NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.VASUMMADHI SUNDARA RAGHUVAN**	**UHID**	**: UHJA23018283**
Age / Sex	: 41 Years / Female	OP NO/Reg Dt	: 13-02-2024 09:39 AM
Spouse / Father Name	: SUNDAR RAGHAVAN	Department	:
Address	: hongasandra, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

For health checkup

Wt - 71.8
HT - 151
Bp - 121/83
Spo2 - 98
PR - 84.

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

Investigations:

No h/ DM, HTN, Thyroid

No h/ any surgery

Treatment / Care of Plan / Provisional Diagnosis :

No h/ ca fdr Com

P/A - Obese abdo

Follow Up Advice :

P/s - G hypertrophied pg folder.

Advice
CT
Physician gom

MC - 16yrs
B/c
All BND
Not tubectomised
LMP - 25/1/24
Anc - 3 regul

Breast - Bt

Signature of the Doctor

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HT - 151
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Spo2 - 98
PR - 84.

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KMC Reg. No. 90384

Investigations:

No h/ DM, HTN, Thyroid

No h/ any surgery

No h/ an fdr Com

Treatment / Care of Plan / Provisional Diagnosis :

ML - 16 yrs
Ble
All BVD
not tubectomised
LMP - 25/1/24
pnc regl

Follow Up Advice :

P/A - obese abdo

P/s - G hypertrophied pap taken.

Advice

Physician Consultation

Breast - Nil

Signature of the Doctor

13-Feb-2024 AM11:03:58

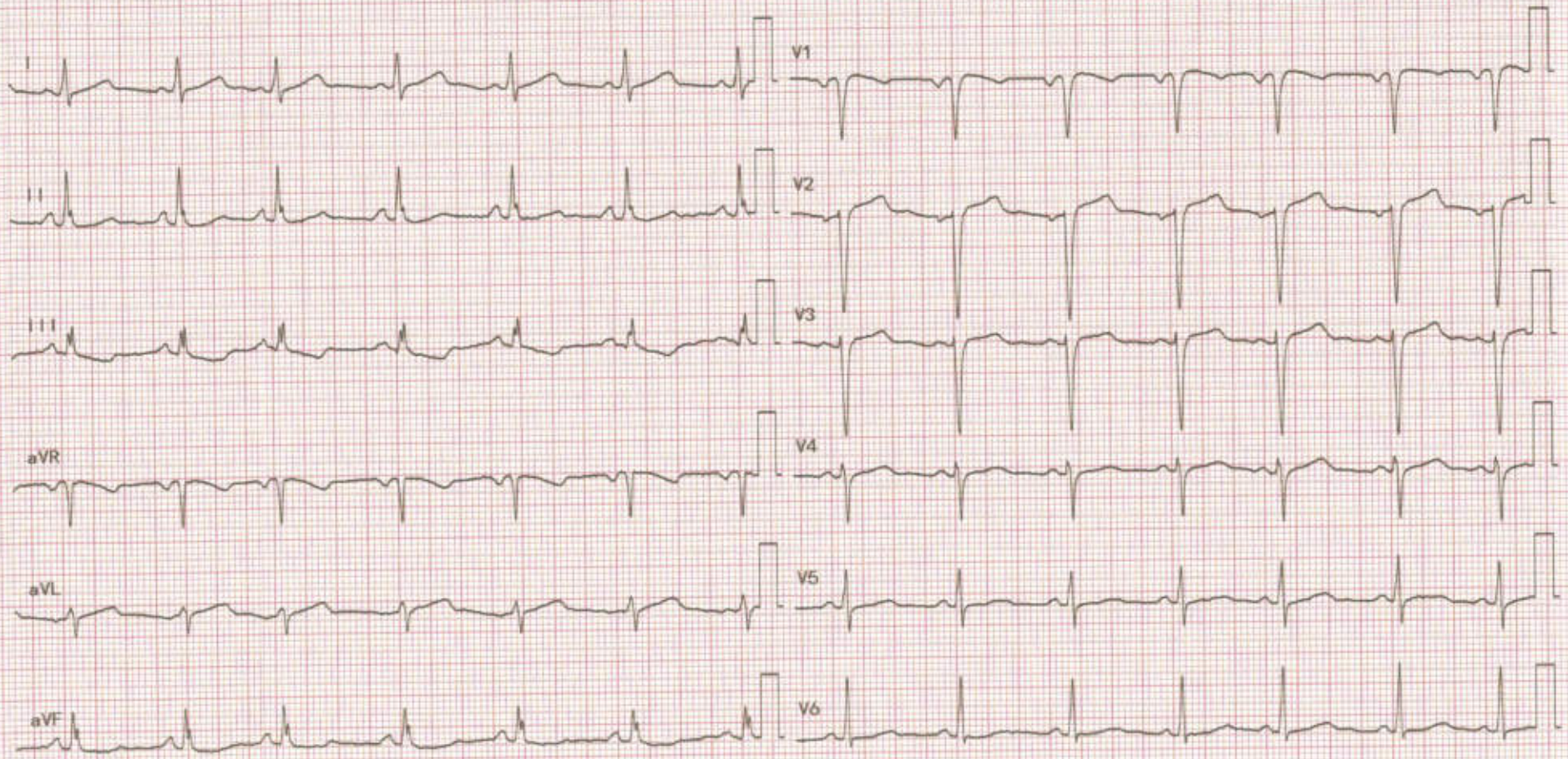
ID:18283
Name:Mrs.Vasummadhi.S
ex:F Birth date: 41 years
cm kg / mmHg
ledication:
ymptoms:
istory:

ent. rate	84	bpm
R int	142	ms
RS dur	86	ms
T/QTc(E) int	370/ 411	ms
/QRS/T axis	73/ 66/ -4	°
V5/SV1 amp	0.69/ 1.04	mV
V5+SV1 amp	1.73	mV

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (I, aVF, V6)]
6220 Possible left atrial enlargement [-0.1 mV Pwave in lead V1/V2]
9130 ** borderline ECG **

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

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Address	: hongasandra, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Nil systemic.

VA 6/9 PH 6/6

6/12 PH 6/6.

Investigations:

AMS OU WNL

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (WNL) OU CD ↓ 0.4:1

PH (+).

Inf: OU Refractive. (Progressive glasses)

Follow Up Advice :

RE: −0.50 DS / −0.50 DC x 70 6/6

LE: −0.75 DS / −0.50 DC x 100 6/6.

BE Add +1.00 DS for near.

Signature of the Doctor

Dr

Patient name :	Mrs. VASUMADHI SUNDARA RAGHUVAN	Date :	13/02/24
Age :	41 years GENDER: FEMALE	Patient ID :	18283
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 : 4.2 (3.5-5.5)	MV EV : 68.4	AV : 51.3	MR : NORMAL
LA : 3.3 (1.9-4.0)	LVIDS : 2.0 (2.4-4.2)	AV : 107		AR : NORMAL
RA : 1.9 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 99.4		PR : NORMAL
RV : 2.1 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.9 (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. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

UNITED HOSPITAL
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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	Vasummadhi sundara Raghuvan	**Date**	13/02/24
Age	41 years	**Hospital ID**	UHJA23018283
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.

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. Elluru Santosh Kumar
Consultant Radiologist

Please bring this report during your visit to the Hospital / ಆಸ್ಪತ್ರೆಗೆ ಬರುವಾಗ ಈ ರಿಪೋರ್ಟನ್ನು ತನ್ನಿ

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Vasummadhi sundara Raghuvan	**Date**	13/02/24
Age	41 years	**Hospital ID**	UHJA23018283
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (15.1 cms) and shows mild 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 focal lesion.

Right Kidney is normal in size (10.3 x 4.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.9 x 4.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Retroperitoneum- Obscured by bowel gas.

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 7.9 x 4.3 x 5.0 cms. Myometrial and endometrial echoes are normal. Endometrium measures 7.0 mm.
Right ovary is normal in size and echopattern, measures 4.8 cc.
Left ovary is normal in size and echopattern, measures 5.4 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: *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

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

Dr. Elluru Santosh Kumar
Consultant Radiologist

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Vasummadhi sundara Raghuvan	**Date**	13/02/24
Age	41 years	**Hospital ID**	UHJA23018283
Sex	Female	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Mild cardiomegaly is seen.

The bony thorax is grossly normal.

IMPRESSION:

- **Mild cardiomegaly.**
- **No other significant radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. VASUMMADHI SUNDARA RAGHUVAN	Order No	: 1000072820
UHID	: UHJA23018283	Registered On	: 13/02/2024 09:39:57 AM
Age/Sex	: 41/Years Female	Collected On	: 13/02/2024 09:46:06 AM
Ward / Bed No	:	Reported On	: 13/02/2024 01:27:38 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022626
Station	: At Hospital	Mobile No	: 9551225525
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	264	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	423	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	10.0	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	240.30	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	2.58	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	15.21	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.48	ı IU/mL	0.34 - 5.60 ı IU/mL (Non Pregnant) 0.3 - 4.5 ı IU/mL (I trimester) 0.5 - 5.2 ı IU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	185	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	191	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	34.2	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	112.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	38.20	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.4		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.2		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	150.8	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.8	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.37	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.07	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.30	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.99	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	4.31	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	0.92		2:1
SERUM SGOT (Method:IFCC without P5P)	13	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	15	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	96	U/L	46-122
GGT (Method:IFCC)	39	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	11.4	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	5	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.61	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	8.19		12¯20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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MC-5013

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Test Name	Result	Unit	Bio. Ref. Interval
HAEMATOLOGY			
COMPLETE BLOOD COUNT(CBC)			Sample: Whole blood (EDTA)
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	12.13	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.2	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9210	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	51.64	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.32	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.88	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.72	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.44	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.62	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	80.6	fL	78-100
MCH (Method: Calculated)	26.3	pg	27-31
MCHC (Method: Calculated)	32.6	g/dL	31-37
RDW - CV (Method: Calculated)	15.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.09	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)	8.50	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	22.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	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

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.030		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Present (1.5%)		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)	Present (+)		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	6-8	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
PREETHI R

---End of Report---

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

Dr - Anuradha

- FBS - 264
- PPBS - 423
- HBA1C - 10

} Type -> DM - not having any medication

Adv

- Low fat diet, Sugar restricted food
- physical activity.
- high protein diet

FBS & PPBS after 1 month.

(1) PROHANCE - D 1 tsp - 1 milk / water x daily once

(2) Tab GLUCOMET - GP2 1-0-1 CBIF

(3) Tab DAPAGLYL - M 10/100 0-1-0 GAF / 10 cont.

(4) Tab GEMCAL XL 0-0-1 x 2 months GAF

HBA1C, FBS, PPBS after 3 months.