UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SHANMUGAPRIYA L	Order No	: 1000071850
UHID	: UHJA23017853	Registered On	: 07/02/2024 09:52:37 AM
Age/Sex	: 32/Years Female	Collected On	: 07/02/2024 10:02:23 AM
Ward / Bed No	:	Reported On	: 07/02/2024 02:21:42 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022102
Station	: At Hospital	Mobile No	: 9786421490
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	85	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	96	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.7	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	88.19	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.98	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.63	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.51	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)	179	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	38	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	62.5	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	107.9	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	7.59	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	2.8		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.7		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	115.5	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.0	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.74	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.43	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.33	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.9	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.20	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.70	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.55		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	21	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	52	U/L	46-122
GGT (Method:IFCC)	14	U/L	< 38

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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Test Name	Result	Unit	Bio. Ref. Interval
HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	12.46	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	38.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6320	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	74.27	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	18.57	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	0.15	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.85	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.16	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.18	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	91.0	fL	78-100
MCH (Method: Calculated)	29.8	pg	27-31
MCHC (Method: Calculated)	32.8	g/dL	31-37
RDW - CV (Method: Calculated)	13.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.83	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)	9.67	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.4	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-20

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

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	25	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)	Present (+)		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	2-4	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
PRAVEEN T

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs.SHANMUGAPRIYA L	Date :	07/02/24
Age :	32 years GENDER: FEMALE	Patient ID :	17853
Ref by :	DR.CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV : 77.1	AV : 56.3	MR : NORMAL
LA : 2.8 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 89.6		AR : NORMAL
RA :2.1 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 99.9		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO 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

IMPRESSION :

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

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

7-Feb-2024 AM11:05:32

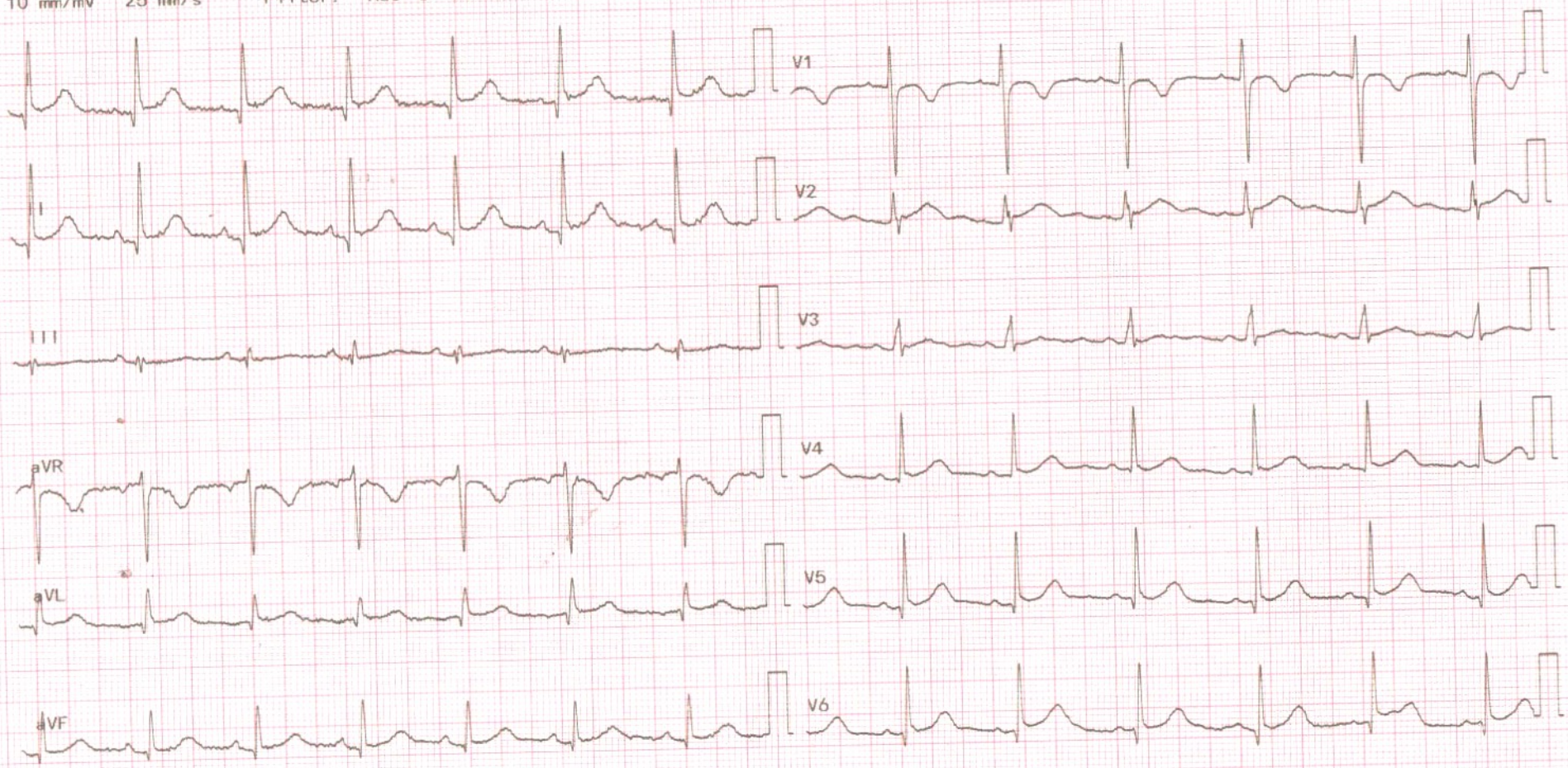
ID:17853
Name:Mrs.Shanmugapriya.L
lex:F Birth date:
cm kg / mmHg
ledication:
lymptoms:
listory:

