

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. VIJAY KUMAR K	Order No : 1000097477
UHID : UHJ A24006013	Registered On : 28/09/2024 08:09:32 AM
Age/Sex : 33/Years Male	Collected On : 28/09/2024 08:32:31 AM
Ward / Bed No :	Reported On : 28/09/2024 11:32:36 AM
Reference : Dr. Ashmitha Padma	Bill No : OPBJ A240008288
Station : At Hospital	Mobile No : 9620307010
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	98	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	95	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	111	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.16	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.74	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.28	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	233	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	132	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	44.9	mg/dL	< 40 - Low ≥ 60 - High



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

NABH No.1
Patient Name : Mr.VIJAY KUMAR K

UHID : UHJA24006013

Age / Sex : 33 Years / Male

OP NO/Reg Dt : 28-09-2024 08:09 AM

Spouse / Father Name : KUMAR

Department :

Address : FLAT NO 114, 1ST FLOOR, DS MAX
SASTA BSK 5TH STAGE, , Bengaluru

Referred By :

Consultant : Dr.Ashmitha Padma MBBS, MD
(GENERAL MEDICINE), PGDCC,FEM
KMC No. : 02M1087

Complaints / Findings / Observations :

Wt-75.51kg

HT-172cm

BP-140/80
mmHg

Investigations:

SpO₂-96%

PP 60b/w

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL (A Unit of United Brothers Healthcare Services Private Limited)

United Hospital

No.110 (30), Madhavan Park Circle, 10th Main Rd,
3rd Block Jayanagar, Bangalore - 560029

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LDL CHOLESTEROL (Method: Calculated)	161.70	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	26.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.19		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.60		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	188.10	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.0	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	1.03	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.68	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.14	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.54	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.31	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.79	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.54		2:1



NABH



No.1

PATIENT NAME :	Mr. VIJAY KUMAR K	DATE :	28/09/24
AGE :	33 YEARS GENDER : MALE	PATIENT ID :	24008288
REF BY :	CMO	OP/ IP :	HEALTH CHECK

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

(cm)	(cm)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV: 0.8	AV: 0.5	MR : NORMAL
LA : 3.4 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 1.1		AR : NORMAL
RA : 2.1 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 0.9		PR : NORMAL
RV : 1.8 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR, PASP-30mmHg
TAPSE : 1.9 (>1.6)	LVPWD : 1.1 (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 AND COLLAPSING

IMPRESSION:

BRADYCARDIA OBSERVED DURING THE STUDY (HR – 58 bpm)

NORMAL CHAMBER DIMENSIONS

NORMAL LV SYSTOLIC FUNCTION EF : 60%

NORMAL LV DIASTOLIC FUNCTION

NO PULMONARY ARTERY HYPERTENSION

NO REGIONAL WALL MOTION ABNORMALITIES

NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	21	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	52	U/L	50-116
GGT (Method:IFCC)	38	U/L	< 55



Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Vijay Kumar K	Date	28/09/24
Age	33 years	Hospital ID	UHJA24006013
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS
FINDINGS:

Liver is normal in size and *shows mildly 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 focal lesion.

Right Kidney is normal in size (10.6 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (11.0 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis. *Prominent extra renal pelvis is seen, measures 1.5 cms in AP dimension.*

Retroperitoneum - Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is over distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 13.5 cc.

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

IMPRESSION:

- Mild fatty infiltration of liver (Grade I).
- No other definite sonological abnormality detected.



Dr. Elluru Santosh Kumar
Consultant Radiologist

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HAEMATOLOGY
COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.58	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.1	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4500	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	56.22	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	37.15	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.13	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.30	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.20	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.62	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	80.3	fL	78-100
MCH (Method: Calculated)	25.9	pg	27-31
MCHC (Method: Calculated)	32.3	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.88	Lakhs/Cum	1.5-4.5



NABH



No.1



DEPARTMENT OF RADIODIAGNOSIS

Name	Vijay Kumar K	Date	28/09/24
Age	33 years	Hospital ID	UHJA24006013
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.

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.10	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	21.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-15
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Method)	A		
Rh Factor (Method:Agglutination Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

ID: 24006013

Name: MR VIJAY KUMAR

Birth date: / /

33 years

1100 Sinus rhythm

0102 ARTIFACT PRESENT

9110 ** normal ECG **

Sex: M cm kg mmHg

Indication:

Symptoms:

History:

Heart rate 55 bpm

R int 170 ms

RS dur 94 ms

T/QTC(E) int 410/398 ms

/QRS/T axis 54/26/7 °

M5/SV1 amp 1.40/1.21 mV

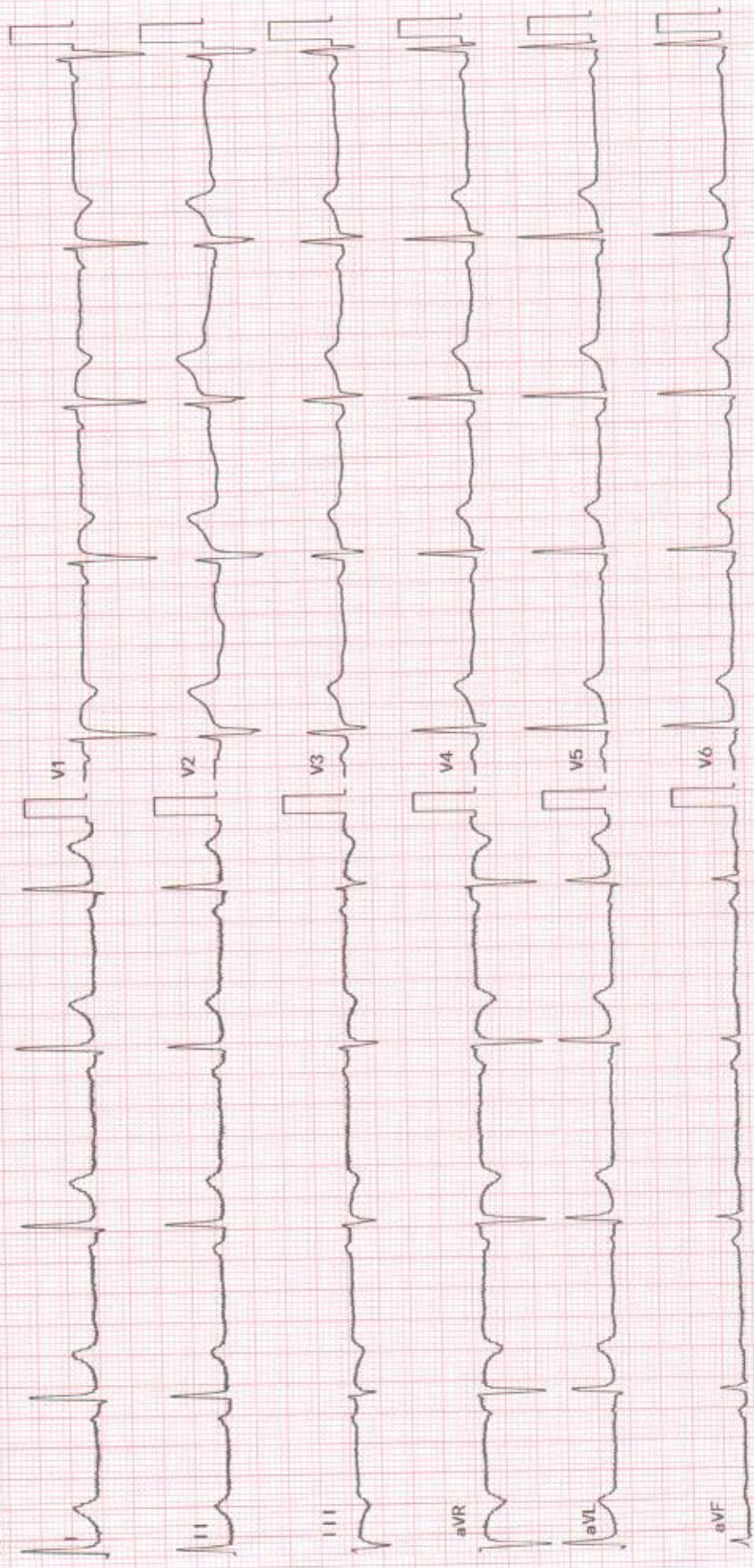
M5+SV1 amp 2.62 mV

Unconfirmed Report
Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s



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<u>CLINICAL PATHOLOGY</u>			
URINE EXAMINATION, ROUTINE			Sample: Urine
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.005		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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EPITHELIAL CELLS	0-2	/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 (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Arpitha S R

---End of Report---



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