UNITED HOSPITAL
Care Par Excellence

ilac-MRA MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. RANI R ASHA	Order No	: 1000074351
UHID	: UHJA23019013	Registered On	: 24/02/2024 08:53:40 AM
Age/Sex	: 35/Years Female	Collected On	: 24/02/2024 09:30:46 AM
Ward / Bed No	:	Reported On	: 24/02/2024 01:57:46 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023507
Station	: At Hospital	Mobile No	: 9538752794
Payer Name	: Mediwheel	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval
FASTING GLUCOSE (Method: Hexokinase)	110	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	153	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	6.0	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	125.49	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.01	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.04	≂g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.82	ı IU/mL	0.34 - 5.60 ı IU/mL (Non Pregnant) 0.3 - 4.5 ı IU/mL (I trimester) 0.5 - 5.2 ı IU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	204	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	113	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	37.3	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	144.1	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	22.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.4		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.8		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	166.7	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.9	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	7	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.71	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.56	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.48	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.9	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.79	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.11	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.21		2:1
SERUM SGOT (Method:IFCC without P5P)	14	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	11	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	63	U/L	46-122
GGT (Method:IFCC)	16	U/L	< 38

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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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)	13.63	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	42.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9370	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	71.68	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	21.68	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.32	%	0-6
MONOCYTES (Method:Optical/Impedance)	4.90	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.42	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.96	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	84.9	fL	78-100
MCH (Method: Calculated)	27.5	pg	27-31
MCHC (Method: Calculated)	32.4	g/dL	31-37
RDW - CV (Method: Calculated)	14.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.30	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)	8.22	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	21.5	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	09	mm/hour	1-20

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

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

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

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/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
Rashmita

---End of Report---

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

ID:23019013
Name:mrs.rani r asha

24-Feb-2024 AM10:37:01

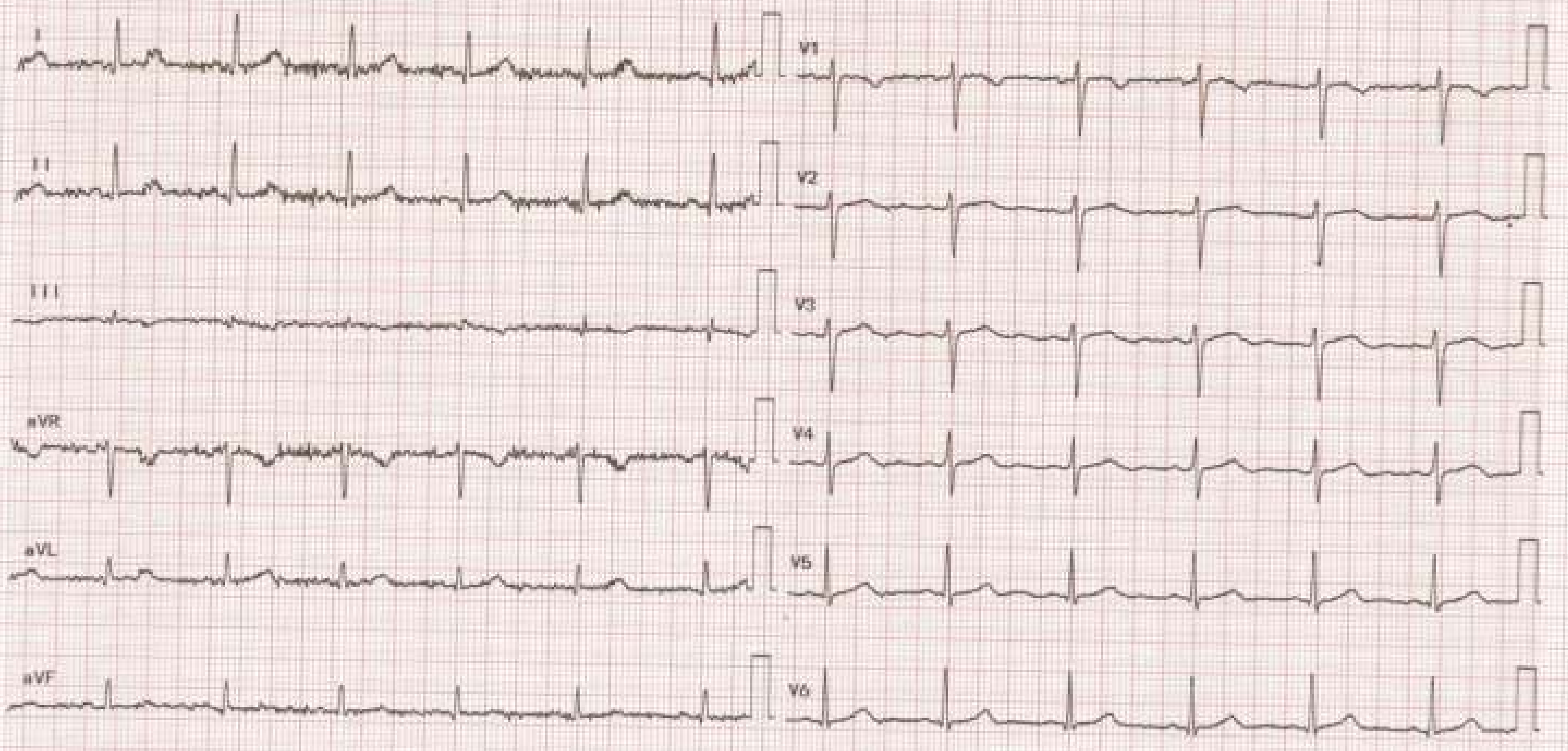
ex:F
cm kg
Birth date:
/ mmHg
35 years
ndication:
ymptoms:
istory:

