



Patient Details
 Nam: Mrs. KANCHANA M J
 Age/Sex: 39 Y/F
 PTID: PTH202400262507
 Age: Birth Date 04-02-1985
 Reg Date: 27-07-24 08:12

**HEALTH CHECK - UP
 OUT PATIENT
 CASE SHEET**

21/07/24

Annual / Periodic / Corporate Health Examination Flowsheet

Date _____

Consultant Dr. SIKLA Dept: GM Type: New / Follow Up / Revisit

MHC / SHC / EHC / CHC / WH / Corporate / Annual Health Exam / Pre Employment Referring Dr/Centre _____

CC: cpo upper abd pain
 HOPI: no vomiting

MEDS: None Compliant

Allergies: _____ / NKDA

PMHx: _____ None PSHx: _____

- DM
- HTN
- Asthma / COPD
- CAD
- Others: _____
- Social Hx _____
- Sm
- ETOH
- Other: _____

- Family Hx
- Non Contributing
 - DM Mom
 - HTN
 - CAD
 - Other: _____

O/E: Vitals

HT <u>146</u> cms	WT <u>73</u> Kg	BMI	RR	% Sats <u>99%</u>	P <u>98</u> /m	BP Rt <u>110/70</u> mmHg
P <u>—</u>	I <u>—</u>	Cy <u>—</u>	Cl. <u>—</u>	L <u>—</u>	E <u>—</u>	Temp: _____ °F
HEENT: _____						BP Lt _____

CVS (20) P/A —
 RS (20) Ext —

CNS _____

BU = +ve

Labs / Studies :

CBC
8.4 / 11.2 / 313
34.7

Lipids
32 / 149 / 91
98

Electrolytes
0.60

Urine Routine
fasting urine Nil
Post

FBS	PPBS
106	93
HBAIC 6.9 %	

VIT D

VIT B12

LFT

Y-Bilirubin - 0.80
SUDT - 17
SAPT - 15
ESR - 45

ECG → NSR with

Others

2 DECHO

TMT

PFT

CXR - PA → Normal

U/S ABD →

V. acid - 4.30

BUN - 5.14

TSH - 1.32

Assessment 1. PCOS
2. Cholelithiasis
3. Newly diagnosed T2DM

4. _____
5. _____
6. _____

Plan : a) Lifestyle Modification Diet Low Salt Low Fat DM Diet Exercise

b) _____
c) Rx weight reduction by 10%.

Regular walking

FBS / Annals
PPBS

So Consult

1. Dr. Suresh Babu
SB

Fit for Employment Unfit for Employment

Pending

Follow Up _____

Dr. Karthik N

REG No.: 82833

DR. KARTHIK N
MBBS, MD (GENERAL MEDICINE),
FELLOW IN DIABETOLOGY (BMJ)
CONSULTANT GENERAL MEDICINE
KTC MA - 8763

Patient Details
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 Reg Date: 27-07-2024

GENERAL OUT PATIENT FOLLOWUP SHEET

Main Sheet

27/07/24

PTID _____ Date _____

Name _____ Age / Sex _____

Address _____ Phone No. _____

Consultant Ne

Department _____

Background History
 HT / DM/IHD/Others

Wt	HT
HR	F

Current Problems

Examination

Provisional

Plan

Follow up

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OPHTHALMOLOGY CASE SHEET

Name: Mrs. KANCHANA M J
 Age/Sex: 39 Y/F
 PTID: PTH202400262507
 Birth Date: 04-02-1985
 Reg Date: 27-07-24 08:12

Address _____ IP No. _____ Date 27/07/24

Consultant's Name Dr. Navneet Age / Sex _____
 Referring Doctor's Name _____ Phone No. _____

