UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SIDDAIAH H	Order No	: 1000068669
UHID	: UHJA23016530	Registered On	: 26/01/2024 09:50:52 AM
Age/Sex	: 36/Years Male	Collected On	: 26/01/2024 09:57:42 AM
Ward / Bed No	:	Reported On	: 26/01/2024 01:39:30 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230020603
Station	: At Hospital	Mobile No	: 9902516546
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	102	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	109	mg/dL	70-140
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.93	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.76	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.25	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	231	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	148	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	49.5	mg/dL	< 40 - Low ≥ 60 - High
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	151.9	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	29.60	mg/dL	< 30

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Test Name	Result	Unit	Bio. Ref. Interval
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.67		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.07		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	181.5	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.9	mg/dL	3.5-7.2
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.24	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.22	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.03	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.50	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.90	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.55		2:1
SERUM SGOT (Method:IFCC without P5P)	21	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	24	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	127	U/L	50-116

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Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
GGT (Method:IFCC)	28	U/L	< 55
CREATININE (Method:Modified Jaffe, Kinetic)	0.94	mg/dL	0.9-1.3

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)	15.82	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	47.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5400	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.47	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	21.68	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.81	%	0-6
MONOCYTES (Method:Optical/Impedance)	9.69	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.35	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.47	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	87.2	fL	78-100
MCH (Method: Calculated)	28.9	pg	27-31
MCHC (Method: Calculated)	33.2	g/dL	31-37
RDW - CV (Method: Calculated)	13.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.17	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)	7.11	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

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

ABO Group (Method:Agglutination Gel Method)	O	
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	5.0		5.0-8.0
SPECIFIC GRAVITY	1.025		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
PREETHI R

---End of Report---

Naveen.M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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AG RATIO (Method: Calculated)	1.55		2:1
SERUM SGOT (Method:IFCC without P5P)	21	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	24	U/L	< 50
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HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.82	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	47.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5400	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.47	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	21.68	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.81	%	0-6
MONOCYTES (Method:Optical/Impedance)	9.69	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.35	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.47	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	87.2	fL	78-100
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PLATELET COUNT (Method:Electrical Impedance)	2.17	Lakhs/Cum	1.5-4.5

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PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

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

ABO Group (Method:Agglutination Gel Method)	O	
Rh Factor (Method:Agglutination Gel Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

Naveen.N

Dr. Naveen Kumar
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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	5.0		5.0-8.0
SPECIFIC GRAVITY	1.025		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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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
PREETHI R

---End of Report---

Naveen.M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

26-Jan-2024 AM10:12:22

1 2180

ID:16530

Name:siddaiah h

Birth date:

36 years

1100 Sinus rhythm

9110 ** normal ECG **

ex:M

cm kg / mmHg

edication:

ymptoms:

istory:

