



NABH



NABL



No.1

Patient name :	Mr. KARUNAKRAN R	Date :	07/02/24
Age :	35 years GENDER: MALE	Patient ID :	17854
Ref by :	DR. CMO	OP/IP :	HEALTH CHECK

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

(c.m)	(c.m)	(cm/sec)		
AO : 2.9 (2.5-3.7)	LVIDD : 5.0 (3.5-5.5)	MV EV : 96.2	AV : 63.1	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 3.7 (2.4-4.2)	AV : 145		AR : TRIVIAL AR
RA : 2.5 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 90.2		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : -----	AV : -----	TR : TRIVIAL TR
TAPSE: 1.7 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (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, AML PROLAPSE
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL, TRIVIAL TR, JET GRDT-25mmHg
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

Name: Mr. Kaaruna Karan. R
Sex: M
cm kg
Birth date: / mmHg

35 years

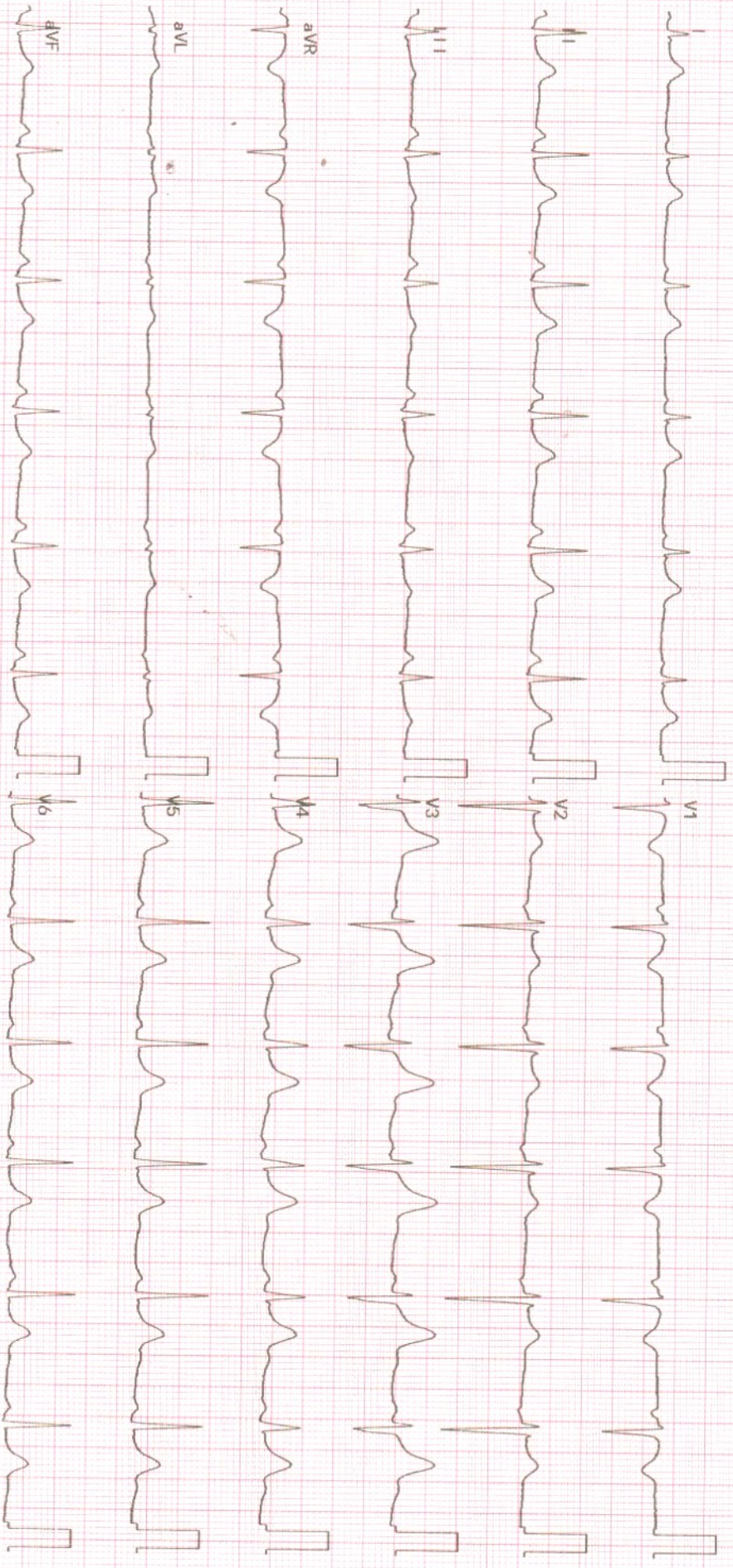
1100 Sinus rhythm
9110 ** normal ECG **

Indication:
Symptoms:
History:
Heart rate: 73 bpm
RR int: 142 ms
RS dur: 80 ms
T/QTc(E) int: 382/407 ms
I/QRST axis: 70/ 64/ 45
V5/SV1 amp: 1.28/ 0.99 mV
V5+SV1 amp: 2.27 mV