Medical History: Diabetes, Hypertension / Cardiac / Asthma

Drug Allergy Nil

Ophthalmic History: Cataract / Glaucoma / Retina

Family History _____

PRESENT PROBLEMS Regular check up

PRESENT GLASSES / CL

IPD	Sphere	Cylinder	Axis	Add	Contact Lens
Right					
Left					

VISION

Vision	UCVA	Near	PH	PG	Colour
Right	6/12P	N6			
Left	6/12	N6			

SUGGESTED CORRECTION

IPD	Sphere	Cylinder	Axis	Vision	Add
Right	-1.00		90	6/6	
Left	-1.25			6/6	

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OUR BRANCHES

1994

1994

1994

1994

1994

1994

1994



Dec 20, 2021 - Dec 19, 2029



LABORATORY INVESTIGATION REPORT

Name	: Mrs. KANCHANA M J	MR No	: PTH202400262507
Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 10:57
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		


HAEMATOLOGY

Parameters	Observed Values	Units	Reference Range	Sample
COMPLETE BLOOD COUNTS (AUTOMATED) (CBC),				
(Sample Received On:27 Jul, 2024 10:44:00 AM)				
HAEMOGLOBIN (AUTOMATED)	11.2	g/dL	11.5- 16	Plasma(EDTA)
TC (TOTAL COUNT) (AUTOMATED)	8440	Cell/mm ³	4000 - 11000	
NEUTROPHILS	59.4	%	40-75	
LYMPHOCYTES	32.2	%	20-45	
EOSINOPHILS	4.0	%	1 - 6	
MONOCYTES	4.2	%	1 - 10	
BASOPHILS	0.2	%	0 - 1	
RBC COUNT	4.26	Million cell/mm ³	3.7 - 5.6	
PLATELET COUNT	313700	Cells/mm ³	150000 - 450000	
PCV	34.7	%	34 - 48	
MCV	81.5	fL	75-95	
MCH	26.4	pg	30 - 35	
MCHC	32.4	g/dL	30 - 35	

DISCLAIMER : The result obtained relate only to the sample given/received & tested. A single test result is not always indicative of a disease, it has to be correlated with clinical data for interpretation.

---End of Report---

VERIFIED BY
Ayesha Khan


DR JAYALAKSHMI | MBBS,DCP,MD
Consultant Pathologist
KMC No.54878

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CIN: U85100KA2011PTC059175

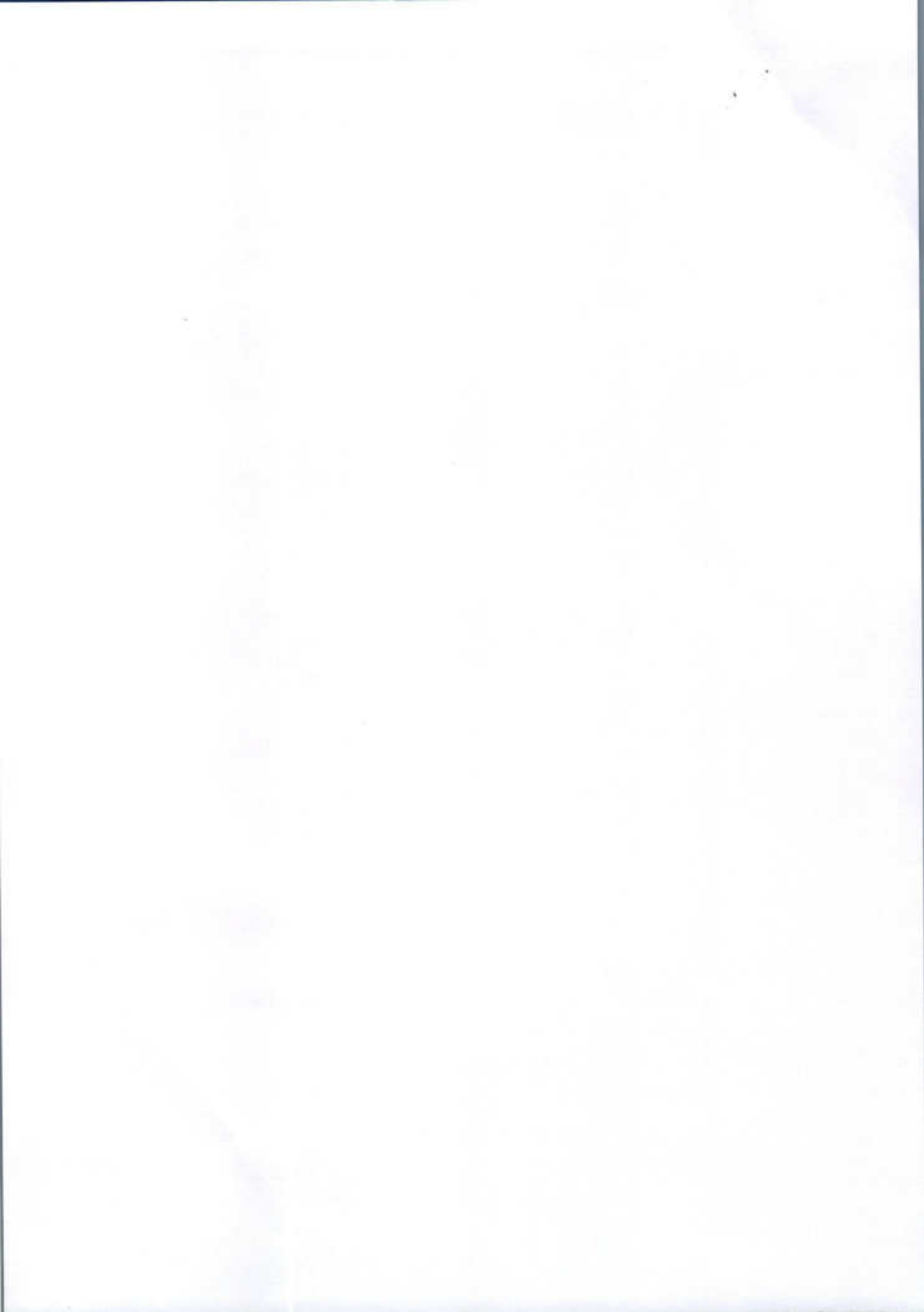
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Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 11:20
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

