

DEPARTMENT OF LABORATORY MEDICINE

| | | | |
|---------------|----------------------------------|---------------|--------------------------|
| Patient Name | : Mr. RAJ EEV RANJ AN | Order No | : 1000092981 |
| UHID | : UHJ A24004413 | Registered On | : 10/08/2024 08:12:04 AM |
| Age/Sex | : 33/Years Male | Collected On | : 10/08/2024 08:35:30 AM |
| Ward / Bed No | : | Reported On | : 10/08/2024 03:29:00 PM |
| Reference | : Dr. Preventive Health Check Up | Bill No | : OPBJ A240006159 |
| Station | : At Hospital | Mobile No | : 9591412818 |
| Payer Name | : Mediwheel | Report Status | : Final Report |

| Test Name | Result | Unit | Bio. Ref. Interval |
|--|--------|--------|--|
| <u>BIOCHEMISTRY</u> | | | |
| FASTING GLUCOSE (Method: Hexokinase) | 100 | mg/dL | ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes |
| POST PRANDIAL GLUCOSE (Method: Hexokinase) | 85 | mg/dL | 70-140 |
| GLYCOSYLATED HAEMOGLOBIN (HBA1C) | | | Sample: Whole blood (EDTA) |
| HBA1C (Method: HPLC) | 4.7 | % | ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes |
| Estimated Average Glucose (eAG) (Method: Calculated) | 88 | mg/dL | |
| THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH) | | | Sample: Serum |
| TOTAL T3 (Method:CLIA) | 1.33 | ng/mL | 0.87-1.78 |
| TOTAL T4 (Method:CLIA) | 9.36 | ng/dL | 5.1-14.1 |
| THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive) | 2.00 | μIU/mL | 0.34-5.60 |
| LIPID PROFILE | | | Sample: Serum |
| TOTAL CHOLESTEROL (Method:CHOD-POD) | 301 | mg/dL | ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High |
| TRIGLYCERIDES (Method:Enzymatic GPO-POD) | 304 | mg/dL | < 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High |
| HDL CHOLESTEROL (Method:ENZYMATIC METHOD) | 55.0 | mg/dL | < 40 - Low ≥ 60 - High |

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| LDL CHOLESTEROL (Method: Calculated) | 185.2 | mg/dL | <100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high |
| VLDL CHOLESTEROL (Method: Calculated) | 60.79 | mg/dL | < 30 |
| TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated) | 5.47 | | Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 |
| LDL/HDL CHOLESTEROL RATIO (Method: Calculated) | 3.36 | | < 2.5 Optimal |
| NON HDL CHOLESTEROL (Method: Calculated) | 246 | mg/dL | < 130 |
| URIC ACID (Method:Uricase - POD(Enzymatic)) | 5.4 | mg/dL | 3.5-7.2 |
| CREATININE (Method:Modified Jaffe, Kinetic) | 0.73 | mg/dL | 0.9-1.3 |
| LIVER FUNCTION TEST | | | Sample: Serum |
| TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization) | 0.52 | mg/dL | 0.3-1.2 |
| DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization) | 0.10 | mg/dL | 0.0-0.2 |
| INDIRECT BILIRUBIN (Method: Calculated) | 0.43 | mg/dL | 0.2-1.0 |
| TOTAL PROTEIN (Method:BIURET) | 6.6 | g/dL | 6.6-8.3 |
| ALBUMIN (Method:BCG) | 4.33 | g/dL | 3.5-5.2 |
| GLOBULIN (Method: Calculated) | 2.27 | g/dL | 2.3-3.5 |
| AG RATIO (Method: Calculated) | 1.90 | | 2:1 |

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| SERUM SGOT (Method:IFCC without P5P) | 31 | U/L | < 50 |
| SERUM SGPT (Method:IFCC without P5P) | 45 | U/L | < 50 |
| ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer) | 64 | U/L | 50-116 |
| GGT (Method:IFCC) | 20 | U/L | < 55 |



Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

| | | | |
|--|-------|-------------|------------|
| HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method) | 13.24 | g/dL | 13.5-17.5 |
| PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated) | 39.4 | % | 42-52 |
| TOTAL WBC COUNT (TLC) (Method:Coulter Principle) | 6320 | Cells/Cum | 4000-11000 |
| DIFFERENTIAL COUNT | | | |
| NEUTROPHILS (Method:Optical/Impedance) | 57.70 | % | 40-75 |
| LYMPHOCYTES (Method:Optical/Impedance) | 28.12 | % | 20-45 |
| EOSINOPHILS (Method:Optical/Impedance) | 6.08 | % | 0-6 |
| MONOCYTES (Method:Optical/Impedance) | 7.86 | % | 2-10 |
| BASOPHILS (Method:Optical/Impedance) | 0.24 | % | 0-2 |
| RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle) | 4.61 | million/cum | 4.5-5.9 |
| MCV (Method:Derived from RBC Histogram) | 85.5 | fL | 78-100 |
| MCH (Method: Calculated) | 28.7 | pg | 27-31 |
| MCHC (Method: Calculated) | 33.6 | g/dL | 31-37 |
| RDW - CV (Method: Calculated) | 14.7 | % | 11.5-14.5 |
| PLATELET COUNT (Method:Electrical Impedance) | 2.29 | Lakhs/Cum | 1.5-4.5 |

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| MEAN PLATELET VOLUME(MPV) <small>(Method:Derived from PLT Histogram)</small> | 9.85 | fl | 9-13 |
| PLATELET DISTRIBUTION WIDTH (PDW) <small>(Method: Calculated)</small> | 19.5 | fl | 9-19 |
| ERYTHROCYTE SEDIMENTATION RATE(ESR) <small>(Method:Modified Westergren Method)</small> | 10 | mm/hour | 1-15 |

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

| | |
|---|----------|
| ABO Group <small>(Method:Agglutination Method)</small> | A |
| Rh Factor <small>(Method:Agglutination Method)</small> | Positive |

Interpretation Notes

Note: Both forward and reverse grouping performed



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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

| | | | |
|------------------|-------------|----|-------------|
| VOLUME | 30 | mL | |
| COLOUR | Pale Yellow | | |
| APPEARANCE | Clear | | |
| PH | 5.0 | | 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 | 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
Arpitha S R

---End of Report---



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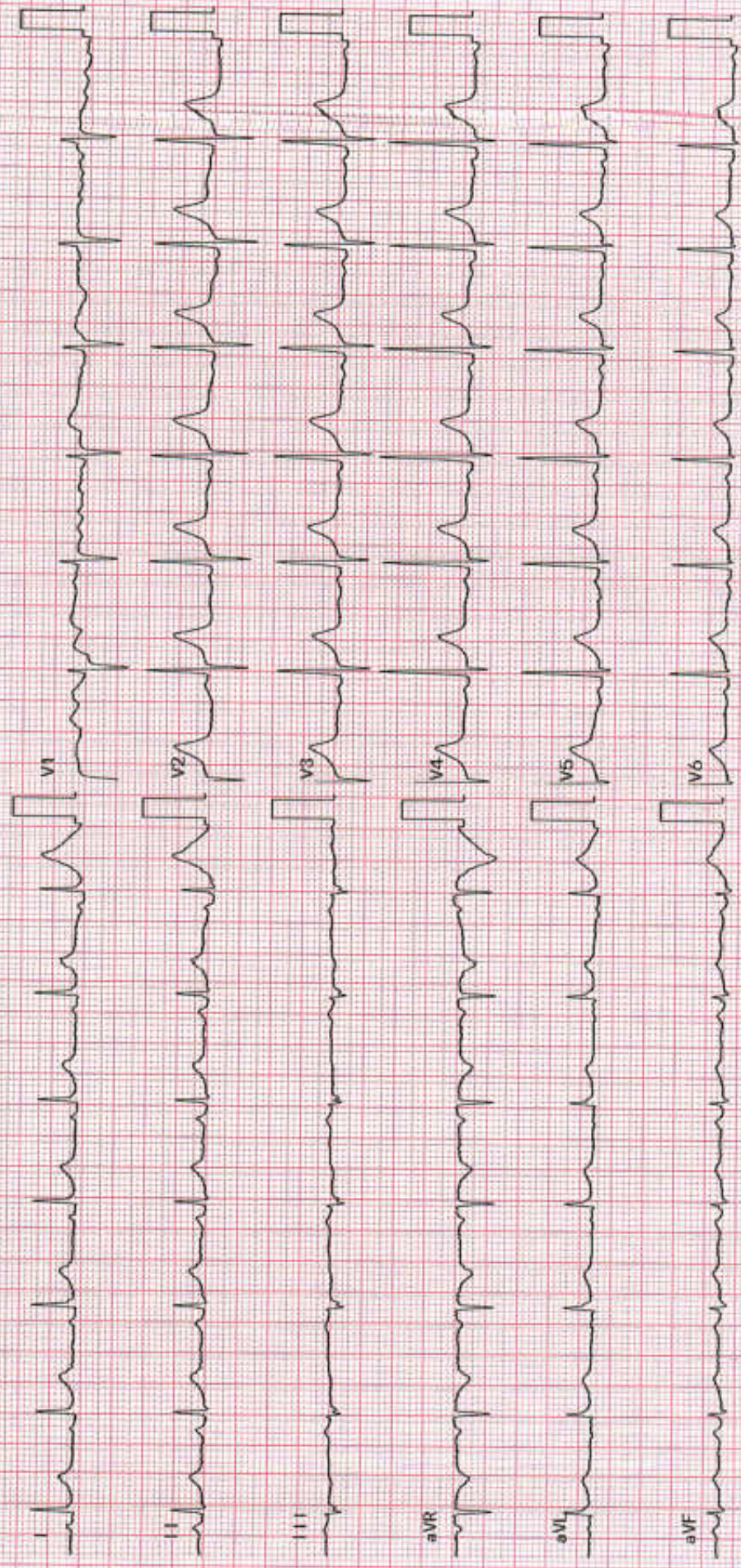
ID: 4413
 Name: rajeev
 Birth date: / /
 Sex: M
 Weight: kg
 Height: mmHg
 Indication:
 Symptoms:
 History:
 Ent. rate: 88 bpm
 R int: 132 ms
 RS dur: 74 ms
 P/QTc(E) int: 334/ 379 ms
 VQRS/T axis: 52/ 11/ 27
 V5/SV1 amp: 1.44/ 0.69 mV
 V5+SV1 amp: 2.13 mV

