

Rice flakes with Milk 1 cup / Ragimalt 1 glass / Dry fruits - 10 - 15 nos

Lunch: 1pm - 2 pm

Rice 1 1/2 bowl / Pulkas 3 / Millets 1 bowl / Rice 1/2 bowl + Pulka 1 /

Ragiball 1 + Dhal / Sambar 1 cup + Rasam 1 cup + Green leafy /

Vegetable Palya 1 cup + Salad 1 cup + Curds / Buttermilk 1 cup

Evening: 4pm - 6 pm

Coffee/ Tea 1 cup + Biscuits 3 nos / Fruit 1 / Sprouts / Boiled legumes 1 cup

Dinner: 8.00 pm - 9.00 pm

Same as Lunch or Breakfast ✓

Bed Time:

Milk - 1 Cup / Butter Milk - 1 Glass

Non Veg: Skin out chicken 3 / Fish 3 (Weekly once/ 15 days once) Avoid Mutton.

Oil 3 tsp

Fluids: 2lts/day

Exercise: Regular

FOODS TO BE RESTRICTED:

- * Dairy Products: Whole milk, milk cream, ghee, butter, cheese
- * Animal Products: Red meat, skin with chicken, sea foods, organ meats (liver, kidney, brain and heart)
- * Cooking Oil: Dalda
- * Bakery products: Cakes, puffs, cream biscuits, chocolates, pizza, pasta, maida processed foods
- * Drinks: Milk shakes, sweetened juices, proprietary drinks, carbonated, alcohol
- * Fried foods, fried dhals, gravy foods, processed and canned foods, spices

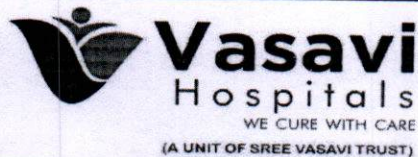
FOODS TO BE RECOMMENDED:

- * Cereals: Whole grains, unpolished rice/ brown rice/ broken wheat
- * Pluses: Whole gram, dhals, sprouts
- * Vegetables: All fibrous vegetables, green leafy vegetables, salads
- * Fruits: All fruits
- * Milk and Milk Products: Skimmed milk, butter milk, skimmed curds
- * Animal products: Skin out chicken, fish, egg
- * Fats & Oils: source of oil should be changed every month like canola oil, groundnut oil, olive oil, rice bran oil, sunflower oil, safflower oil, soya oil, mustard oil, sesame oil.

Tips:

- * Never skip meals
- * Eat high fibre food
- * Exercise regularly
- * Include vegetables, green leafy vegetables and fruits in your diet
- * Keep on changing source of oil every month.
- * Follow the healthy guidelines while eating out
- * Choose healthy snacks
- * Small and frequent meals at regular intervals should be taken
- * Chew food properly

OPD Prescription



Reg. No 210274 Issue Date 13/3/2023
 Name Mr. Gueuprasad Todur Age/Sex 34y/m
 Doctor Dr. Seidhae S Department _____
 Patient Mob. 9742423174 Category _____

BP: 120/70 Height: 176cm Weight: 77kg Pain: _____ Pulse: 90b/min Temperature: 37.0 SpO2: 99%

Allergies: YES NO Details: _____ COVID 19 Positive: YES NO

Previous Drug Reactions: YES NO Details: _____

History and complaints: No fresh complaints

Past History: ole no pallor as-se heard
no icterus- Rs-blc NVBS-
no cyanosis

Examination: _____ Drug orders: _____

Investigations: Advice
① low purine diet

Provisional/Final Diagnosis: ② 3-4 ltrs of water/day
③ Recheck uric acid levels after 3 months

Advice: (Lifestyle / Rehab / Diet) _____

Nutritional Screening: Poor Moderate Well

Fall Risk: No Risk Low high

Follow up: Dr. Seidhae S Date: _____ Time: _____

Name & Signature of the Consultant with Stamp: _____

#15, 70th Cross, 14th Main, 1st Stage, Kumaraswamy Layout (Opp.to 15E Bus Stop), Bangalore-560078.
 Appointment: 080 71 500 500 | Emergency: 080 71 500 555

Patient Name : Mr. Gurusadas Joddu. **Age / Sex :** 54 / m **UHID No.:** 210274 **Date :** 13/8/23.

Chief Complaints :

Routine checkup.
No visual complaints.
No f/a/o glaucoma.

Others : Cold, Fever, Nausea, Vomiting, Giddiness.