BIOCHEMISTRY

Parameters	Observed Values	Units	Reference Range	Sample
GLUCOSE - FASTING SUGAR(FBS), (Sample Received On:27 Jul, 2024 10:44:00 AM) Lab ID No: LAB567998				
FASTING BLOOD SUGAR[GOD-POD]	106	mg/dL	70 - 106	Serum
LIPID PROFILE (CHOL,TGL,LDL ,HDL), (Sample Received On:27 Jul, 2024 10:44:00 AM) Lab ID No: LAB567998				
CHOLESTEROL- TOTAL[CHOD-POD]	149.00	mg/dL	Desirable : <200 Borderline High : 200 - 239 High : >=240	Serum
TRYGLYCERIDES[GPO]	91	mg/dL	<150	
CHOLESTEROL - LDL[Calculated]	98.8	mg/dL	Up to 130	
CHOLESTEROL - HDL[Polymer detergent]	32.0	mg/dL	Low : <40 High : >=60	
CHOLESTEROL - VLDL[Calculated]	18.20	mg/dL	<40	
LDL : HDL RATIO	3.09		<3.5	
Lab ID No: LAB567998				
URIC ACID - SERUM[Uricase POD]	4.30	mg/dL	2.5 - 6.5	Serum
(Sample Received On:27 Jul, 2024 10:44:00 AM)				
Lab ID No: LAB567998				
BUN (BLOOD UREA NITROGEN)[Urease]	5.14	mg/dL	7 - 20	Serum
(Sample Received On:27 Jul, 2024 10:44:00 AM)				
CREATININE- SERUM, (Sample Received On:27 Jul, 2024 10:44:00 AM) Lab ID No: LAB567998				
CREATININE - SERUM[Creatinine Amidohydrolase]	0.60	mg/dL	0.5 - 1.2	Serum
Lab ID No: LAB567998				
PROTEIN TOTAL[Biuret]	8.10	g/dL	6.4 - 8.3	Serum
(Sample Received On:27 Jul, 2024 10:44:00 AM)				

LIVER FUNCTION TEST (TBIL,DBIL,PROTEIN,ALB,OT,PT,ALP,GGT),
(Sample Received On:27 Jul, 2024 10:44:00 AM)

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Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 11:20
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

