UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. VIKRAM S DODDAMNI	Order No	: 1000074390
UHID	: UHJA23019022	Registered On	: 24/02/2024 09:31:02 AM
Age/Sex	: 33/Years Male	Collected On	: 24/02/2024 10:58:01 AM
Ward / Bed No	:	Reported On	: 24/02/2024 01:58:39 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023519
Station	: At Hospital	Mobile No	: 9008743316
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	120	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)	6.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	139.84	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.29	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.16	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.30	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	152	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	134	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	27.7	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	97.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	26.80	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)	3.5		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	124.3	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.7	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.63	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.87	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.19	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.68	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.05	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.35	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.72		2:1

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SERUM SGOT (Method:IFCC without P5P)	36	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	47	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	133	U/L	50-116
GGT (Method:IFCC)	44	U/L	< 55

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)	13.96	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	41.8	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	8680	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	67.63	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	23.84	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.41	%	0-6
MONOCYTES (Method:Optical/Impedance)	4.72	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.40	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.74	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	88.1	fL	78-100
MCH (Method: Calculated)	29.5	pg	27-31
MCHC (Method: Calculated)	33.4	g/dL	31-37
RDW - CV (Method: Calculated)	15.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.65	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)	7.34	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	14	mm/hour	1-15

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	B	
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	5.5		5.0-8.0
SPECIFIC GRAVITY	1.030		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	2-4	/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		

Verified By
NAGARATNA

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

ID:23019022
Name:mr.vikram s doddaman
ex:M Birth date:
cm kg / mmHg
edication:
ymptoms:
istory:

24-Feb-2024 AM10:33:55

33 years

1100 Sinus rhythm
9110 ** normal ECG **

ent. rate	71	bpm
R int	138	ms
RS dur	82	ms
T/QTc(E) int	376/ 398	ms
/QRS/T axis	33/ 38/ 14	°
V5/SV1 amp	0.90/ 0.61	mV
V5+SV1 amp	1.51	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

Patient name :	Mr. VIKRAM S DODDAMANI	Date :	24/02/24
Age :	33 years GENDER: MALE	Patient ID :	19022
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 4.9 (3.5-5.5)	MV EV : 86.3	AV : 67.9	MR : TRIVIAL MR
LA : 3.5 (1.9-4.0)	LVIDS : 3.1 (2.4-4.2)	AV : 100		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 105		PR : NORMAL
RV : 2.1 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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, TRIVIAL MR
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL, TRIVIAL TR, PASP-20mmHg
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%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.VIKRAM S DODDAMNI**	**UHID**	**: UHJA23019022**
Age / Sex	: 33 Years / Male	OP NO/Reg Dt	: 24-02-2024 09:31 AM
Spouse / Father Name	: SHIVAPUTHRA	Department	: Health Check
Address	: # B108,Temple Bells Premiar Appartment Rajarajeshwari Nagar Banglroe ,	Refered By	: Corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Vignesh

Complaints / Findings / Observations : ENT Prescription

Camp for Routine ENT Examination.

Investigations:

Ear, Nose, Throat & Oral Cavity — Within Normal limits

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

DR. VIGNESH J
MBBS, DLO(MANIPAL), DNB(DELHI), FHNS(KIDWAI)
ENT, HEAD AND NECK CANCER SURGEON
REG. NO: 92095

Signature of the Doctor

Out Patient Record

Patient Name	**: Mr.VIKRAM S DODDAMNI**	**UHID**	**: UHJA23019022**
Age / Sex	: 33 Years / Male	OP NO/Reg Dt	: 24-02-2024 09:31 AM
Spouse / Father Name	: SHIVAPUTHRA	Department	: Health check
Address	: # B108,Temple Bells Premiar Appartment Rajarajeshwari Nagar Banglroe ,	Refered By	: corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr.Shwetha

Complaints / Findings / Observations : ophthomology prescription

Routine Eye [illegible]

Investigations:

VA R 6/6 (N)

A/L (N)

Treatment / Care of Plan / Provisional Diagnosis :

Fundus L (N)

Follow Up Advice : [illegible] [illegible] [illegible]

Adv

Yearly review

Signature of the Doctor
24/2/24

NABH NABL No.1

UNITED HOSPITAL
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Address	: # B108,Temple Bells Premiar Appartment Rajarajeshwari Nagar Banglroe ,	Refered By	: Corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Anuleeha

Complaints / Findings / Observations :

WT-113.3
HT-179
BP-134/
SPO2-98%
PR-77B

HBAIC- 6.5
PPBS - 232 } pre diabetic
FBS - 120

Investigations:

Treatment / Care of Plan / Provisional Diagnosis : ADO

- Low fat diet
- physically fit - (core strengthening exercise)
- weight reduction.
- Salt / sugar restricted food.

Follow Up Advice :

(1) Dietician opinion.

Medically fit

lipid profile. HBAIC, FBS, PPBS after 3 months.

Signature of the Doctor

UNITED HOSPITAL
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Jayanagar, Bangalore
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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Vikram S Doddamani	**Date**	24/02/24
Age	33 years	**Hospital ID**	UHJA23019022
Sex	Male	**Ref.**	Healthcheck

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is enlarged in size (15.0 cms) and shows moderately 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 *lumen shows few small calculi measuring 2-4 mm.* There is no evidence of 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 (9.5 x 4.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.4 x 3.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Retroperitoneum - Obscured by bowel gas.

Urinary Bladder is minimally distended.

Prostate is normal in echopattern and size, measures ~ 17.8 cc.

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

IMPRESSION: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Mild hepatomegaly with moderate fatty infiltration (Grade II).**
- **Cholelithiasis. No evidence of cholecystitis.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Vikram S Doddamani	**Date**	24/02/24
Age	33 years	**Hospital ID**	UHJA23019022
Sex	Male	**Ref.**	Healthcheck

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Poor inspiratory radiograph.

Bilateral lung fields are grossly normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No significant radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist