DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI CHANDRASEKAR	Order No	: 1000068737
UHID	: UHJA23016571	Registered On	: 27/01/2024 08:35:22 AM
Age/Sex	: 51/Years Female	Collected On	: 27/01/2024 08:42:08 AM
Ward / Bed No	:	Reported On	: 27/01/2024 12:25:36 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230020635
Station	: At Hospital	Mobile No	: 9448108935
Payer Name	: Mediwheel	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval
FASTING GLUCOSE (Method: Hexokinase)	96	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	87	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.7	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	88.19	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.88	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.53	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.50	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	234	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	82	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	59.8	mg/dL	< 40 - Low ≥ 60 - High

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI CHANDRASEKAR	Order No	: 1000068737
UHID	: UHJA23016571	Registered On	: 27/01/2024 08:35:22 AM
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Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	190.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.39	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)	3.1		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	174.2	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.9	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.51	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	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)	3.82	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.77	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.37		2:1
SERUM SGOT (Method:IFCC without P5P)	21	U/L	< 35

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI CHANDRASEKAR	Order No	: 1000068737
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Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	17	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	64	U/L	46-122
GGT (Method:IFCC)	19	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	18.3	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.46	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	19.5		12¯20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI CHANDRASEKAR	Order No	: 1000068737
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Payer Name	: Mediwheel	Report Status	: Final Report

HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC) — Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	11.98	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	36.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	3500	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	38.40	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	54.26	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.82	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.19	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.33	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	3.82	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	95.2	fL	78-100
MCH (Method: Calculated)	31.4	pg	27-31
MCHC (Method: Calculated)	32.9	g/dL	31-37
RDW - CV (Method: Calculated)	14.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.44	Lakhs/Cum	1.5-4.5

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI CHANDRASEKAR	Order No	: 1000068737
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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.76	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-30

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
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

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI CHANDRASEKAR	Order No	: 1000068737
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Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.010		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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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. J ANAKI CHANDRASEKAR	Order No	: 1000068737
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Station	: At Hospital	Mobile No	: 9448108935
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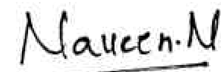
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		



Verified By
PRAVEEN T

---End of Report---

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. JANAKI CHANDRASEKAR	Order No	: 1000068737
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Test Name	Result	Unit	Bio. Ref. Interval
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POST PRANDIAL GLUCOSE (Method: Hexokinase)	87	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.7	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	88.19	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.88	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.53	≂g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.50	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	234	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	82	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	59.8	mg/dL	< 40 - Low ≥ 60 - High

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Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	190.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.39	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)	3.1		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	174.2	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.9	mg/dL	2.6-6.0

LIVER FUNCTION TEST

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.51	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	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)	3.82	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.77	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.37		2:1
SERUM SGOT (Method:IFCC without P5P)	21	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	17	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	64	U/L	46-122
GGT (Method:IFCC)	19	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	18.3	mg/dL	17-43

BUN/CREATININE RATIO

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.46	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	19.5		12¯20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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DEPARTMENT OF LABORATORY MEDICINE

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC) — Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	11.98	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	36.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	3500	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	38.40	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	54.26	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.82	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.19	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.33	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	3.82	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	95.2	fL	78-100
MCH (Method: Calculated)	31.4	pg	27-31
MCHC (Method: Calculated)	32.9	g/dL	31-37
RDW - CV (Method: Calculated)	14.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.44	Lakhs/Cum	1.5-4.5

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.76	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-30

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
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

DEPARTMENT OF LABORATORY MEDICINE

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Station	: At Hospital	Mobile No	: 9448108935
Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.010		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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DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
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		

Verified By
PRAVEEN T

---End of Report---

Naveen.N
Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

1 2180

MICRO MED CHARTS

27-Jan-2024 AM9:55:59

ID:16571

Name:Mrs.Janaki.C

Birth date:

51 years

lex:F

cm kg / mmHg

ledication:

lymptoms:

listory:

lent. rate	74	bpm
IR int	170	ms
IRS dur	96	ms
IT/QTc(E) int	344/ 372	ms
I/QRS/T axis	67/ 79/ 90	°
IV5/SV1 amp	1.22/ 0.76	mV
IV5+SV1 amp	1.98	mV

1100 Sinus rhythm

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

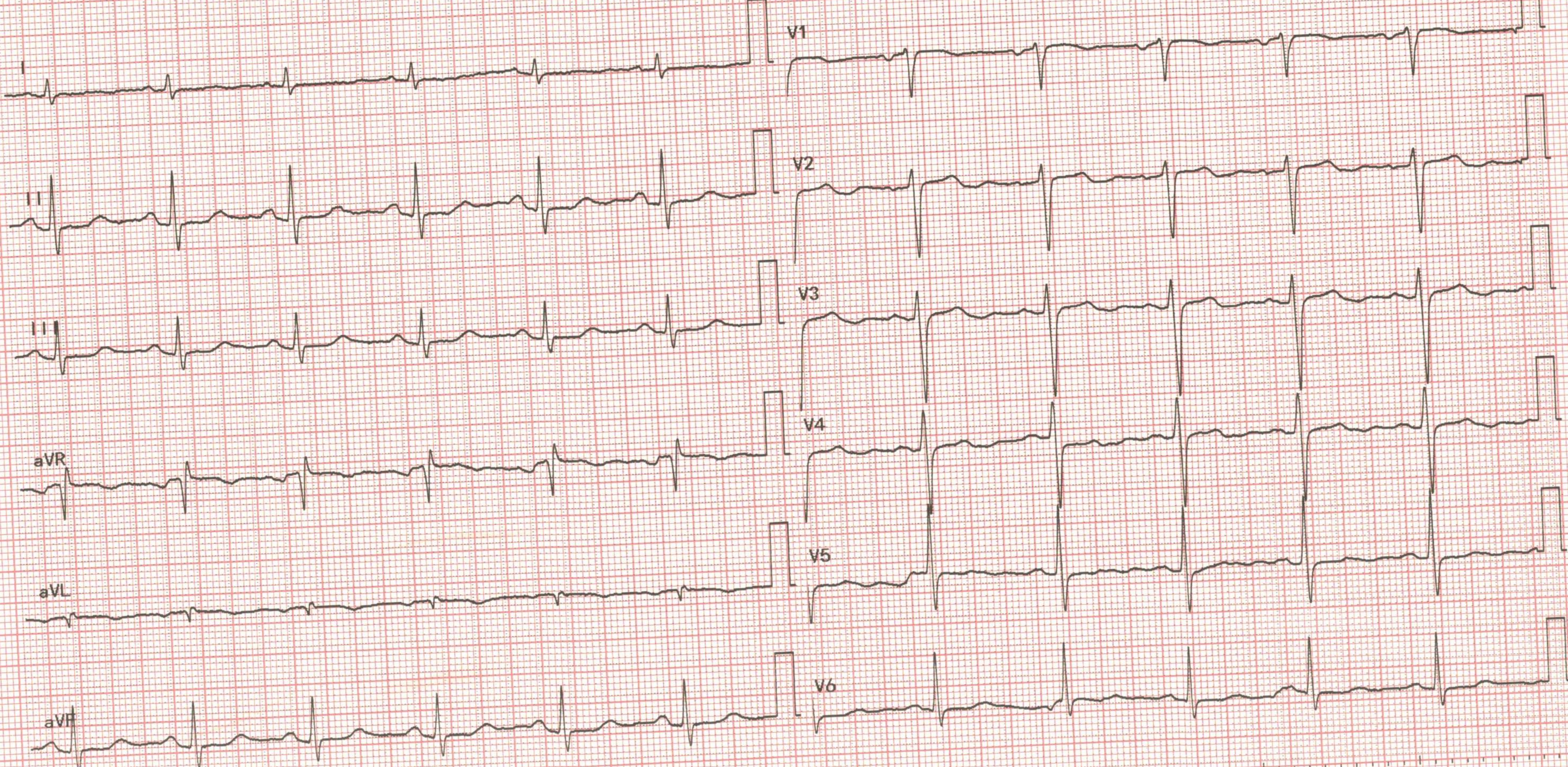
9130 ** borderline ECG **

Unconfirmed Report

Reviewed by:

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

10 mm/mV



Exam:UNITED HOSPITAL

2250K 03-08 07-01 Dept.:

NABH NABL No.1

Patient name :	Mrs. JANAKI CHANDRASEKAR	Date :	27/01/24
Age :	51 years GENDER: FEMALE	Patient ID :	16571
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.5 (2.5-3.7)	LVIDD :3.5 (3.5-5.5)	MV EV : 82.0	AV : 55.8	MR : NORMAL
LA : 2.7 (1.9-4.0)	LVIDS : 2.2 (2.4-4.2)	AV : 114		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 56.3		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.8 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.8 (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	: SCLEROTIC CHANGES, NON- STENOTIC, JET GRDT-5mmHg
Tricuspid Valve	: NORMAL, TRIVIAL TR, JET GRDT-25mmHg
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

SCLEROTIC AORTIC VALVE
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

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.JANAKI CHANDRASEKAR**	**UHID**	**: UHJA23016571**
Age / Sex	: 51 Years / Female	OP NO/Reg Dt	: 27-01-2024 08:35 AM
Spouse / Father Name	: CHANDRASEKHAR	Department	: Health Check
Address	: # B106 esteem Enclave arekere Bannarghattta Road , BANGALORE CITY H	Refered By	: Mediwheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Vignesh

Complaints / Findings / Observations : ENT Prescription

Came for Routine ENT checkup.

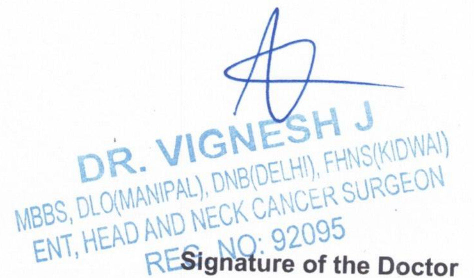
Investigations:

→ B/L Ears,
Nose,
oral cavity,
oropharynx
} WNL.

Treatment / Care of Plan / Provisional Diagnosis :

TFT.

Follow Up Advice :



Signature of the Doctor

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Address	: # B106 esteem Enclave arekere Bannarghattta Road , BANGALORE CITY H	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Routine Eye test

Investigations:

VAG 6/6p N6 CN6 P/P

AC ⊖

Treatment / Care of Plan / Provisional Diagnosis : Fundus ⊖

Imp: presbyopia

Follow Up Advice :

Yearly review.

Signature of the Doctor

27/1/24

DEPARTMENT OF RADIODIAGNOSIS

Name	Janaki Chandrasekar	**Date**	27/01/24
Age	51 years	**Hospital ID**	UHJA23016571
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Homogeneous fatty background echotexture is seen in both breasts.
Homogeneous fibroglandular background echotexture is seen in both breasts.
Heterogeneous background echotexture is seen in both breasts.

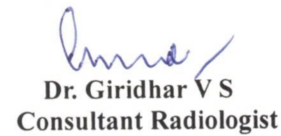
No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **No significant abnormality detected in this study.**



Dr. Giridhar V S
Consultant Radiologist

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore
A Unit of United Brothers Healthcare Services Private Limited
No. 110(30), Madhavan Park Circle, 10th Main Road, 3rd Block, Jayanagar, Bangalore - 560 011. T: 080 4566 6666 E: appointment@unitedhospital.in W: www.unitedhospital.com

NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Janaki Chandrasekar	Date	27/01/24
Age	51 years	Hospital ID	UHJA23016571
Sex	Female	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 partially distended.

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 (9.6 x 1.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.8 x 1.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

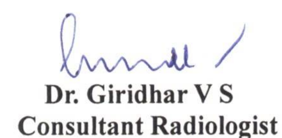
Retroperitoneum- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus is anteverted and normal in size, measures 9.3 x 3.4 x 4.8 cms. Myometrial and endometrial echoes are normal. Endometrium measures 6 mm.
Right ovary is normal in size and echopattern, measures -- cc.
Left ovary is normal in size and echopattern, measures -- 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:

- **No definite sonological abnormality detected.**



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DEPARTMENT OF RADIODIAGNOSIS

Name	Janaki Chandrasekar	Date	27/01/24
Age	51 years	Hospital ID	UHJA23016571
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

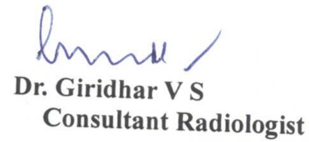
Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**



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