32 years 1100 Sinus rhythm
9110 ** normal ECG **

lent. rate	83	bpm
R int	148	ms
RS dur	76	ms
T/QTc(E) int	380/ 420	ms
/QRS/T axis	73/ 42/ 40	°
V5/SV1 amp	1.34/ 1.45	mV
V5+SV1 amp	2.79	mV

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNI[illegible]D HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Mrs Shanmugapriya L
32yrs

Dr. Yoga Lakshmi SK
MBBS, MS OBG, [illegible]
Consultant Obs[illegible]
Gynecologist, [illegible]
and IVF Specialist
KMC Reg. No. 90384

7/2/24

For health check up

BP - 94/60 PR 72/m
SpO2 - 99

No h/o DM, HTN, [illegible]

K/c/o Hypothyroid
not on any Rx

h/o Any surgery
↳ Breast cancer surgery

No h/o any family [illegible]

M/H - [illegible]

P/S - [illegible]
↳ Cervical [illegible]

MC - 1y
P2L2
All FTVD
Not tubectomised
CMO - [illegible]
[illegible]

Lt Breast -
Outer lower quadrant

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United Hospital
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3rd Block Jayanagar, Bangalore - 560 011
T: 080 4566 6666
E: appointments@unitedhospital.in
W: www.unitedhospitals.com

Out Patient Record

Patient Name	**: Mrs.SHANMUGAPRIYA L**	**UHID**	**: UHJA23017853**
Age / Sex	: 32 Years / Female	OP NO/Reg Dt	: 07-02-2024 09:52 AM
Spouse / Father Name	: KARUNAKARAN	Department	: Health
Address	: # 159/A,5th Main 4th Block Rajajinagar Banglore , BANGALORE CITY H O,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr Shweta

Complaints / Findings / Observations :

H/o low vision in RE → detected 10 yrs back. Nil systemic

Investigations:

VA: c 6/60 PH 6/60.

6/6, N6.

Treatment / Care of Plan / Provisional Diagnosis :

AC/S OU Normal

Fundus OU CDR 0.3:1, HMA (mild)

Follow Up Advice :

Inj: RE : Amblyopia.

Signature of the Doctor

7/2/24.

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Shanmugapriya L	**Date**	07/02/24
Age	32 years	**Hospital ID**	UHJA23017853
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Homogeneous fibroglandular background echotexture is seen in both breasts.

There is a ovoid circumscribed lesion measuring 1.9 x 1.3 x 1.0 cms in the skin / dermis plane at 6 o'clock position of left breast, at the site of previous surgery. The lesion is heteroechoic with no internal vascularity.

Two tiny hypoechoic lesions measuring 4-5 mm are noted in the right breast 3 o'clock and 9 o'clock position.

No other focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **Ovoid circumscribed lesion in the skin / dermis plane at 6 o'clock position of left breast as mentioned above – likely epidermal inclusion cyst.**
- **Two tiny hypoechoic lesions in the right breast - likely tiny fibroadenomas. BIRADS2 – Benign.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

Please bring this report during your visit to the Hospital / ಆಸ್ಪತ್ರೆಗೆ ಬರುವಾಗ ಈ ರಿಪೋರ್ಟನ್ನು ತನ್ನಿ

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DEPARTMENT OF RADIODIAGNOSIS

Name	Shanmugapriya L	**Date**	07/02/24
Age	32 years	**Hospital ID**	UHJA23017853
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 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 evidence of mass or focal lesions.

Right Kidney is normal in size (9.5 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.9 x 4.1 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 7.6 x 3.8 x 5.0 cms. Myometrial and endometrial echoes are normal. Endometrium measures 4.0 mm.
Right ovary is normal in size and echopattern, measures 9.5 cc.
Left ovary is normal in size and echopattern, measures 7.6 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

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DEPARTMENT OF RADIODIAGNOSIS

Name	Shanmugapriya L	**Date**	07/02/24
Age	32 years	**Hospital ID**	UHJA23017853
Sex	Female	**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

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		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Anuradha

Complaints / Findings / Observations :

Regular health check up

Ht - 152 cm
Wt - 53.6 kg
PR - 72 bpm
SpO2 - 99%
BP - 94/60

Investigations:

Treatment / Care of Plan / Provisional Diagnosis : Adv

. Tab SPORIDEX AF 150 1-0-1 x 5d (A/F)

Tab PAN no 1-0-1 x 5d CB(F)

Follow Up Advice :

. Cap D-RISE 60K weekly once x 8 weeks

Medically fit

Signature of the Doctor