33 years
 1100 Sinus rhythm
 9110 ** normal ECG **

Unconfirmed Report
 Reviewed by:

10 mm/mV

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



(2)



NABH

No.1

Out Patient Record

Patient Name : Mr.RAJEEV RANJAN

UHID : UHJA24004413

Age / Sex : 33 Years / Male

OP NO/Reg Dt : 10-08-2024 08:12 AM

Spouse / Father Name : PAVAN KUAMR RANJAN

Department :

Address : jp nagar 8th phase, , Bengaluru Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

BP - 122 / 90 mmHg
SpO2 - 99 %
P - 79 bpm
Ht - 168 cm
wt - 73.5 kg

Investigations:

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

☎ 080 4511 1111



| | | | |
|-----------------------|-------------------------------|---------------------|---------------------|
| PATIENT NAME : | Mr. RAJEEV RANJAN | DATE : | 10/08/24 |
| AGE : | 33 YEARS GENDER : MALE | PATIENT ID : | 24004413 |
| REF BY : | CMO | OP/ IP : | HEALTH CHECK |

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

| (cm) | (cm) | (cm/sec) | |
|--------------------|-----------------------|------------------------------|------------------------------|
| AO : 3.2 (2.5-3.7) | LVIDD : 4.3 (3.5-5.5) | MV EV : 0.7 AV : 0.5 | MR : NORMAL |
| LA : 3.4 (1.9-4.0) | LVIDS : 2.6 (2.4-4.2) | AV : 0.8 | AR : NORMAL |
| RA : 2.3 (<4.4) | IVSD : 0.9 (0.6-1.1) | PV : 1.0 | PR : NORMAL |
| RV : 2.2 (<3.5) | IVSS : 1.1 (0.9-1.2) | TV EV : ---- AV : ---- | TR : TRIVIAL TR, PASP-27mmHg |
| TAPSE: 1.8 (>1.6) | LVPWD : 0.9 (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:

TACHYCARDIA OBSERVED DURING THE STUDY (HR – 105 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



NABH



No.1



DEPARTMENT OF RADIODIAGNOSIS

| | | | |
|-------------|---------------|--------------------|--------------|
| Name | Rajeev Ranjan | Date | 10/08/24 |
| Age | 33 years | Hospital ID | UHJA24004413 |
| 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 (10.9 cms), shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (10.4 x 5.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (9.5 x 5.3 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 distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 18 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.**

UNITED HOSPITAL (A Unit of United Brothers Healthcare Services Private Limited)
Dr. Manu Srinivas H., MD, RD
Consultant Radiologist



NABH



No.1



DEPARTMENT OF RADIODIAGNOSIS

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| Name | Rajeev Ranjan | Date | 10/08/24 |
| Age | 33 years | Hospital ID | UHJA24004413 |
| 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. Manu Srinivas H, MD, RD
Consultant Radiologist