Past History : Eye Treatment (Y/N) Eye Operation (Y/N)

General Health : DM HTN Heart Disease Br. Asthma Allergies Any Others

VISION

Right Eye

Left Eye

PL :

6/6

6/6

Distant PH :

GL :

Near

PL :

N6

N6

GL :

Colour vision: (Normal)

AMSLER GRID :

AR Reading:

Dry	SPH	CYL	AXIS
RE			
LE			

Wet	SPH	CYL	AXIS
RE			
LE			

Acceptance :

RIGHT EYE				LEFT EYE			
SPH	CYL	AXIS	VA	SPH	CYL	AXIS	VA

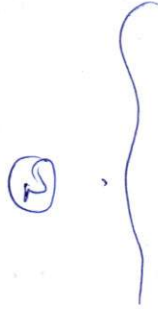
IPD :

Ocular Examination : Extra Ocular Movements :-

RIGHT EYE

LEFT EYE

Anterior Segment



- Lids :
- LAC. Apparatus
- Conj
- Cornea :
- AC depth :
- Iris

Posterior Segment

CDR 0.5
NRR OK

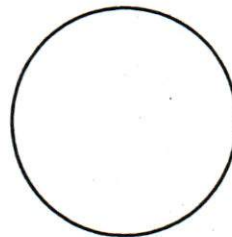
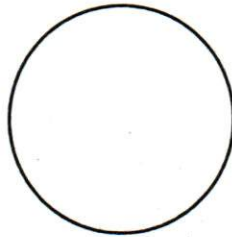
- Pupil
- Lens
- Media
- DISC
- Macula
- Blood Vessels
- BGF

CDR 0.5 NRR OK

Fundus:

Right Eye

Left Eye



IOP : < 14
13 mmHg

Provisional Diagnosis:

Both eyes normal

Medicine & Advice:

Annual eye check up

11/3/23

Date & Time

Dr. Name & Signature

UHID / IP NO	210274 (12926)	RISNo./Status :	56613/
Patient Name :	Mr. GURUPRASAD TODUR	Age/Gender :	34 Y/M
Referred By :	Dr. SRIDHAR SRINIVASAN G	Ward/Bed No :	OPD
Bill Date/No :	13/03/2023 8:55AM/ OPCR/23/7350	Scan Date :	
Report Date :	13/03/2023 12:28PM	Company Name:	Final

WE CURE WITH CARE
(A Unit of Sree Vasavi Trust)

M- MODE MEASUREMENTS

AO	2.73	cm	RVIDD	1.20	cm
LA	4.00	cm	IVSD	0.95	cm
AO/LA RATIO	0.75	cm	LVIDD	4.23	cm
AV CUP	1.46	cm	LVPWD	1.18	cm
EPSS	0.9	cm	IVSS	1.03	cm
DE	1.83	cm	LVIDS	2.52	cm
EF SLOPE	0.7	cm	LVPWS	1.33	cm
SV	57.41		EDV	79.92	ml
CO			ESV	22.84	ml
HR			EF	71.53	%
LVMl			FS	40.40	%
OTHERS			LV MASS	178.32	grams

DESCRIPTIVE FINDINGS: Technically Adequate Study. Normal Sinus rhythm during Study.

LEFT VENTRICLE	Normal in size
LEFT ATRIUM	Normal in size
RIGHT VENTRICLE	Normal in size
RIGHT ATRIUM	Normal in size
WALL MOTION ANALYSIS	No RWMA
TRICUSPID VALVE	Normal
MITRAL VALVE	Normal
PULMONIC VALVE	Normal
AORTIC VALVE	Normal
IAS & IVS	Intact
AORTA & PA	Normal In Size
SYSTEMIC & PULMONARY VENIS	Normally Draining
PERICARDIUM	Normal
OTHERS	No Intra Cardiac Thrombus, Tumour or Vegetation

CARDIOLOGY

UHID / IP NO	210274 (12926)	RISNo./Status :	56613/
Patient Name :	Mr. GURUPRASAD TODUR	Age/Gender :	34 Y/M
Referred By :	Dr. SRIDHAR SRINIVASAN G	Ward/Bed No :	OPD
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Report Date :	13/03/2023 12:28PM	Company Name:	Final

DOPPLER STUDY

VALVES	VELOCITY	GRADIENT	REGURGITATION	OTHERS
P V	0.71m/s		NO PR	
MV	E: 0.91 m/s A: 0.47 m/s		NO MR	
AV	1.08 m/s		NO AR	
TV	E: 0.60m/s A: 0.40m/s		NO TR	
OTHERS				


