DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SUKANYA T	Order No	: 1000099531
UHID	: UHJA24006705	Registered On	: 17/10/2024 12:34:46 PM
Age/Sex	: 58/Years Female	Collected On	: 17/10/2024 01:33:54 PM
Ward / Bed No	:	Reported On	: 17/10/2024 02:10:09 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240009233
Station	: Corp	Mobile No	: 9980923543
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	83	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	92	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	4.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	94	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	**0.70**	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.62	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.60	µIU/mL	0.38-5.33
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	**209**	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	68	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	52.8	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	**142.60**	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	13.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.96		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	**2.70**		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	**156.20**	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.7	mg/dL	2.6-6.0
CREATININE (Method:Modified Jaffe, Kinetic)	0.77	mg/dL	0.6-1.1
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	11	mg/dL	7.93-20.07
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.63	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.52	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.75	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.35	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.12		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	11	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	91	U/L	46-122
GGT (Method:IFCC)	9	U/L	< 38
PHOSPHOROUS (Method:Phospho Molybdate)	3.2	mg/dL	2.5-4.5
VITAMIN B12 (Method:CLIA)	547	pg/mL	180-914

Interpretation Notes

Vitamin B12 or Cobalamin assay helps to diagnose the cause of anemia or neuropathy; to evaluate nutritional status in some patients; to monitor effectiveness of treatment for B12 deficiency. Vitamin B12 is necessary for normal RBC formation, tissue and cellular repair, and DNA synthesis. Vitamin B12 is also important for nerve health; a deficiency in either B12 or Folate can lead to macrocytic anemia. Interpretation of the result should be considered in relation to clinical circumstances. The concentration of Vitamin B12 obtained with different assay methods cannot be used interchangeably due to differences in assay methods and reagent specificity.

VITAMIN D (25-OH) (Method:CLIA)	36.9	ng/mL	<20 ng/mL - Deficient 20-29 ng/mL - Insufficient 30-100 ng/mL - Sufficient >100 ng/mL - Toxic

Interpretation Notes

Vitamin D is a lipid-soluble steroid hormone that is produced in the skin through the action of sunlight or is obtained from dietary sources. Vitamin D promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Deficiency in children causes Rickets and in adults leads to Osteomalacia. Less severe vitamin D inadequacy may lead to secondary hyperparathyroidism and subsequently increasing the risk of osteoporosis. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs).

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Test Name	Result	Unit	Bio. Ref. Interval

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

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SUKANYA T	Order No	: 1000099531
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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	12.70	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	39.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6130	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	68.84	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	22.44	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.42	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.23	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.07	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.65	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	84.1	fL	78-100
MCH (Method: Calculated)	27.3	pg	27-31
MCHC (Method: Calculated)	32.5	g/dL	31-37
RDW - CV (Method: Calculated)	14.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.74	Lakhs/Cum	1.5-4.5
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	**7.68**	fl	9-13

DEPARTMENT OF LABORATORY MEDICINE

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Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240009233
Station	: Corp	Mobile No	: 9980923543
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Test Name	Result	Unit	Bio. Ref. Interval
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	**19.3**	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4220	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method:Calculated Automated)	90	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1380	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	440	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	**0**	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	**40**	mm/hour	1-30

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Method)	O	
Rh Factor (Method:Agglutination Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	7.5		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			

DEPARTMENT OF LABORATORY MEDICINE

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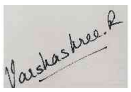
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240009233
Station	: Corp	Mobile No	: 9980923543
Payer Name	: Mediwheel	Report Status	: Final Report

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		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
Rashmita

---End of Report---



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

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SUKANYA T**	**UHID**	**: UHJA24006705**
Age / Sex	: 58 Years / Female	OP NO/Reg Dt	: 17-10-2024 08:33 AM
Spouse / Father Name	: .	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

Ht - 158cm
Wt - 83.5kg
BP - 140/86
PR - 94b/m
SPO2 - 98.1

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH No.1

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Care Par Excellence
Jayanagar, Bangalore

17/../21

Mrs Sukanya. T 58y

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and
Gynecologist, Laparoscopy
and IVF Specialist
KMC Reg. No. 90304

BP - 140/80.

post hyst
- TAH + BSO.

