

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mrs. SUMALATHA	Order No : 1000073781
UHID : UHJ A23018760	Registered On : 20/02/2024 09:06:23 AM
Age/Sex : 36/Years Female	Collected On : 20/02/2024 09:46:13 AM
Ward / Bed No :	Reported On : 20/02/2024 01:36:42 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230023195
Station : At Hospital	Mobile No : 9480891108
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	119	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	183	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	7.0	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	154.19	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.02	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	5.35	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	3.60	µIU/mL	0.34 - 5.60 µIU/mL (Non Pregnant) 0.3 - 4.5 µIU/mL (I trimester) 0.5 - 5.2 µIU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	157	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	103	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	40.0	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	96.4	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	20.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.9		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.4		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	117	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.3	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10.5	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.58	mg/dL	0.6-1.1
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.57	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.47	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.7	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.50	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.20	g/dL	2.3-3.5

Sample: Serum

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AG RATIO (Method: Calculated)	1.40		2:1
SERUM SGOT (Method:IFCC without P5P)	22	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	35	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	65	U/L	46-122
GGT (Method:IFCC)	32	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)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	13.39	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	40.9	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9070	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	63.11	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	26.49	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.24	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.86	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.30	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.87	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	83.9	fL	78-100
MCH (Method: Calculated)	27.5	pg	27-31
MCHC (Method: Calculated)	32.7	g/dL	31-37
RDW - CV (Method: Calculated)	14.4	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.56	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.09	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	21.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-20
BLOOD GROUPING & RH TYPING			
Sample: Whole blood (EDTA)			
ABO Group (Method:Agglutination Gel Method)	A		
Rh Factor (Method:Agglutination Gel Method)	Negative		

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

PHYSICAL EXAMINATION

VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.015		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

DEPARTMENT OF LABORATORY MEDICINE

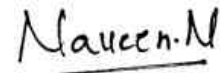
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EPITHELIAL CELLS	4-6	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

URINE SUGAR, FASTING Absent
(Method:GOD-POD)