Lab ID No: LAB567998

Test Name	Result	Unit	Reference Range	Specimen
BILIRUBIN- TOTAL[Reflectance Spectrophotometry]	0.8	mg/dL	0.2 - 1.3	Serum
BILIRUBIN- DIRECT[Reflectance Spectrophotometry]	0.2	mg/dL	0 - 0.3	
BILIRUBIN- INDIRECT[Reflectance Spectrophotometry]	0.6	mg/dL	0 - 0.6	
TOTAL PROTEIN[Biuret]	8.10	g/dL	6.4 - 8.3	
ALBUMIN[Bromocresol Green]	4.20	g/dL	3.5 - 5	
GLOBULIN	3.9	g/dL	2 - 3	
A:G RATIO	1.1		0.8 - 2.5	
SGOT (AST)[Multipoint Rate with P-5-P]	17.00	U/L	14 - 36	
SGPT (ALT)[Multipoint Rate with P-5-P]	15.00	U/L	< 35	
GGT[-glutamyl-p-nitroanilide]	25.00	IU/L	12 - 43	
ALP[Enzymatic]	77.00	U/L	38 - 126	

DISCLAIMER : The result obtained relate only to the sample given/received & tested. A single test result is not always indicative of a disease, it has to be correlated with clinical data for interpretation.

---End of Report---

VERIFIED BY
Nutan N

Jaya

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Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 12:00
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

HAEMATOLOGY

Parameters	Observed Values	Units	Reference Range	Sample
ESR (Sample Received On:27 Jul, 2024 10:44:00 AM)	45	mm/hr	0 - 20	Plasma(EDTA)

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---End of Report---

VERIFIED BY
Ayesha Khan

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Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 12:31
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

HAEMATOLOGY

Parameters	Observed Values	Units	Reference Range	Sample
BLOOD GROUPING & RH TYPING,				
(Sample Received On: 27 Jul, 2024 10:44:00 AM)				
BLOOD GROUP	"A"			Plasma(EDTA)
RH Type	POSITIVE			
Note	Blood group done by forward grouping only. Suggested confirmation by forward and reverse typing method for the purpose of blood transfusion etc.			

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---End of Report---

VERIFIED BY
Bindhu B R

Jaya
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Name	: Mrs. KANCHANA M J	MR No	: PTH202400262507
Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 12:50
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

BIOCHEMISTRY

Parameters	Observed Values	Units	Reference Range	Sample
GLUCOSE POST PRANDIAL SUGAR (PPBS), (Sample Received On:27 Jul, 2024 12:00:56 PM) POST PRANDIAL BLOOD SUGAR[GOD-POD]	93	mg/dL	70 - 140	Serum

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---End of Report---

VERIFIED BY
Nutan N

Jaya
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Name	: Mrs. KANCHANA M J	MR No	: PTH202400262507
Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 12:51
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

BIOCHEMISTRY

Parameters	Observed Values	Units	Reference Range	Sample
FASTING URINE SUGAR (Sample Received On:27 Jul, 2024 10:44:00 AM)	NIL			Urine

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---End of Report---

VERIFIED BY
Nutan N

Jaya
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LABORATORY INVESTIGATION REPORT

Name	: Mrs. KANCHANA M J	MR No	: PTH202400262507
Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 13:06
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

BIOCHEMISTRY

Parameters	Observed Values	Units	Reference Range	Sample
THYROID PROFILE (T3 T4 TSH),				
(Sample Received On: 27 Jul, 2024 10:44:00 AM)				
T3[Chemiluminescence]	1.430	ng/mL	0.970 - 1.69	Serum
T4[Chemiluminescence]	13.00	ug/dL	5.53 - 11.0	
TSH[Chemiluminescence]	1.132	micIU/mL	0.4001 - 4.049	
			1st Trimester : > 0.1298 - 3.120	
			2nd Trimester : > 0.2749 - 2.652	
			3rd Trimester : > 0.3127 - 2.947	

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---End of Report---

VERIFIED BY
Shwetha S

Jaya
DR JAYALAKSHMI | MBBS, DCP, MD
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KMC No.54878

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Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 13:11
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		


