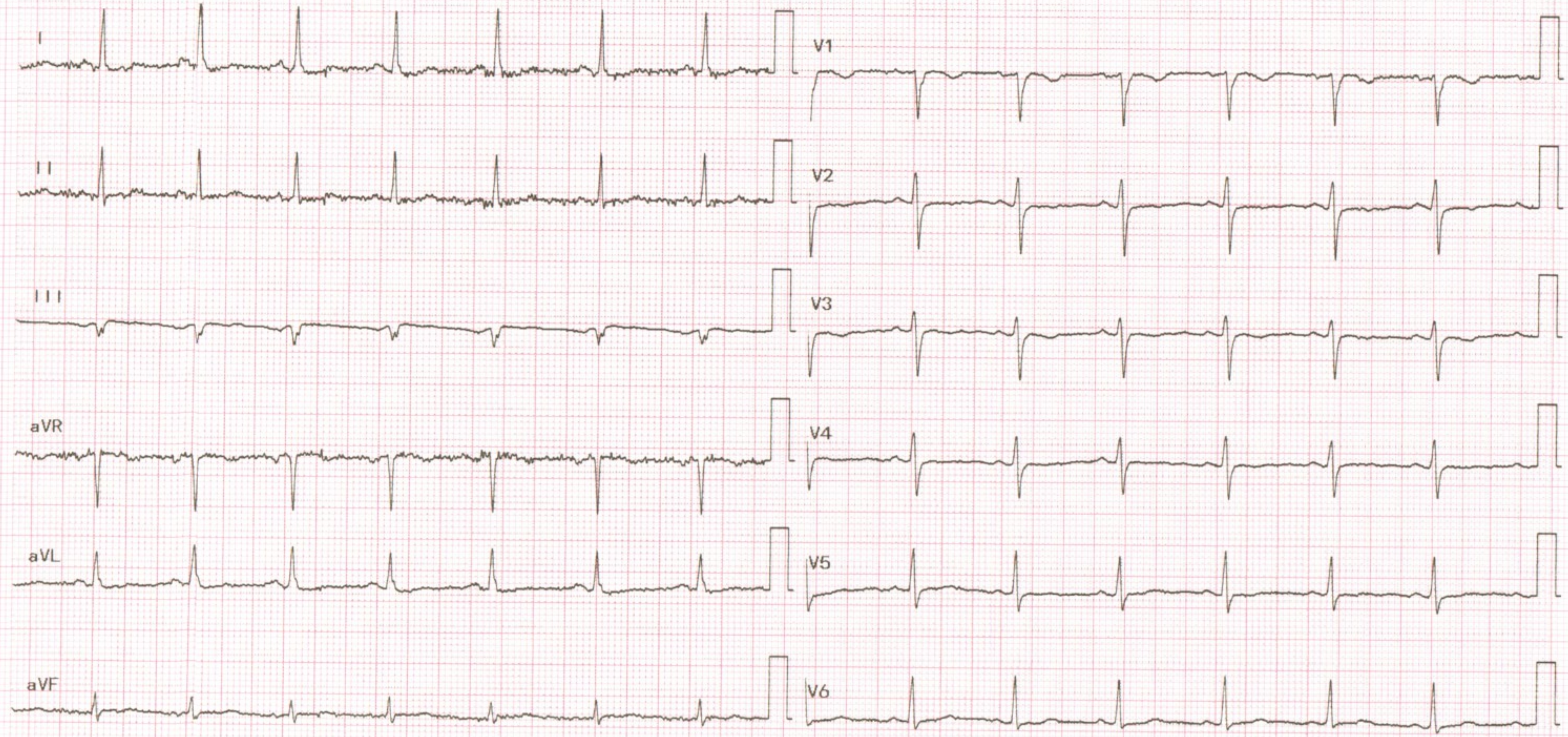
ID:24O6035
Name:ms sandhya n
28-Sep-2024 AM11:01:43

ex:F	Birth date:	34 years
cm	kg / mmHg	
edication:		
ymptoms:		
istory:		
ent. rate	90	bpm
R int	128	ms
RS dur	88	ms
T/QTc(E) int	310/ 358	ms
/QRS/T axis	12/ 15/ 43	°
V5/SV1 amp	0.74/ 0.85	mV
V5+SV1 amp	1.59	mV

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (I, aVL, V5, V6)]
8305 Short QTc interval [QTc int. < 360 ms]
0102 ARTIFACT PRESENT
9150 ** abnormal ECG **

Unconfirmed Report
Reviewed by:



2350K 03-08 07-01 Dept.:
Exam: UNITED HOSPITAL
SCHILLER Part No.2.157017M CE 0123 JBE

NABH

No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. SANDHYA N		
Age :	34 years GENDER: FEMALE	Date :	28/09/2024
Ref by :	CMO	Patient ID :	24006035
		OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV : 0.9	AV : 0.6	
LA : 3.0 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 1.0		MR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.8		AR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	PR : NORMAL
TAPSE: 2.0 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		TR : TRIVIAL TR, PASP-24mmHg
	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

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 PATIL
CONSULTANT CARDIOLOGIST

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sandhya N	Date	28/09/24
Age	34 years	Hospital ID	UHJA24006035
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (16.4 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 evidence of mass or focal lesions.

Right Kidney is normal in size (9.9 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.4 x 4.6 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 over distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and normal in size, measures 8.6 x 3.0 x 5.0 cms. Myometrial and endometrial echoes are normal. Endometrium measures 5.7 mm.
Right ovary is normal in size and echopattern, measures 2.5 cc.
Left ovary is normal in size and echopattern, measures 4.0 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:

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

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

Out Patient Record

Patient Name	**: Ms.SANDHYA N**	**UHID**	**: UHJA24006035**
Age / Sex	: 34 Years / Female	OP NO/Reg Dt	: 28-09-2024 09:39 AM
Spouse / Father Name	: NAGARAJ K.G	Department	:
Address	: NO, 13, 4TH CROSS, A-STREET MAGADI ROAD, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

WT: 68.1 kg
HT: 154 cm
SPO2: 98%
PR: 96 bpm
BP: 110/80 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Ms. SANDHYA N	Order No	: 1000097575
UHID	: UHJA24006035	Registered On	: 28/09/2024 09:39:48 AM
Age/Sex	: 34/Years Female	Collected On	: 28/09/2024 09:59:18 AM
Ward / Bed No	:	Reported On	: 28/09/2024 02:22:08 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240008317
Station	: At Hospital	Mobile No	: 9164956837
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
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)	100	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	114	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.03	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.54	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	0.62	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)	190	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	155	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	49.7	mg/dL	< 40 - Low ≥ 60 - High

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

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Station	: At Hospital	Mobile No	: 9164956837
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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	109.30	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	31.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.82		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.20		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	140.30	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.8	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.64	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.59	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.47	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.96	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.24	g/dL	2.3-3.5

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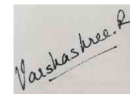
Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.22		2:1
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	15	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	40	U/L	46-122
GGT (Method:IFCC)	26	U/L	< 38



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

UNITED HOSPITAL
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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)	10.57	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	33.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6160	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	63.10	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	27.70	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.09	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.99	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.12	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.21	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	78.5	fL	78-100
MCH (Method: Calculated)	25.1	pg	27-31
MCHC (Method: Calculated)	32.0	g/dL	31-37
RDW - CV (Method: Calculated)	15.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.02	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)	9.87	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	24.3	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	32	mm/hour	1-20

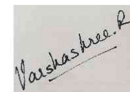
BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
ABO Group (Method:Agglutination Method)	A
Rh Factor (Method:Agglutination Method)	Positive

Interpretation Notes

Note: Both forward and reverse grouping performed



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

DEPARTMENT OF LABORATORY MEDICINE

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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	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.5		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			

DEPARTMENT OF LABORATORY MEDICINE

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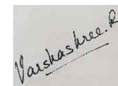
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	0-2	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	NIL		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Arpitha S R

---End of Report---



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

NABH

No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Sandhya N	**Date**	28/09/24
Age	34 years	**Hospital ID**	UHJA24006035
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