Verified By
NAGARATNA

---End of Report---



Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

20-Feb-2024 AM9:22:08

ID: 18760

Name: Mrs. Sumalatha

Birth date: / /

36 years

1100 Sinus rhythm

4068 Nonspecific T wave abnormality [flat T or negative T (II, aVF, V5, V6)]

9130 ** borderline ECG **

mmHg

86 bpm

144 ms

78 ms

354/ 397 ms

61/ -62/ -30

0.57/ 0.62 mV

1.20 mV

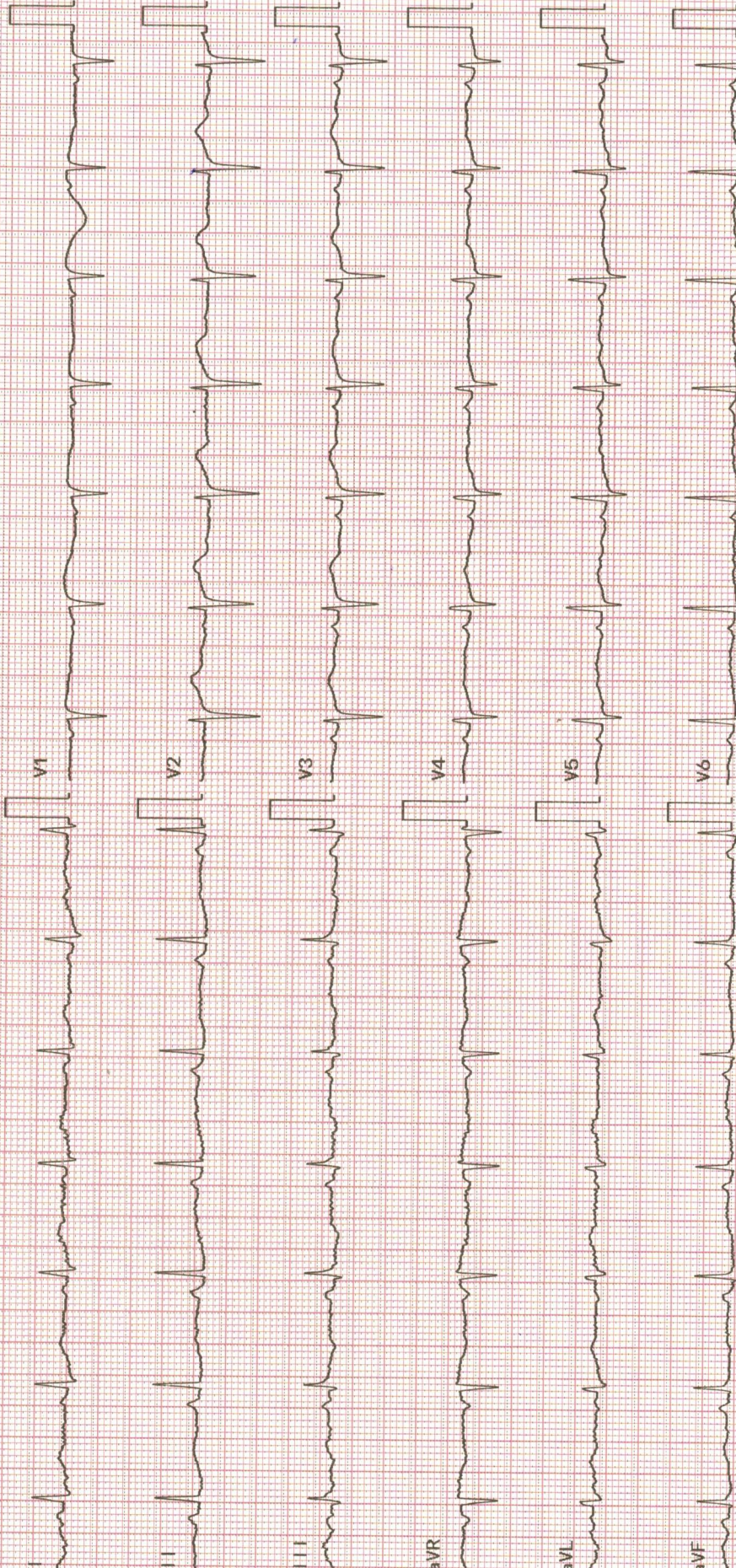
Unconfirmed Report

Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

25 mm/s





NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. SUMALATHA	Date :	20/02/24
Age :	36 years GENDER: FEMALE	Patient ID :	18760
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY**M - MODE AND DOPPLER MEASUREMENTS**

(c.m)	(c.m)	(cm/sec)		
AO : 2.8 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV : 77.6	AV : 59.2	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 3.0 (2.4-4.2)	AV : 106		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 113		PR : NORMAL
RV : 2.1 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 0.7 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.9 (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 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



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 NORMAL LV SYSTOLIC FUNCTION EF : 60%
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 NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
 CONSULTANT CARDIOLOGIST



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Jayanagar, Bangalore

Out Patient Record

Patient Name : Mrs.SUMALATHA

UHID : UHJA23018760

Age / Sex : 36 Years / Female

OP NO/Reg Dt : 20-02-2024 09:06 AM

Spouse / Father Name : NANDEESH M H

Department :

Address : # Arekere New Extension 4th Cross Anush
Ashvik Nilaya Yellapura Tumkur,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

for health check up

HT- 155 cm
wt- 89 kg
BP- 163/106
SpO2- 97%
PR 80b/w

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and
Gynecologist, Laparoscopy
and IVF Specialist
KMC Reg. No. 90384

Investigations:

no y. AM, Hb, etc

Treatment / Care of Plan / Provisional Diagnosis :

Has h.p. Bleeds p/w

Follow Up Advice :

On mifepristone, pt is on blood pills.

PTA - w/ spots

P/S = pt started bleeding
Brownish discharge (+) (+)

MC - 2 day
P/A
AA - 200
USS
Cranial thickness
LMP - 27/1/24
P/A - 100g

Boh

Signature of the Doctor

Letter of c/s
people agreement
(Letter of Medical by for
DRUR)

Last resort
if medical by teacher

↓
UAC

BR



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Jayanagar, Bangalore

Out Patient Record

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UHID : UHJA23018760

Age / Sex : 36 Years / Female

OP NO/Reg Dt : 20-02-2024 09:06 AM

Spouse / Father Name : NANDEESH M H

Department :

Address : # Arekere New Extension 4th Cross Anush
Ashvik Nilaya Yellapura Tumkur,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. : (Ophtho)

Complaints / Findings / Observations :

not using glasses. Had taken 1 pair of glasses previous
nil systems.

Vh } N₃
6/24 PK 6/18
6/18 PK 6/12

Investigations:

Mtg OU : Grated cornea
Pupils RR.

-1.50 / -4.00 X 13°
-0.50 / -6.25 X 170°

Treatment / Care of Plan / Provisional Diagnosis :

Fundus OU CDH 0.3:1, PRAH
(added)

Follow Up Advice :

Ih. OU Referral

Adv @ Dilated fundus examination
@ Dilated AR.

Signature of the Doctor
Dr. Shubra



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No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore**DEPARTMENT OF RADIODIAGNOSIS**

Name	Sumalatha	Date	20/02/24
Age	36 years	Hospital ID	UHJA23018760
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS (TAS & TVS)**FINDINGS:**

Liver is enlarged in size (17 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 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 (9.8 x 3.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (10.9 x 4.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum- Obscured by bowel gas.

Urinary Bladder is well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.

Uterus is anteverted and **bulky in size, measures 9.4 x 6.8 x 5.8 cm. Myometrial echoes are heterogeneous. Endomyometrial junction is indistinct.** Endometrium measures 3 mm. **IUCD is seen in situ in upper uterine cavity.**

Right ovary is normal in size and echopattern, measures 4.1 cc.

Left ovary is normal in size and echopattern, measures 3.8 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: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Bulky uterus with heterogeneous myometrial echoes - of concern for adenomyosis.**
- **IUCD in situ in upper uterine cavity.**
- **Mild hepatomegaly with moderate fatty infiltration (Grade II).**

Dr. Elluru Santosh Kumar



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**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sumalatha	Date	20/02/24
Age	36 years	Hospital ID	UHJA23018760
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Mild cardiomegaly is seen.

The bony thorax is grossly normal.

IMPRESSION:

- Mild cardiomegaly.
- No other significant radiographic abnormality.

Dr. Elluru Santosh Kumar
Consultant Radiologist



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PTA - w/ spots
 P/S = pt started
 bleeding

Brownish discharge (+) (+)

MC - 2 day
 P/A
 AA - 200
 USS
 Cruminal tablet
 LMP - 27/1/24
 PRC - 10 days

Boh

Signature of the Doctor

Letter of c/s
people agreement
(Letter of Medical by for
DRUR)

Last resort
if medical by teacher

↓
UAC

BR