P2 L2
All LSCS
Tubectomy
post hysterectomy

No n/ 2014.
DM, HTN, Thy
H/ Breast Cancer → Aunt
3/. father Cancer
father → post cervical Cancer

Lt Breast → FNAC → done → pt says it was (N) Breast - Dx

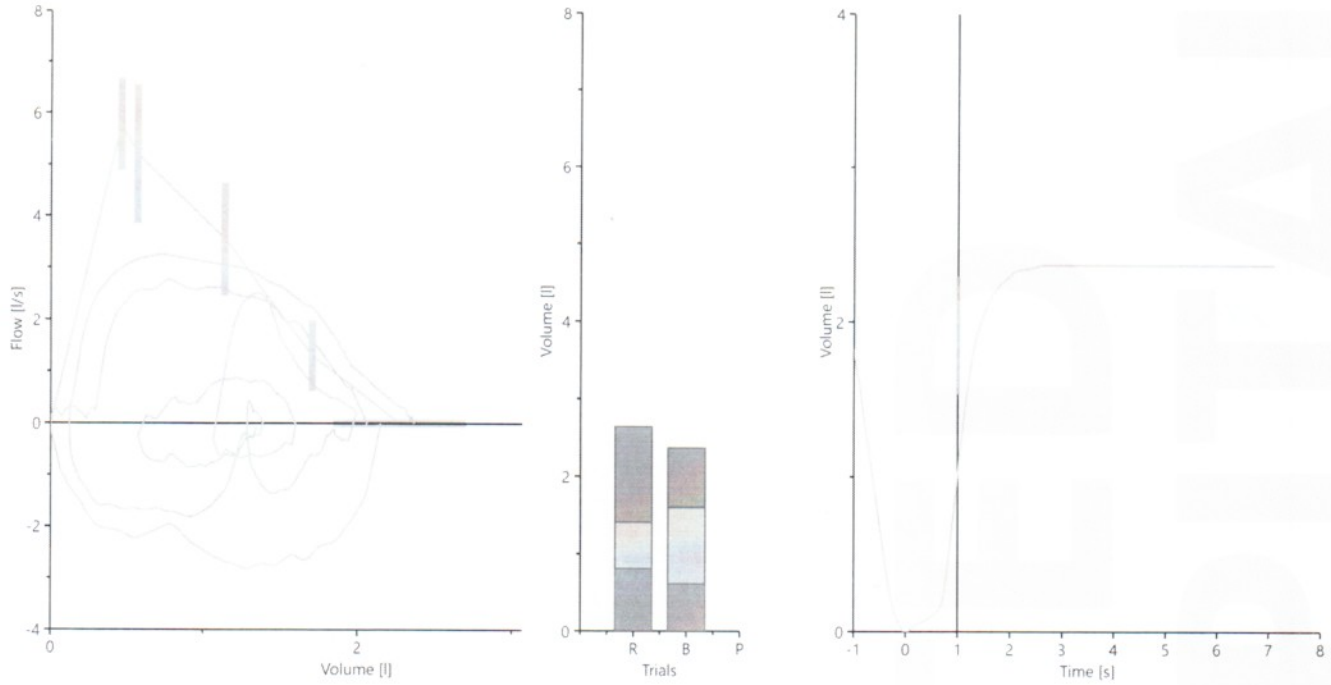
B/A - Sfb

Admin
Ceng L Sonomamogy
Yes

Lung Function | Respiratory Diagnostics

Last name	T	Age	58 years	BMI	34.2
First name	MRS.SUKANYA	Height	157.0 cm	Visit ID	HEALTH CHECK
Date of birth	1/20/1966	Weight	84.3 kg	Smoker	
Patient Id	24006705	Gender	female	Diagnosis	

Measured: 10/17/2024 12:31 PM LFX 1.9.0 Ambient: 27.7 °C 898 hPa 58.2 % 10/17/2024 12:34 PM LFX 1.9.0
Ref. module: ECCS93



		Pred	Pre	% Pred	Z-Score
VC IN	[L]	2.35	2.15	91 %	
FVC	[L]	2.28	2.37	104 %	
FEV 1	[L]	1.91	2.23	116 %	
FEV1%VCin	[%]	78.08	103.59	133 %	
MEF 75	[L/s]	5.20	3.18	61 %	
MEF 50	[L/s]	3.56	3.04	86 %	
MEF 25	[L/s]	1.31	2.02	155 %	
MMEF	[L/s]	2.91	2.84	98 %	
PEF	[L/s]	5.78	3.25	56 %	

Interpretation

/* Automatic Interpretation - Forced Spirometry - 12:31 PM: Spirometry results are within normal limits. /*

NABH No.1

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PATIENT NAME :	Mrs. SUKANYA T	DATE :	17/10/24
AGE :	58 YEARS GENDER : FEMALE	PATIENT ID :	24006705
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 : 4.0 (3.5-5.5)	MV EV: 0.6	AV: 0.5	MR : NORMAL
LA : 3.0 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 0.8		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.5		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR, PASP-26mmHg
TAPSE : 1.8 (>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:

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

DEPARTMENT OF RADIODIAGNOSIS

Name	Sukanya T	**Date**	17/10/24
Age	58 years	**Hospital ID**	UHJA24006705
Sex	Female	**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 evidence of mass or focal lesions.