ent. rate	76	bpm
R int	136	ms
RS dur	86	ms
T/QTc(E) int	382/ 412	ms
/QRS/T axis	40/ 35/ 17	°
V5/SV1 amp	0.88/ 0.95	mV
V5+SV1 amp	1.83	mV

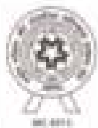
1100 Sinus rhythm
0102 ARTIFACT PRESENT
9110 ** normal ECG **

Unconfirmed Report
Reviewed by:

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



Z350K 03-08 07-01 Dept. :
Exam:UNITED HOSPITAL



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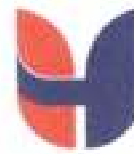


Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs.RANI R ASHA	UHID	: UHJA23019013
Age / Sex	: 35 Years / Female	OP NO/Reg Dt	: 24-02-2024 08:53 AM
Spouse / Father Name	: PRAVEEN KUMAR A	Department	: Health Check
Address	: # 8 NS Palya 1st Main Road 16th Cross BTM 2nd Stage Banglroe76, BANGALORE	Refered By	: Corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr Vignesh

Complaints / Findings / Observations : ENT Prescription

Came for Routine ENT Checkup

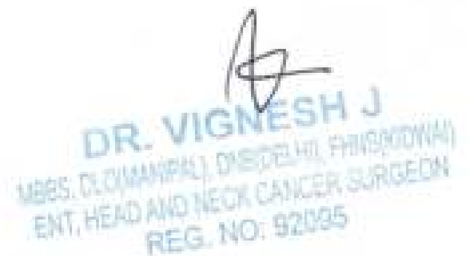
ENT Examination

Within Normal Limits

Investigations:

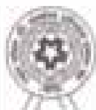
Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :



Signature of the Doctor

NABH


NABL

No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs.RANI R ASHA	UHID	: UHJA23019013
Age / Sex	: 35 Years / Female	OP NO/Reg Dt	: 24-02-2024 08:53 AM
Spouse / Father Name	: PRAVEEN KUMAR A	Department	:
Address	: # 8 NS Palya 1st Main Road 16th Cross BTM 2nd Stage Banglroe76, BANGALORE	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

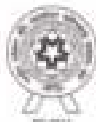
WT - 67.9
HT - 152
BP - 88/67
SPO2 - 98%
PR - 79 b/m

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor



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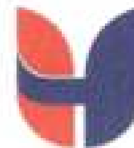

