

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. SUKESH HEGDE	Order No : 1000074741
UHID : UHJ A23019200	Registered On : 27/02/2024 09:13:26 AM
Age/Sex : 35/Years Male	Collected On : 27/02/2024 09:20:13 AM
Ward / Bed No :	Reported On : 27/02/2024 01:52:37 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230023750
Station : At Hospital	Mobile No : 7760852253
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	109	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	71	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105.40	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.22	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	9.5	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	2.76	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	208	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	89	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	45.4	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	144.8	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	17.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.5		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.1		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	162.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.7	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	1.09	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.61	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.50	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.33	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.07	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.41		2:1

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SERUM SGOT (Method:IFCC without P5P)	20	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	14	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	54	U/L	50-116
GGT (Method:IFCC)	21	U/L	< 55



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)	13.94	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	42.3	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4990	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	41.25	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	41.22	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	10.87	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.23	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.43	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.11	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	82.8	fL	78-100
MCH (Method: Calculated)	27.3	pg	27-31
MCHC (Method: Calculated)	33.0	g/dL	31-37
RDW - CV (Method: Calculated)	14.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.71	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.65	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.5	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	9	mm/hour	1-15
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Gel Method)	A		
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	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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

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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		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---

Naveen M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

1100 Sinus rhythm
 2231 First degree AV block [PR int. >= 210 ms]
 6220 Possible left atrial enlargement [-0.1 mV Pwave in lead V1/V2]
 9150 ** abnormal ECG **

years

Birth date: / mmHg

Sex: M kg

Indication:

Symptoms:

History:

Heart rate 67 bpm

PR int 210 ms

RS dur 104 ms

T/QTc(E) int 400/ 415 ms

V/QRS/T axis 66/ 51/ 48 °

M5/SV1 amp 2.32/ 1.53 mV

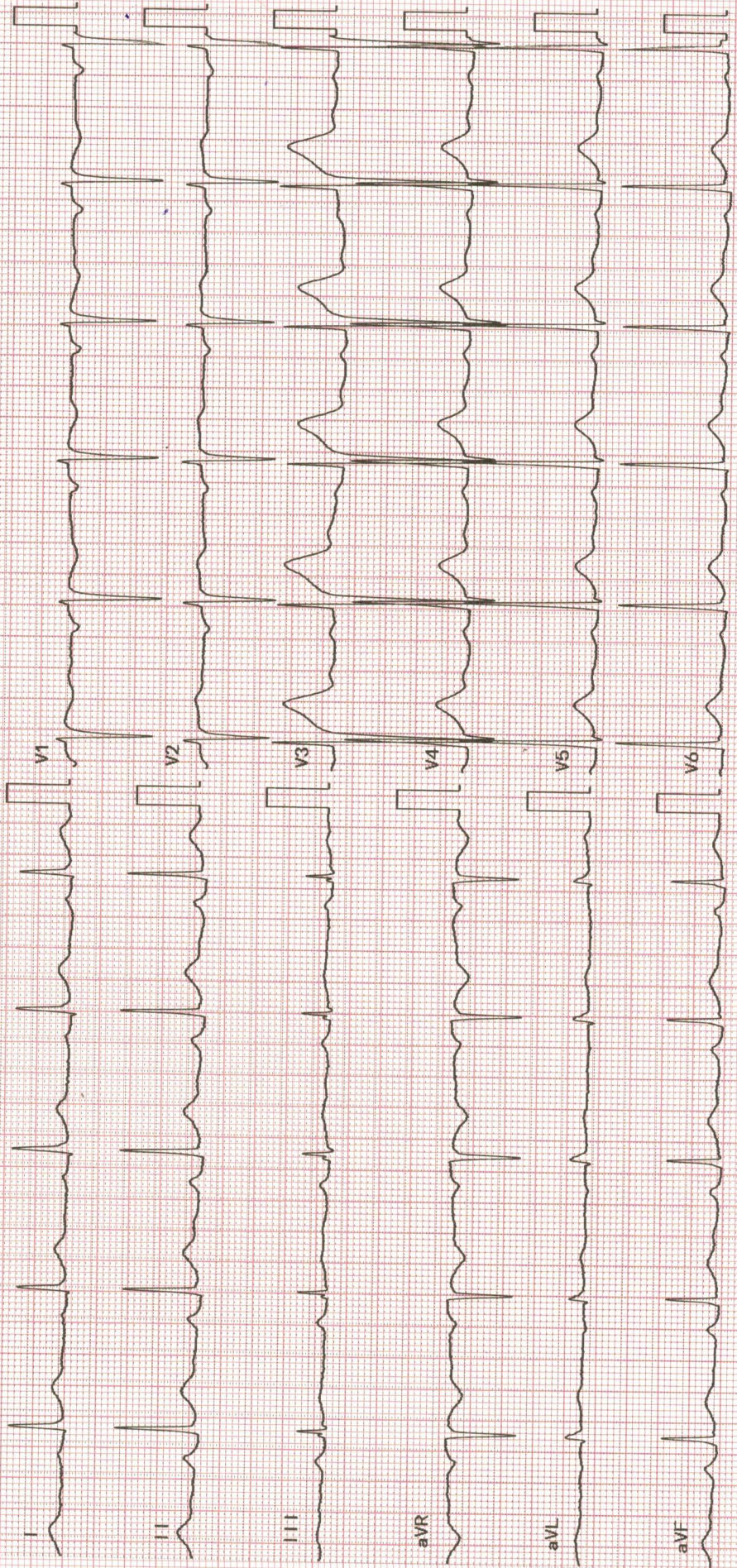
M5+SV1 amp 3.85 mV

Unconfirmed Report
Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s





NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mr.SUKESH HEGDE

UHID : UHJA23019200

Age / Sex : 35 Years / Male

OP NO/Reg Dt : 27-02-2024 09:13 AM

Spouse / Father Name : KARUMAKER HEGDE

Department :

Address : jp nagar 24 main rd 310 floy no, , Bengaluru
Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. : Dr. Ashwatha Padma

Complaints / Findings / Observations :

WT - 85.5

HT - 184cm

Bp - 126/72

SpO2 - 98

PR - 70b

Investigations:

CDL - 144

Treatment / Care of Plan / Provisional Diagnosis :

Repeat fasting lipid
profile
after 3 weeks.

High fibre diet

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Sukesh Hegde	Date	27/02/24
Age	35 years	Hospital ID	UHJA23019200
Sex	Male	Ref.	Health check

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 (10.7 x 3.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.1 x 4.4 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 ~ 14.7 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



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sukesh Hegde	Date	27/02/24
Age	35 years	Hospital ID	UHJA23019200
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. *Small right cervical rib is seen.*

IMPRESSION:

- No radiographic abnormality.

Dr. Elluru Santosh Kumar
Consultant Radiologist