SUMMARY FINDINGS:

NORMAL CARDIAC CHAMBERS & VOLUMES

NO REGIONAL WALL MOTION ABNORMALITY AT REST

NORMAL LV SYSTOLIC FUNCTION (EF-71 %)

NO CLOT / EFFUSION / VEGETATION/PAH


Dr. PRANEETHS
CONSULTANT
CARDIOLOGIST

Mr. Deva Sagayam C

Rate 81

PR 158

QRSD 92

QT 360

QTc 418

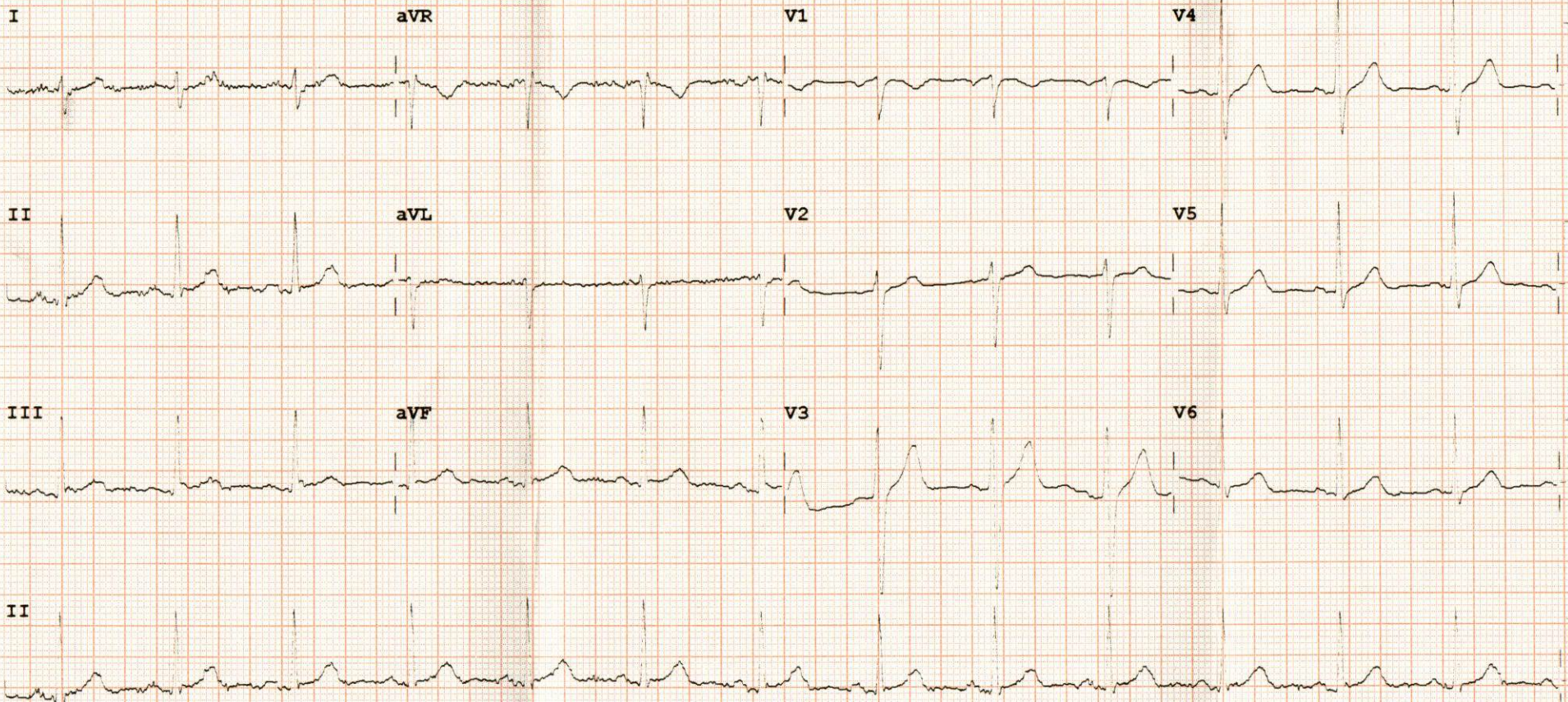
--AXIS--

P 61

QRS 92

T 54

12 Lead; Standard Placement



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 50~ 0.15-100 Hz

100B

CL

P?