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Out Patient Record

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Spouse / Father Name	: PRAVEEN KUMAR A	Department	: Health check
Address	: # 8 NS Palya 1st Main Road 16th Cross BTM 2nd Stage Banglroe76, BANGALORE	Refered By	: Corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha

Complaints / Findings / Observations : ophthomology presciption

VA < 6/6 (OU)

Investigations:

AC (N)

Fundus (N)

Treatment / Care of Plan / Provisional Diagnosis :

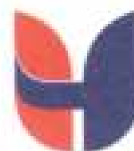
Imp! Normal study

Follow Up Advice :

Yearly review

Signature of the Doctor
24/2/24

NABH NABL No.1



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Spouse / Father Name	: PRAVEEN KUMAR A	Department	: Health Check
Address	: # 8 NS Palya 1st Main Road 16th Cross BTM 2nd Stage Banglroe76, BANGALORE	Refered By	: Corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Mohan

Complaints / Findings / Observations :

S/B Dr Mohan

Pt came for regular health check.
No known co-morbidities.

Investigations:

Reports : HbA1c ~ 6
CBC - (N)
RFT - uric acid ↑
ECG - Normal sinus Rhythm.

Treatment / Care of Plan / Provisional Diagnosis :

USG - Abdomen + Pelvis - WNL.

Adv :- 1. Regular exercises.
2. Calorie deficit diet / (↓ whole carbohy[drates]
↑ Fibres in diet).

Follow Up Advice :

Signature of the Doctor

EXERCISE STRESS TEST REPORT

Patient Name: RANI R ASHA.
Patient ID: 19013
Height: 152 cm
Weight: 67 kg

DOB: 20.05.1988
Age: 35yrs
Gender: Female
Race: Indian

Study Date: 24.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: DR. RAHUL PATIL
Attending Physician: DR. RAHUL PATIL
Technician: YAMINI/THABITHA

Medications:
--

Medical History:
NO H/Q DM & HTN

Reason for Exercise Test:
Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:14	0.00	0.00	82	100/70	
	STANDING	00:11	0.00	0.00	77	100/70	
	HYPERV.	00:02	0.00	0.00	75	100/70	
	WARM-UP	00:12	0.00	0.00	76	100/70	
EXERCISE	STAGE 1	03:00	1.70	10.00	118	100/70	
	STAGE 2	03:00	2.50	12.00	130	110/80	
	STAGE 3	01:09	3.40	14.00	155	120/90	
RECOVERY		07:01	0.00	0.00	90	120/90	

The patient exercised according to the BRUCE for 7:08 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 85 bpm rose to a maximal heart rate of 157 bpm. This value represents 84 % of the maximal, age-predicted heart rate. The resting blood pressure of 100/70 mmHg , rose to a maximum blood pressure of 120/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation
Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions
GOOD EFFORT TOLERANCE
NORMAL HR AND BP RESPONSE
NO ANGINA OR ARRHYTHMIAS NOTED
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician________________ **Technician**________________

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Jayanagar, Bangalore

NABH NABL No.1

A Unit of United Brothers Healthcare Services Private Limited

No. 110(30), Madhavan Park Circle, 10th Main Road, 3rd Block, Jayanagar, Bangalore - 560 011. T: 080 4566 6666 E: appointment@unitedhospital.in W: www.unitedhospital.com

DEPARTMENT OF RADIODIAGNOSIS

Name	Rani R Asha	Date	24/02/24
Age	35 years	Hospital ID	UHJA23019013
Sex	Female	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 contracted. No obvious calculi are seen in the visualized portion of theh lumen. Suggested review scan if any gallbladder pathology is suspected.

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 evidence of mass or focal lesions.

Right Kidney is normal in size (8.1 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (8.7 x 3.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus is anteverted and normal in size, measures 7.1 x 2.8 x 4.5 cms. Myometrial and endometrial echoes are normal. Endometrium measures 11.4 mm.
Right ovary is normal in size and echopattern, measures 4.2 cc.
Left ovary is normal in size and echopattern, measures 2.2 cc.
Both adnexa: Normal. No mass is seen.

There is 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