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

10 mm/mV

Unconfirmed Report
Reviewed by:



Out Patient Record

Patient Name : Mr.KARUNAKARAN R UHID : UHJA23017854
Age / Sex : 35 Years 7 Male OP NO/Reg Dt : 07-02-2024 09:56 AM
Spouse / Father Name : RAJAGOPAL N Department :
Address : Jayanagar, BANGALORE CITY H O, Referred By :
Bengaluru Urban, Karnataka, INDIA, 560002 Consultant : Dr.Preventive Health Check Up
KMC No. : Dr. Shwetha

Complaints / Findings / Observations : ophthalmology Prescription
nil significant

Investigations:

V_n }
(glass) 6/6 }
6/6 } y:

M.S. normal

Treatment / Care of Plan / Provisional Diagnosis :

End's ov CData 0.3:1, RAFF
(injected)

Inform : ov Ref Eval

Follow Up Advice :

Signature of the Doctor
7/2/24 :

Out Patient Record

Patient Name : Mr.KARUNAKARAN R

UHID : UHJA23017854

Age / Sex : 35 Years / Male

OP NO/Reg Dt : 07-02-2024 09:56 AM

Spouse / Father Name : RAJAGOPAL N

Department : Health Check

Address : Jayanagar, BANGALORE CITY H O,
Bengaluru Urban, Karnataka, INDIA, 560002

Referred By : Medicheck

Consultant : Dr.Preventive Health Check Up

KMC No. : Dr. Anulecha

Complaints / Findings / Observations :

Regular health check up

Ht - 174cm
Wt - 70.7kg
BP - 102/62
PR - 78 bpm
SpO2 - 99%

Investigations:

Treatment / Care of Plan / Provisional Diagnosis : ODO

① cap D-RISE GER weekly once
x6 weeks

Follow Up Advice :

Medically fit.


Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Karunakarana R	Date	07/02/24
Age	35 years	Hospital ID	UHJA23017854
Sex	Male	Ref.	Healthcheck

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 focal lesion.

Right Kidney is normal in size (8.9 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.1 x 4.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

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

Urinary Bladder is minimally distended.

Prostate is normal in echopattern and size, measures ~ 12.5 cc.

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

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

DEPARTMENT OF RADIODIAGNOSIS

Name	Karunakaran R	Date	07/02/24
Age	35 years	Hospital ID	UHJA23017854
Sex	Male	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles appear blunted. However on ultrasound no obvious pleural effusion / thickening is seen.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- No significant radiographic abnormality.



Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. KARUNAKARAN R	Order No : 1000071854
UHID : UHJ A23017854	Registered On : 07/02/2024 09:56:28 AM
Age/Sex : 35/Years Male	Collected On : 07/02/2024 09:59:35 AM
Ward / Bed No :	Reported On : 07/02/2024 02:21:54 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230022103
Station : At Hospital	Mobile No : 9626414416
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	94	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	102	mg/dL	70-140
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.10	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.66	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.67	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	164	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	39	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	53.4	mg/dL	< 40 - Low ≥ 60 - High
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	102.8	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	7.79	mg/dL	< 30

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TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.0		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.9		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	110.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.2	mg/dL	3.5-7.2
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.39	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.29	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.10	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.43	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.57	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.72		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	15	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	58	U/L	50-116

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Test Name	Result	Unit	Bio. Ref. Interval
GGT (Method:IFCC)	17	U/L	< 55
CREATININE (Method:Modified Jaffe, Kinetic)	0.91	mg/dL	0.9-1.3



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)	14.53	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.2	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5170	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	31.41	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	57.02	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.29	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.95	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.33	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.92	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	87.9	fL	78-100
MCH (Method: Calculated)	29.5	pg	27-31
MCHC (Method: Calculated)	33.6	g/dL	31-37
RDW - CV (Method: Calculated)	13.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.25	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.13	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.4	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 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

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	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	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
PRAVEEN T

---End of Report---

Naveen M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418