

ID: 2406567

Name: mr shivakumar

Age: / Birth date: /

cm kg mmHg

Indication:

Symptoms:

History:

Rate:

R int

RS dur

QTc(E) int

QRS/T axis

V5/SV1 amp

V5+SV1 amp

57 years

1100 Sinus rhythm  
9110 \*\* normal ECG \*\*

67 bpm

146 ms

86 ms

372/ 387 ms

61/ 80/ 71 °

1.35/ 1.16 mV

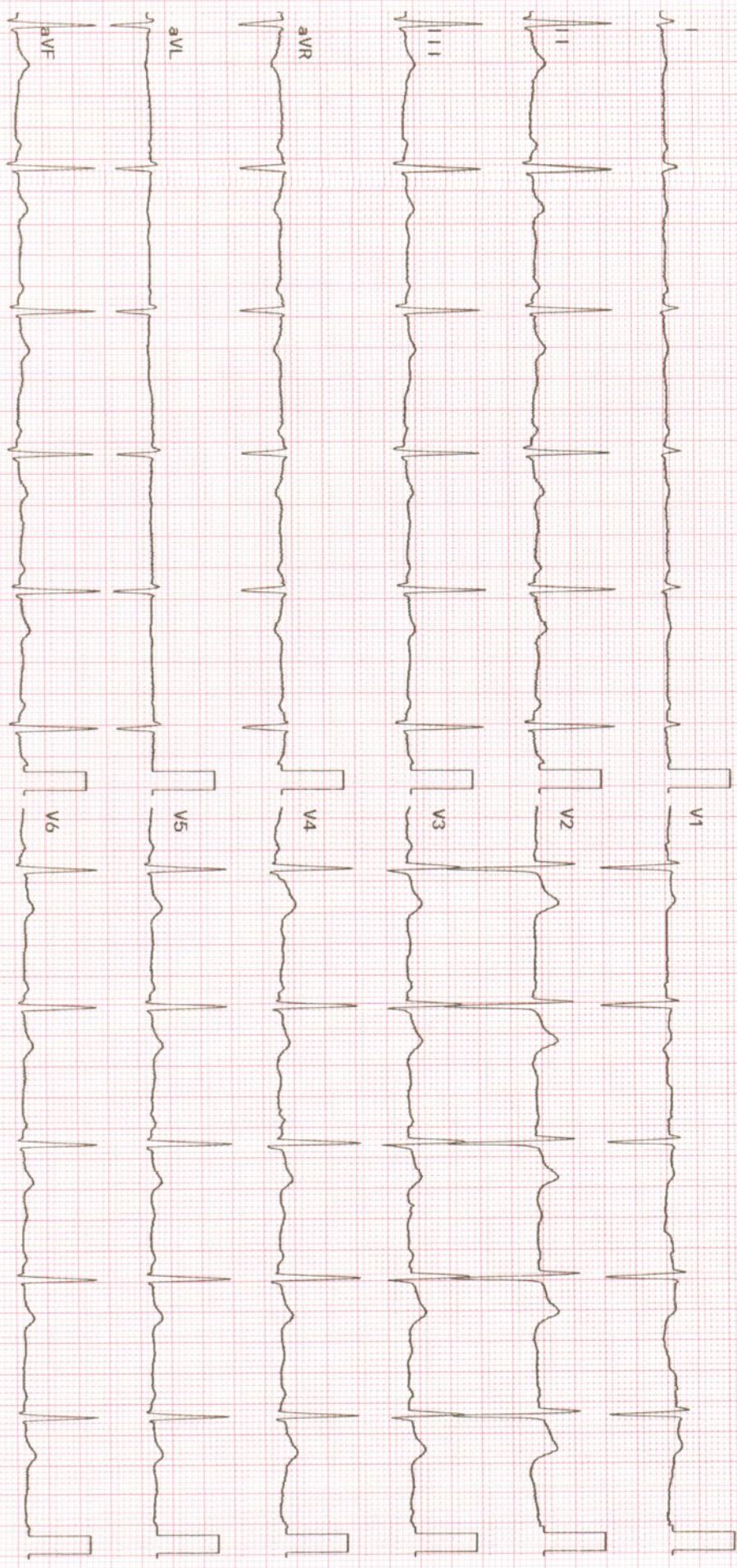
2.51 mV

10 mm/mV 25 mm/s

Filter: H50 D 35 Hz

10 mm/mV

Unconfirmed Report  
Reviewed by:





### Out Patient Record

NABH No.1

Patient Name : Mr.SHIVAKUMAR G N

UHID : UHJA24006568

Age / Sex : 57 Years / Male

OP NO/Reg Dt : 14-10-2024 10:05 AM

Spouse / Father Name : SHIVAKUMAR G N

Department :

Address : ediwheel Full Body Annual Plus Above 50 Male, , Bengaluru Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM

KMC No. : 02M1087

#### Complaints / Findings / Observations :

HT - 168 cm  
wt - 61.1 kg  
SpO<sub>2</sub> - 98 %  
PR - 75 b/min  
BP - 136/85 mmHg

#### Investigations:

#### Treatment / Care of Plan / Provisional Diagnosis :

#### Follow Up Advice :

Signature of the Doctor



NABH



No.1

PATIENT NAME :	Mr. SHIVAKUMAR G N	DATE :	14/10/24
AGE :	57 YEARS GENDER : MALE	PATIENT ID :	24006568
REF BY :	CMO	OP/ IP :	HEALTH CHECK

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


(cm)	(cm)	(cm/sec)	
AO : 2.7 (2.5-3.7)	LVIDD : 4.0 (3.5-5.5)	MV EV: 0.5 AV: 0.7	MR : NORMAL
LA : 3.3 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 1.0	AR : NORMAL
RA : 1.9 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 0.7	PR : NORMAL
RV : 1.8 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ---- AV : ----	TR : TRIVIAL TR, PASP-28mmHg
TAPSE : 1.7 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : GRADE I 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
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%  
 GRADE I LV DIASTOLIC DYSFUNCTION  
 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	Shivakumar G N	Date	14/10/24
Age	57 years	Hospital ID	UHJA24006568
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. Elluru Santosh Kumar  
Consultant Radiologist



NABH



No.1

## DEPARTMENT OF RADIODIAGNOSIS

Name	Shivakumar G N	Date	14/10/24
Age	57 years	Hospital ID	UHJA24006568
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 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 (10.4 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

**Left Kidney** is normal in size (10.7 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis. *There is a tiny simple cortical cyst measuring 5 mm in the lowerpole region.*

**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 ~ 14.3 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

#### IMPRESSION:

- No significant sonological abnormality detected in the abdomen.



Dr. Elluru Santosh Kumar  
Consultant Radiologist

## DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. SHIVAKUMAR G N	Order No : 1000099036
UHID : UHJ A24006568	Registered On : 14/10/2024 10:05:48 AM
Age/Sex : 57/Years Male	Collected On : 14/10/2024 10:15:42 AM
Ward / Bed No :	Reported On : 14/10/2024 12:58:49 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJ A240009027
Station : At Hospital	Mobile No : 9844430933
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	101	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	99	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	4.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
<b>Estimated Average Glucose (eAG)</b> (Method: Calculated)	94	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method:CLIA)	1.16	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method:CLIA)	9.78	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method:CLIA: Ultra-sensitive)	1.51	μIU/mL	0.38-5.33
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method:CHOD-POD)	184	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method:Enzymatic GPO-POD)	73	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	41.4	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	128.00	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	14.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.44		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.09		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	142.60	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	4.7	mg/dL	3.5-7.2
<b>BUN/CREATININE RATIO</b>			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	16	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.72	mg/dL	0.9-1.3
BUN/CRE -RATIO (Method: Calculated)	22.2		12~20 : 1
<b>LIVER FUNCTION TEST</b>			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.01	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.21	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.80	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3

Sample: Serum

Sample: Serum

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.32	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.68	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.61		2:1
SERUM SGOT (Method:IFCC without P5P)	22	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	21	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	77	U/L	50-116
GGT (Method:IFCC)	19	U/L	< 55
<b>PROSTATE SPECIFIC ANTIGEN (PSA)</b> (Method:CLIA)	0.34	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

<b>UREA</b> (Method:Urease GLDH - Kinetic)	33.2	mg/dL	17-43
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**Dr. Varsha Shree R**  
M.D(Pathology)  
CONSULTANT PATHOLOGIST  
KMC No : 103567



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**HAEMATOLOGY**
**COMPLETE BLOOD COUNT(CBC)**

Sample: Whole blood (EDTA)

<b>HAEMOGLOBIN</b> (Method:Photometric Measurement: Oxyhemoglobin method)	16.09	g/dL	13.5-17.5
<b>PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)</b> (Method: Calculated)	49.2	%	42-52
<b>TOTAL WBC COUNT (TLC)</b> (Method:Coulter Principle)	7570	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> (Method:Optical/Impedance)	56.33	%	40-75
<b>LYMPHOCYTES</b> (Method:Optical/Impedance)	32.09	%	20-45
<b>EOSINOPHILS</b> (Method:Optical/Impedance)	3.29	%	0-6
<b>MONOCYTES</b> (Method:Optical/Impedance)	7.98	%	2-10
<b>BASOPHILS</b> (Method:Optical/Impedance)	0.31	%	0-2
<b>RED BLOOD CORPUSCLES(RBC)</b> (Method:Coulter Principle)	5.99	million/cum	4.5-5.9
<b>MCV</b> (Method:Derived from RBC Histogram)	82.1	fL	78-100
<b>MCH</b> (Method: Calculated)	26.9	pg	27-31
<b>MCHC</b> (Method: Calculated)	32.7	g/dL	31-37
<b>RDW - CV</b> (Method: Calculated)	15.1	%	11.5-14.5
<b>PLATELET COUNT</b> (Method:Electrical Impedance)	2.41	Lakhs/Cum	1.5-4.5

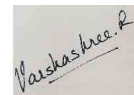
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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.24	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.5	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4260	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method:Calculated Automated)	250	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	2430	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	600	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	03	mm/hour	1-20
<b>BLOOD GROUPING &amp; RH TYPING</b>			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

**PHYSICAL EXAMINATION**

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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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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		
<b>URINE SUGAR, FASTING</b> (Method:GOD-POD)	Absent		
<b>URINE SUGAR (POST PRANDIAL)</b>	Absent		

Verified By  
Rashmita

---End of Report---



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