BIOCHEMISTRY

Parameters	Observed Values	Units	Reference Range	Sample
POST PRANDIAL URINE SUGAR (Sample Received On:27 Jul, 2024 12:00:56 PM)	NIL			Urine

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---End of Report---

VERIFIED BY
Nutan N


DR JAYALAKSHMI | MBBS,DCP,MD
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KMC No.54878

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Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 13:11
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

CLINICAL PATHOLOGY

Parameters	Observed Values	Units	Reference Range	Sample
URINE ROUTINE AND MICROSCOPY (QUALITATIVE METHOD), (Sample Received On: 27 Jul, 2024 10:44:00 AM)				
PHYSICAL EXAMINATION				
Volume	20	mL	NA	Urine
Colour	PALE YELLOW		Pale Yellow	
Appearance	CLEAR		Clear	
CHEMICAL EXAMINATION(Automated)[Reagent Strip Method]				
pH	7.0		5.0 - 8.0	
Specific Gravity	1.005		1.001 - 1.035	
Albumin	NIL		TRACE, - 0.15g/L PRESENT(1+) - 0.3g/L PRESENT(2+) - 1.0g/L PRESENT(3+) - 3.0g/L PRESENT(4+) - 20g/L	
Sugar	NIL		TRACE - 100mg/dl PRESENT(1+) - 200mg/dl PRESENT(2+) - 500mg/dl PRESENT(3+) - 1000mg/dl PRESENT(4+) 2000mg/dl	
Ketone Bodies	nil		NIL	
Nitrite	Negative		NA	
Bilirubin	Negative		Negative	
Urobilinogen	Normal		Normal	
MICROSCOPY[Manual Method]				
RBCs	1-2	/hpf	0 - 3/HPF	
Pus Cells	4-5	/hpf	0 - 5/HPF	
Epithelial Cells	3-4	/hpf	0 - 2/HPF	
Casts	nil		NIL	
Crystals	nil		NIL	
Others	nil			

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LABORATORY INVESTIGATION REPORT

Name	: Mrs. KANCHANA MJ	MR No	: PTH202400262507
Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 13:11
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

VERIFIED BY
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Dec 20, 2021 - Dec 19, 2025



LABORATORY INVESTIGATION REPORT

Name	: Mrs. KANCHANA M J	MR No	: PTH202400262507
Age/Sex	: 39 Y/F	Prescribing Dr	:
Mobile No	: +919538773828	Reported on	: 27-07-2024 13:35
Requesting Ward	:		
Referred By	: DEEPAK (PRO)		

BIOCHEMISTRY

Parameters	Observed Values	Units	Reference Range	Sample
GLYCATED HEMOGLOBIN (HBA1C), (Sample Received On:27 Jul, 2024 10:44:00 AM) GLYCATED HEMOGLOBIN[HPLC]	6.9	%	"Non-Diabetic HbA1c < 5.6 Fasting plasma glucose <100 Pre - Diabetes HbA1c 5.7 - 6.4 Fasting plasma glucose 100 - 125 Diabetes HbA1c > 6.5 Fasting plasma glucose > 126"	Plasma(EDTA)
ESTIMATED AVERAGE GLUCOSE	151	mg/dL		

Note : Any condition altering red cell life will alter the GHB values. Low Hb% values may not correlate with GHB. GHB value should not be taken as a sole criteria for diagnosis. GHB gives average Blood Glucose level for the period of 10 - 12 wks & it need not correlate with blood sugar levels. For Geriatric group, HbA1c reference range depends upon comorbid conditions.

DISCLAIMER : The result obtained relate only to the sample given/received & tested. A single test result is not always indicative of a disease, it has to be correlated with clinical data for interpretation.