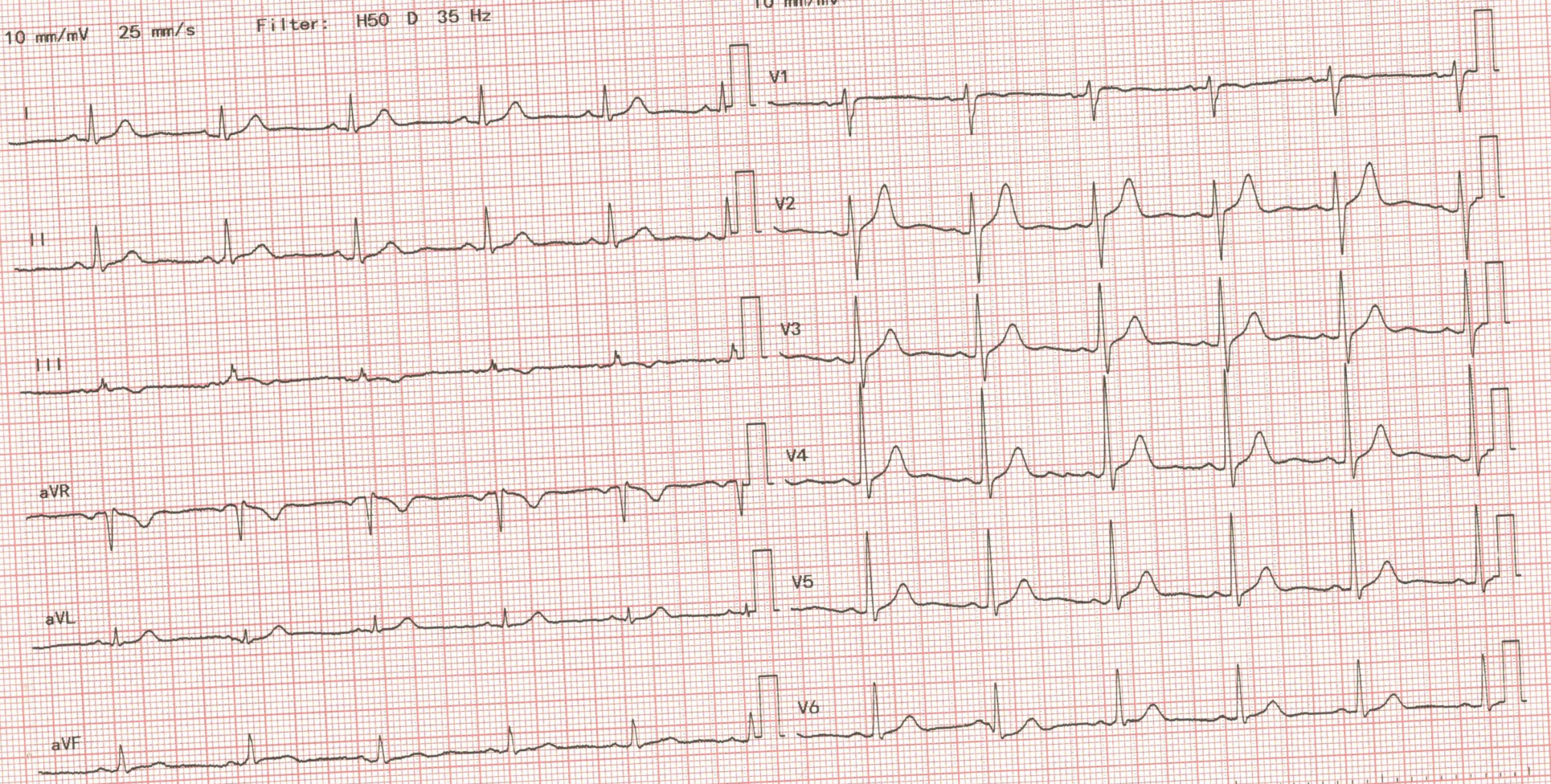
ent. rate	72	bpm
R int	140	ms
RS dur	92	ms
T/QTc(E) int	356/ 380	ms
/QRS/T axis	26/ 37/ 16	°
V5/SV1 amp	1.44/ 0.59	mV
V5+SV1 amp	2.03	mV

Unconfirmed Report

Reviewed by:

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

10 mm/mV



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.SIDDAIAH H**	**UHID**	**: UHJA23016530**
Age / Sex	: 36 Years / Male	OP NO/Reg Dt	: OP230000019654 / 26-01-2024 09:50 AM
Father Name	:	Department	:
Spouse Name	: HENJERAPPA	Refered By	:
Address	: Madhurigiri TUmkur District, BANGALORE CITY H O, Bengaluru Urban, Karnataka, INDIA, 560002	Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

HT: 172 Cm
WT: 94 kg
SpO2: 98 %
PR: 82 bpm
Bp: 120/70 mmHg.

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

DEPARTMENT OF RADIODIAGNOSIS

Patient name	Mr. Siddaiah H	**Patient ID**	UJHA23016530
Age	36 years	**Sex**	Male
Referring doctor	Health check	**Date**	26/01/24

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(11cms, PT -1.2cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size(10.7cms, PT-1.3cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum – Visualized part of the 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.
Prostate is normal in echopattern and size, measures ~ cc.
Fluid - There is no ascites or pleural effusion.
Appendix could not be localized, obscured by bowel gas. No mass / collection in RIF /LIF.

IMPRESSION:

No definite sonological abnormality detected.

Dr. GIRIDHAR V S
Consultant Radiologist

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Siddaiah H	**Date**	26/01/24
Age	36 years	**Hospital ID**	UHJA2316530
Sex	Male	**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. Giridhar V S
Consultant Radiologist