ID:15385 13-Jan-2024 AM9:55:06

Name:gayatri

F Birth date: 49 years

cm kg / mmHg

cation:

toms:

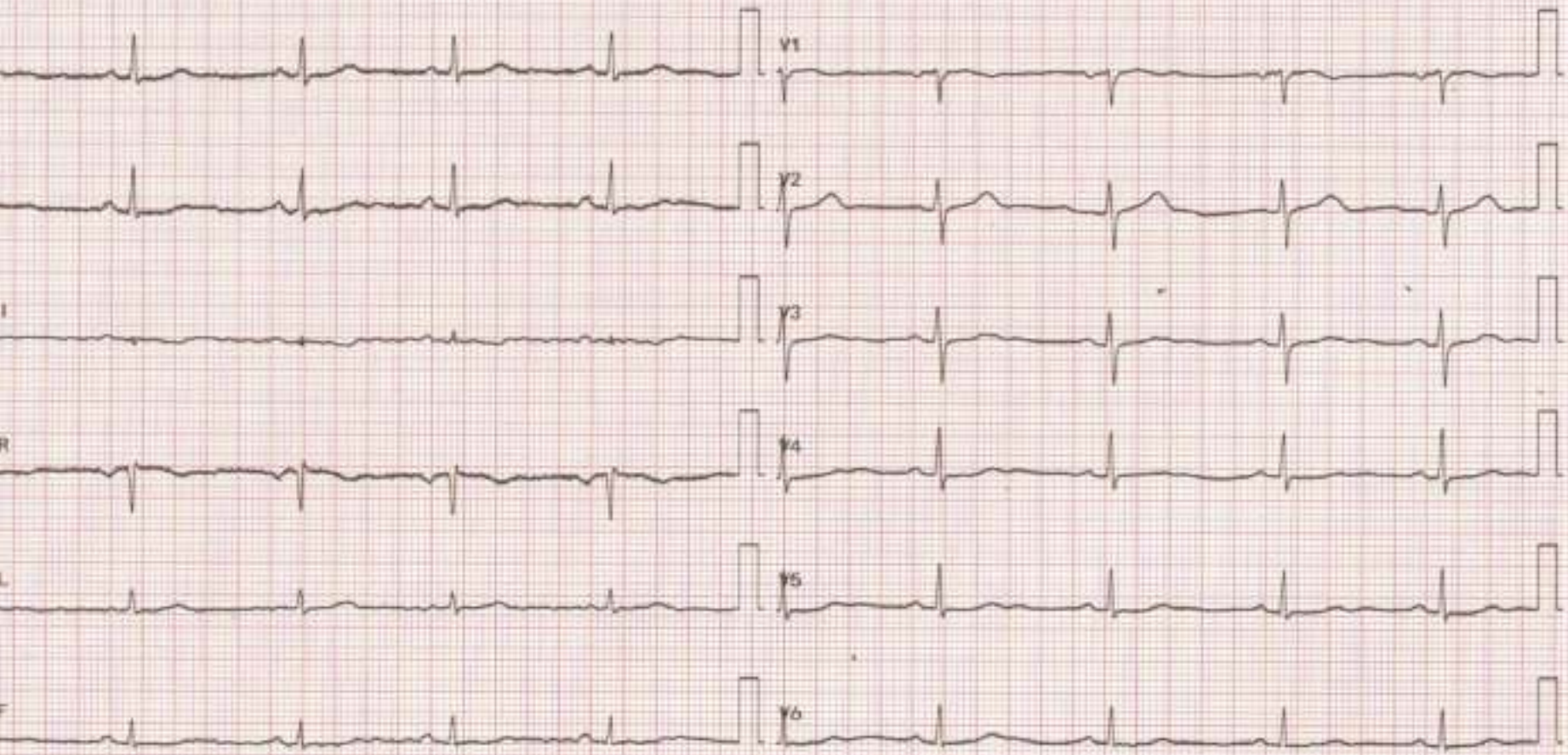
ory:

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (II, V4, V5, V6)]
0102 ARTIFACT PRESENT
9130 ** borderline ECG **

rate	58	bpm
nt	166	ms
dur	80	ms
Qc(E) int	422/ 419	ms
S/T axis	54/ 40/ 19	°
SV1 amp	0.72/ 0.54	mV
SV1 amp	1.26	mV

Unconfirmed Report
Reviewed by:

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



K 03-08 07-01 Dept.: Exam:UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care For Excellence
Jayanagar, Bangalore

Patient name :	Mrs. GAYATHRI	Date :	13/01/24
Age :	49 years GENDER: FEMALE	Patient ID :	15385
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.4 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV : 82.9	AV : 68.9	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 114		AR : NORMAL
RA : 2.4 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 71.8		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.0 (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 : 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, TRIVIAL TR, PASP-30mmHg
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 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

Mrs Gayatri 49y

13/1/24

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and Gynecologist, Laparoscopy and IVF Specialist
KMC Reg. No. 90384

for health check up.

BP - 127/82 SpO2 - 95

I episode of ...
...

P/H obese children

P/S - ... mild @ white ...

P2 L2
All ...
Tubectomy
General.
~~...~~
C/S - ...
...

Best ...

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.GAYATRI**	**UHID**	**: UHJA23015385**
Age / Sex	: 49 Years / Female	OP NO/Reg Dt	: 13-01-2024 08:43 AM
Spouse / Father Name	: GOPAL R	Department	:
Address	: 813, JANANA BHARATHI 2ND BLOCK, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Vn (glass) < 6/9p, 6/9p } n.

nil systemic

Investigations:

AS: OU Normal

Treatment / Care of Plan / Provisional Diagnosis : Fundus (undilated) OU CDratio 0.3:1 & 0.4:1 FR G1

Follow Up Advice : Informed. OU Ref Error. (Progressive glasses.)

RE: -0.50 DC x 45° 6/6

LE: -0.25 DC x 150 6/6.

BE Add +2.00 DS for near.

Signature of the Doctor

Dr. Shweta 13/1/24

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	Gayatri	**Date**	13/01/24
Age	49 years	**Hospital ID**	UHJA23015385
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

Small cyst measuring 6 x 4 mm with thin walls and anechoic contents is seen in the 10 o'clock position of right breast.

There is mild dilatation of one of the duct in the 8-9 o'clock position of right breast, lumen measuring upto 2.9 mm. Contents are anechoic. No obvious lesion is seen.

There is large lipoma measuring 8.2 x 4.3 x 7.2 cms in the upper outer quadrant of the left breast.

No focal solid lesions seen.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **Mild dilatation of one of the duct in the 8-9 o'clock position of right breast as mentioned above. BIRADS 3 – Probably benign.** *Suggested followup scan in 3-6 months.*
- **Small anechoic cyst in the right breast. BIRADS 2 – Benign.**
- **Large lipoma in the upper outer quadrant of the left breast.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

UNITED HOSPITAL
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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	Gayatri	**Date**	13/01/24
Age	49 years	**Hospital ID**	UHJA23015385
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (16.4 cms) and shows moderate 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 (9.4 x 3.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (11.3 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 well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus is anteverted and atrophic, measures 6.6 x 2.7 x 4.7 cms. **Endometrium** measures 3.6 mm.
Both ovaries are atrophic.

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

IMPRESSION:

- **Mild hepatomegaly with moderate fatty infiltration (Grade II).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Gayatri	**Date**	13/01/24
Age	49 years	**Hospital ID**	UHJA23015385
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

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. GAYATRI	Order No	: 1000066219
UHID	: UHJA23015385	Registered On	: 13/01/2024 08:44:00 AM
Age/Sex	: 49/Years Female	Collected On	: 13/01/2024 08:53:56 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:35:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019362
Station	: At Hospital	Mobile No	: 9449313199
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	94	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	110	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.7	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	116.89	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.06	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	7.87	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.89	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	177	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	201	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	34.3	mg/dL	< 40 - Low ≥ 60 - High

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. GAYATRI	Order No	: 1000066219
UHID	: UHJA23015385	Registered On	: 13/01/2024 08:44:00 AM
Age/Sex	: 49/Years Female	Collected On	: 13/01/2024 08:53:56 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:35:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019362
Station	: At Hospital	Mobile No	: 9449313199
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	102.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	40.20	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.1		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.9		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	142.7	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.4	mg/dL	2.6-6.0
UREA/CREATININE RATIO	14.2		
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.53	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.44	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.9	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.11	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.79	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.08		2:1

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. GAYATRI	Order No	: 1000066219
UHID	: UHJA23015385	Registered On	: 13/01/2024 08:44:00 AM
Age/Sex	: 49/Years Female	Collected On	: 13/01/2024 08:53:56 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:35:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019362
Station	: At Hospital	Mobile No	: 9449313199
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	19	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	87	U/L	46-122
GGT (Method:IFCC)	17	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	9.1	mg/dL	17-43

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. GAYATRI	Order No	: 1000066219
UHID	: UHJA23015385	Registered On	: 13/01/2024 08:44:00 AM
Age/Sex	: 49/Years Female	Collected On	: 13/01/2024 08:53:56 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:35:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019362
Station	: At Hospital	Mobile No	: 9449313199
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)	13.62	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	41.8	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	8940	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	59.41	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.05	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.21	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.14	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.19	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.09	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.1	fL	78-100
MCH (Method: Calculated)	26.8	pg	27-31
MCHC (Method: Calculated)	32.6	g/dL	31-37
RDW - CV (Method: Calculated)	14.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.17	Lakhs/Cum	1.5-4.5

UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. GAYATRI	Order No	: 1000066219
UHID	: UHJA23015385	Registered On	: 13/01/2024 08:44:00 AM
Age/Sex	: 49/Years Female	Collected On	: 13/01/2024 08:53:56 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:35:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019362
Station	: At Hospital	Mobile No	: 9449313199
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.10	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.4	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	14	mm/hour	1-20

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

ABO Group (Method:Agglutination Gel Method)	AB	
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

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. GAYATRI	Order No	: 1000066219
UHID	: UHJA23015385	Registered On	: 13/01/2024 08:44:00 AM
Age/Sex	: 49/Years Female	Collected On	: 13/01/2024 08:53:56 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:35:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019362
Station	: At Hospital	Mobile No	: 9449313199
Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

Sample: Urine

URINE EXAMINATION, ROUTINE

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.020		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			

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. GAYATRI	Order No	: 1000066219
UHID	: UHJA23015385	Registered On	: 13/01/2024 08:44:00 AM
Age/Sex	: 49/Years Female	Collected On	: 13/01/2024 08:53:56 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:35:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019362
Station	: At Hospital	Mobile No	: 9449313199
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/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		

Verified By
Parameshwar B

---End of Report---

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

13-Jan-2024 AM9:52:04

ID:15386
Name:goopal

M Birth date: 55 years

cm kg / mmHg

1100 Sinus rhythm
0102 ARTIFACT PRESENT
9110 ** normal ECG **

ication:
ptoms:
tory:

t. rate	63	bpm
int	182	ms
dur	94	ms
QTc(E) int	404/ 412	ms
RS/T axis	55/ 11/ 37	°
/SV1 amp	1.50/ 1.02	mV
+SV1 amp	2.52	mV

Unconfirmed Report
Reviewed by:

mm/mV 25 mm/s Filter: H60 D 35 Hz 10 mm/mV

I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6

350K 03-08 07-01 Dept.: Exam:UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care For Excellence
Jayanagar, Bangalore

Patient name :	Mr. GOPAL R	Date :	13/01/24
Age :	55 years GENDER: MALE	Patient ID :	15386
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.2 (2.5-3.7)	LVIDD : 3.6 (3.5-5.5)	MV EV : 71.3	AV : 83.4	MR : NORMAL
LA : 3.9 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 106		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.2 (0.6-1.1)	PV : 80.0		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 1.2 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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 PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHULS PATIL
CONSULTANT CARDIOLOGIST

NABH NABL No.1

UNITED HOSPITAL
Care For Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.GOPAL R	UHID	: UHJA23015386
Age / Sex	: 55 Years / Male	OP NO/Reg Dt	: 13-01-2024 08:47 AM
Spouse / Father Name	: RAMAIAH	Department	:
Address	: 813, JANANA BHARATHI 2ND BLOCK, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

V/A 6/9P, 6/9P (glass) M

~~[illegible]~~
HTN – 7-8 yrs

Investigations:

A/S OU Normal

Treatment / Care of Plan / Provisional Diagnosis : Fund's OU CD to 0.3:1 (dilated) Full Eng

Ifm: OU Ref Error

Follow Up Advice :

RE: +3.75 DS / −0.50 DC × 80° 6/9

LE: +5.00 DS / −0.50 DC × 80 6/9

BE Add +2.50 DS for near N6

Signature of the Doctor

Dr [illegible]

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	Gopal R	**Date**	13/01/24
Age	55 years	**Hospital ID**	UHJA23015386
Sex	Male	**Ref.**	Healthcheck

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 (9.9 x 5.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (10.6 x 5.4 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 distended, normal in contour and wall thickness. No evidence of calculi, mass or mural lesion.

Prostate is normal in echopattern and size, measures ~ 17.7 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

Please bring this report during your visit to the Hospital

DEPARTMENT OF RADIODIAGNOSIS

Name	Gopal R	**Date**	13/01/24
Age	55 years	**Hospital ID**	UHJA23015386
Sex	Male	**Ref.**	Healthcheck

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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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. GOPAL R	Order No	: 1000066225
UHID	: UHJA23015386	Registered On	: 13/01/2024 08:47:04 AM
Age/Sex	: 55/Years Male	Collected On	: 13/01/2024 08:57:24 AM
Ward / Bed No	:	Reported On	: 13/01/2024 12:42:16 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230019363
Station	: MHC	Mobile No	: 9449313199
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	**113**	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase) Remarks: Rechecked result	84	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	111.14	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.05	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.68	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.44	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	187	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	**161**	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	55.3	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	99.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	**32.20**	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.3		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.7		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	87.5	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.2	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	**7**	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	**0.82**	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	**8.5**		12–20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.94	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.77	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.35	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.75	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.58		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	24	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	62	U/L	50-116
GGT (Method:IFCC)	28	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.46	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.

UREA (Method:Urease GLDH - Kinetic)	**16.0**	mg/dL	17-43

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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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)	**13.29**	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	**40.0**	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5210	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	48.68	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	44.39	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.20	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.49	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.24	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.54	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	88.1	fL	78-100
MCH (Method: Calculated)	29.3	pg	27-31
MCHC (Method: Calculated)	33.2	g/dL	31-37
RDW - CV (Method: Calculated)	13.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.32	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	**7.46**	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	8	mm/hour	1-20

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

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

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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

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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
Parameshwar B

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418