---End of Report---

VERIFIED BY
Nutan N

DR SURAKSHA RAO B | MBBS, MD
Consultant Pathologist
KMC No. 81288

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Dec 20, 2021 - Dec 19, 2025



COLOR DOPPLER ECHOCARDIOGRAPHY REPORT

NAME: MRS. KANCHANA M J

AGE/GENDER: 39Y/FEMALE

PTID : PTH202300262507

DATE: 27/07/2024

REFERRED BY: PACKAGE

INDICATION: Cardiac Evaluation

MEASUREMENTS :

AO	2.4cm	LVID (d)	4.5cm	IVS (d)	08mm
LA	2.9cm	LVID (s)	2.8cm	PW (d)	08mm
EF	60%				

VALVES:

MITRAL VALVE : Normal, Trace MR
AORTIC VALVE : Trileaflet, Normal, No AS/AR
TRICUSPID VALVE : Normal, Trace TR
PULMONARY VALVE : Normal, Trace PR

CHAMBERS:

LEFT ATRIUM : Normal
RIGHT ATRIUM : Normal
LEFT VENTRICLE : Normal in size, Normal LV Systolic Function
RIGHT VENTRICLE : Normal

SEPTAE:

IVS : Grossly Intact
IAS : Grossly Intact

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Dec 20, 2021 - Dec 18, 2025



GREAT ARTERIES:

AORTA : Grossly Normal
PULMONARY ARTERY : Grossly Normal

DOPPLER DATA:

MITRAL VALVE : E - 0.74m/sec, A - 0.69m/sec, E/A - 1.07m/sec
AORTIC VALVE : AV Vmax - 1.12m/sec
PULMONIC VALVE : PV Vmax - 0.61m/sec
TRICUSPID VALVE : TR Vmax - 1.64m/sec + RAP(5mmHg), RVSP=15mmHg

WALL MOTION ABNORMALITIES -- None

PERICARDIUM : Nil
IVC : Normal and Collapsing

FINAL IMPRESSION:

- Normal Chambers and Dimensions
- No RWMA at Rest, LVEF- 60%
- Normal LV Systolic Function
- Preserved LV Diastolic Function
- Normal Valves, Trace MR/TR
- Normal Resting Pulmonary Artery Pressure
- Normal RV Systolic Function, TAPSE : >18mm
- IVC 10mm, Normal and Collapsing >50%
- No Clot/Vegetation/Effusion

Seema
Echocardiographer

DR. K. MANJUNATH
Non-Invasive Cardiologist

(Please correlate with clinical findings)

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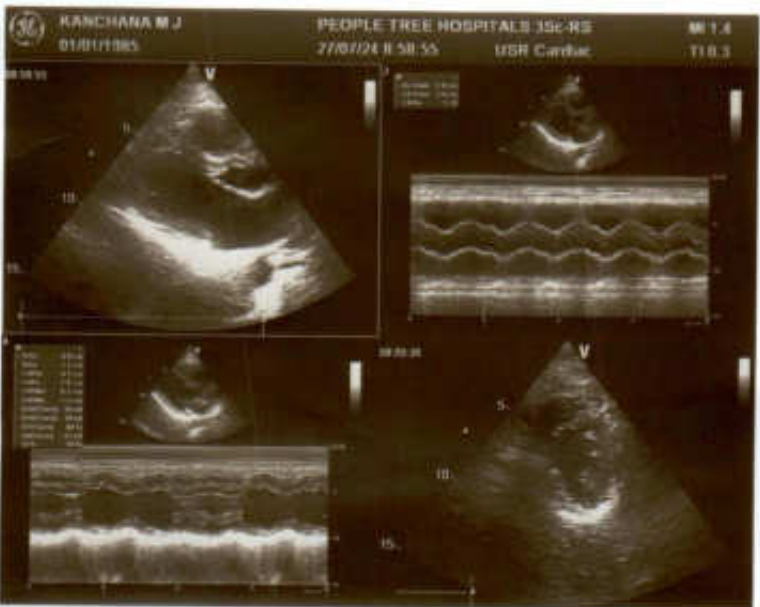
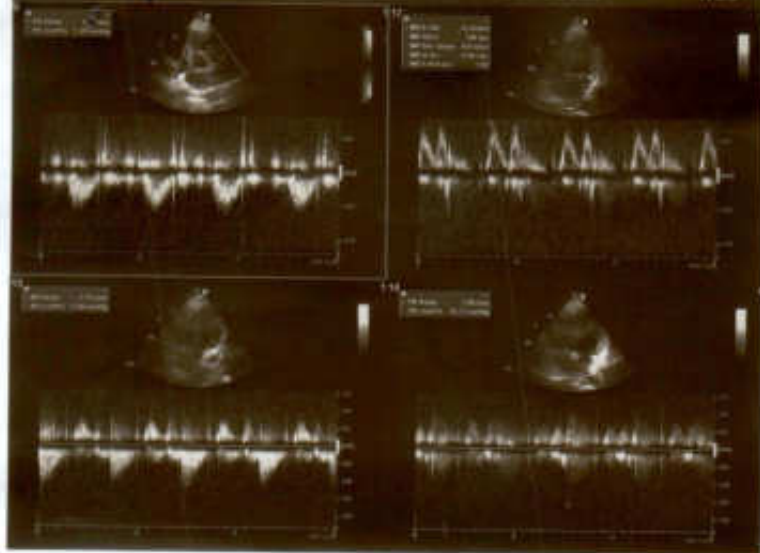
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Radiology Report

Patient Name : Mrs. KANCHANA M J **Age/Sex** : 39 Y/F **Order Date** : 27-07-2024 10:07
Ref by : **MR No.** : PTH202400262507

X RAY CHEST PA VIEW

FINDINGS:

- Lung fields are clear.
- No mediastinal shift.
- Both the hila appear normal.
- CP angles are normal.
- Cardiac diameter is within normal limits.
- Visible bony thoracic cage is normal.

IMPRESSION:

- **NORMAL STUDY**

DR PRADEEP A V
MBBS MD DNB FFM
Ex SR AIIMS DELHI & NIMHANS
**CONSULTANT RADIOLOGIST and
FETAL MEDICINE SPECIALIST**





Radiology Report

Patient Name : Mrs. KANCHANA M J Age/Sex : 39 Y/F Order Date : 27-07-2024 10:07
Ref by : MR No. : PTH202400262507

USG ABDOMEN AND PELVIS

LIVER: Normal in size (14.8cms), contour and echopattern. Intrahepatic biliary radicals are normal. Portal vein appears normal.

A small lobulated hyperechoic lesion measuring 30 x 18mm seen in segment III of liver with no internal vascularity – of concern for hemangioma

GALL BLADDER: Contracted and shows calculus measuring 16mm. CBD is not dilated and measures 5mm

PANCREAS: Normal in size, shape & has uniform echogenicity.

SPLEEN: Enlarged in size (15.6cms). No focal lesions seen.

KIDNEYS: Both the kidneys are normal in position, size, shape and contour.

Cortical echogenicity is normal, corticomedullary differentiation is well maintained.

RT.KIDNEY- 10.4cm in length and 1.8cm in parenchymal thickness. No calculi / hydronephrosis seen.

LT.KIDNEY- 12.0cm in length and 1.1cm in parenchymal thickness. No calculi / hydronephrosis seen.

URINARY BLADDER: Normal in outline and wall thickness.
No calculi or mucosal irregularity seen.

UTERUS: Anteverted and normal in size, shape, contour with uniform echotexture
No focal lesions seen. Endometrial thickness is 4.5mm.
Uterine measurements: 6.2 x 3.4 x 4.0cms

OVARIES: Bilateral ovaries are mild bulky in size and shows few peripherally arranged follicles

Right ovary measures 3.6 x 2.2 x 2.9cms (vol:129cc)

Left ovary measures 4.1 x 3.6 x 1.6cm (vol:12.6cc)

No adnexal mass lesions. No fluid in POD.

No free fluid / dilated / thickened bowel loops are noted.

IMPRESSION:

-A small lobulated hyperechoic lesion (30 x 18mm) in segment III of liver with no internal vascularity

-?hemangioma ??nature

- Contracted GB with cholelithiasis and thick sludge.

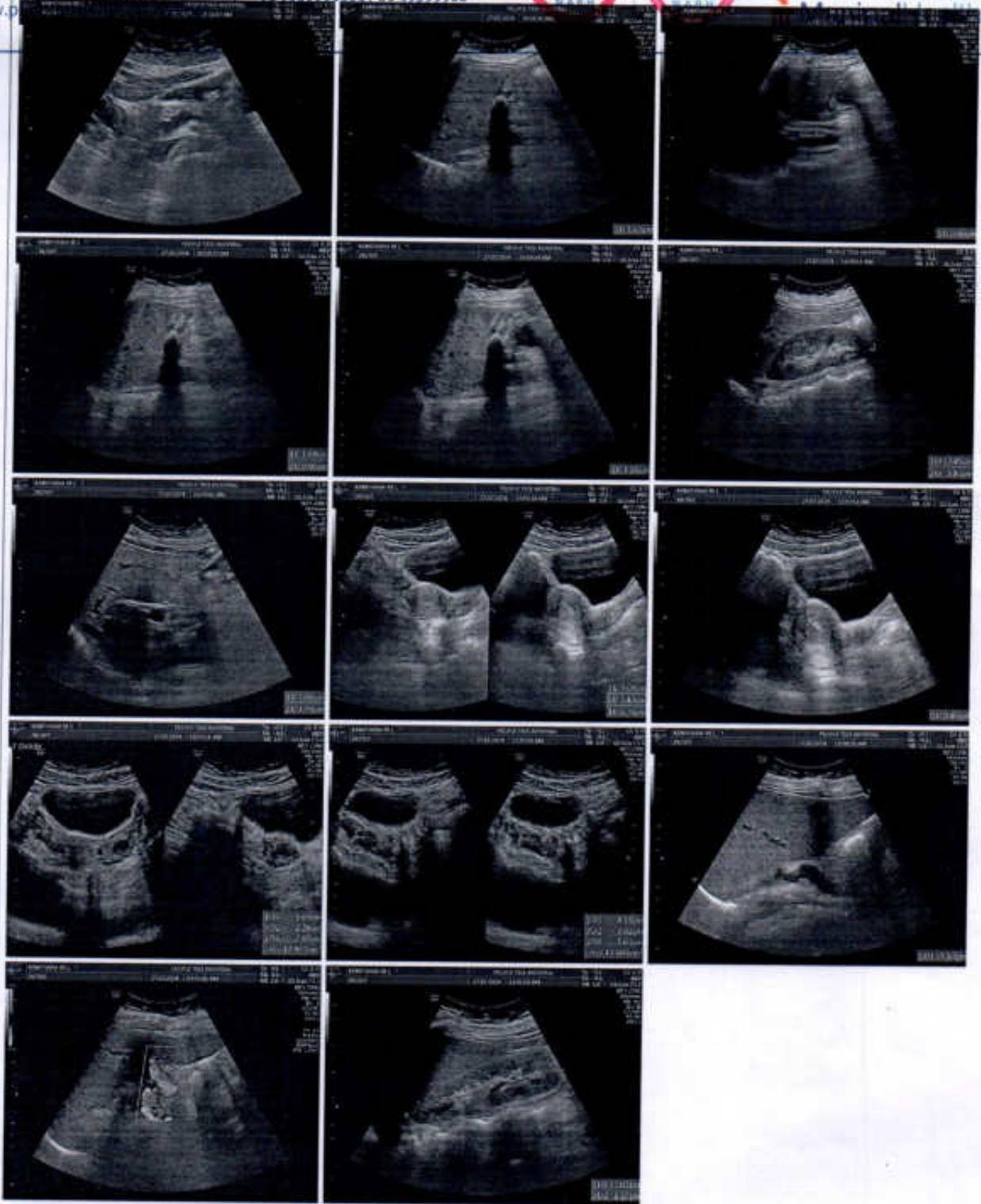
- Splenomegaly.

- Mildly bulky bilateral ovaries with few peripherally arranged follicles- of concern for polycystic ovarian pattern (Recommended lab correlation).

**Recommended triple phase CE-MRI abdomen for further evaluation*


DR ARPITA SANIKOP
CONSULTANT RADIOLOGIST









Radiology Report

Patient Name : Mrs. KANCHANA M J Age/Sex : 39 Y/F Order Date : 27-07-2024 10:07
Ref by : MR No. : PTH202400262507

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IMPRESSION:

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