Right Kidney is normal in size (10.9 x 4.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.6 x 3.5 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 distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is surgically absent.
Both ovaries could not be visualized.

There is 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

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sukanya T	**Date**	17/10/24
Age	58 years	**Hospital ID**	UHJA24006705
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.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

17-Oct-2024 AM9:34:21

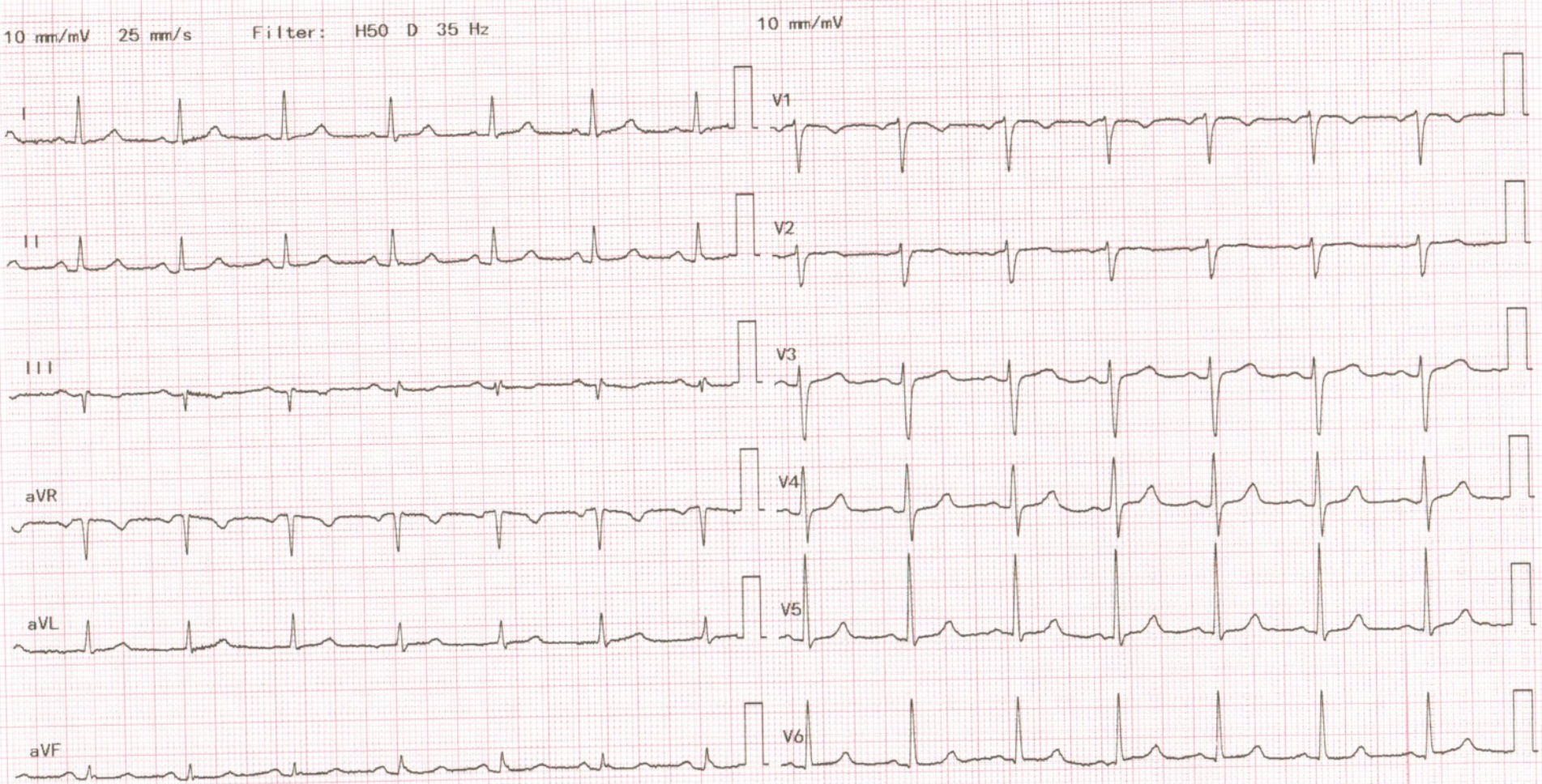
ID:24006708
Name:MRS SUKANYA
Sex:F Birth date: 58 years
cm kg / mmHg
Medication:
Symptoms:
History:

1100 Sinus rhythm
9110 ** normal ECG **

Ant. rate	88	bpm
PR int	154	ms
QRS dur	84	ms
QT/QTc(B) int	344/ 390	ms
P/QRS/T axis	61/ 34/ 32	°
RV5/SV1 amp	1.48/ 0.88	mV
RV5+SV1 amp	2.36	mV

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL