

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SANDEEP	Order No	: 1000074738
UHID	: UHJ A23019199	Registered On	: 27/02/2024 09:09:51 AM
Age/Sex	: 35/Years Male	Collected On	: 27/02/2024 09:16:56 AM
Ward / Bed No	:	Reported On	: 27/02/2024 01:52:45 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230023749
Station	: At Hospital	Mobile No	: 8310304076
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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BIOCHEMISTRY

FASTING GLUCOSE (Method: Hexokinase)	110	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	93	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	108.28	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:C LIA)	1.53	ng/mL	0.87-1.78
TOTAL T4 (Method:C LIA)	10.3	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:C LIA: Ultra-sensitive)	2.09	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	205	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	228	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	38.6	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	120.8	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	45.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.3		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.1		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	166.4	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.8	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	1.08	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.16	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.19	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.97	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.53	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.66	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.69		2:1

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SERUM SGOT (Method:IFCC without P5P)	26	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	47	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	109	U/L	50-116
GGT (Method:IFCC)	26	U/L	< 55



Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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HAEMATOLOGY
COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.56	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	47.2	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5170	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	48.68	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	41.71	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.59	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.76	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.26	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.71	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	82.6	fL	78-100
MCH (Method: Calculated)	27.3	pg	27-31
MCHC (Method: Calculated)	33.0	g/dL	31-37
RDW - CV (Method: Calculated)	13.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.38	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) <small>(Method:Derived from PLT Histogram)</small>	7.64	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) <small>(Method: Calculated)</small>	18.4	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) <small>(Method:Modified Westergren Method)</small>	8	mm/hour	1-15
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group <small>(Method:Agglutination Gel Method)</small>	O		
Rh Factor <small>(Method:Agglutination Gel Method)</small>	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	5.0		5.0-8.0
SPECIFIC GRAVITY	1.025		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

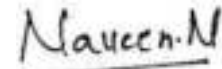
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EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---



Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418



NABH



NABL



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.SANDEEP	UHID	: UHJA23019199
Age / Sex	: 35 Years / Male	OP NO/Reg Dt	: 27-02-2024 09:09 AM
Spouse / Father Name	: UMESH S REVANKAR	Department	:
Address	: #t2 3dr floor garuda enclave jp nagar 1st phase , , Bengaluru Urban, Karnataka,	Referred By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr Ashnitha Padma

Complaints / Findings / Observations :

Wt - 88y
 HT - 179
 Bp - 128/
 SpO2 - 98
 PR - 88

Investigations:

LDL - 120.

Treatment / Care of Plan / Provisional Diagnosis :

After 3 mths

fasting lipid
 profile

Follow Up Advice :

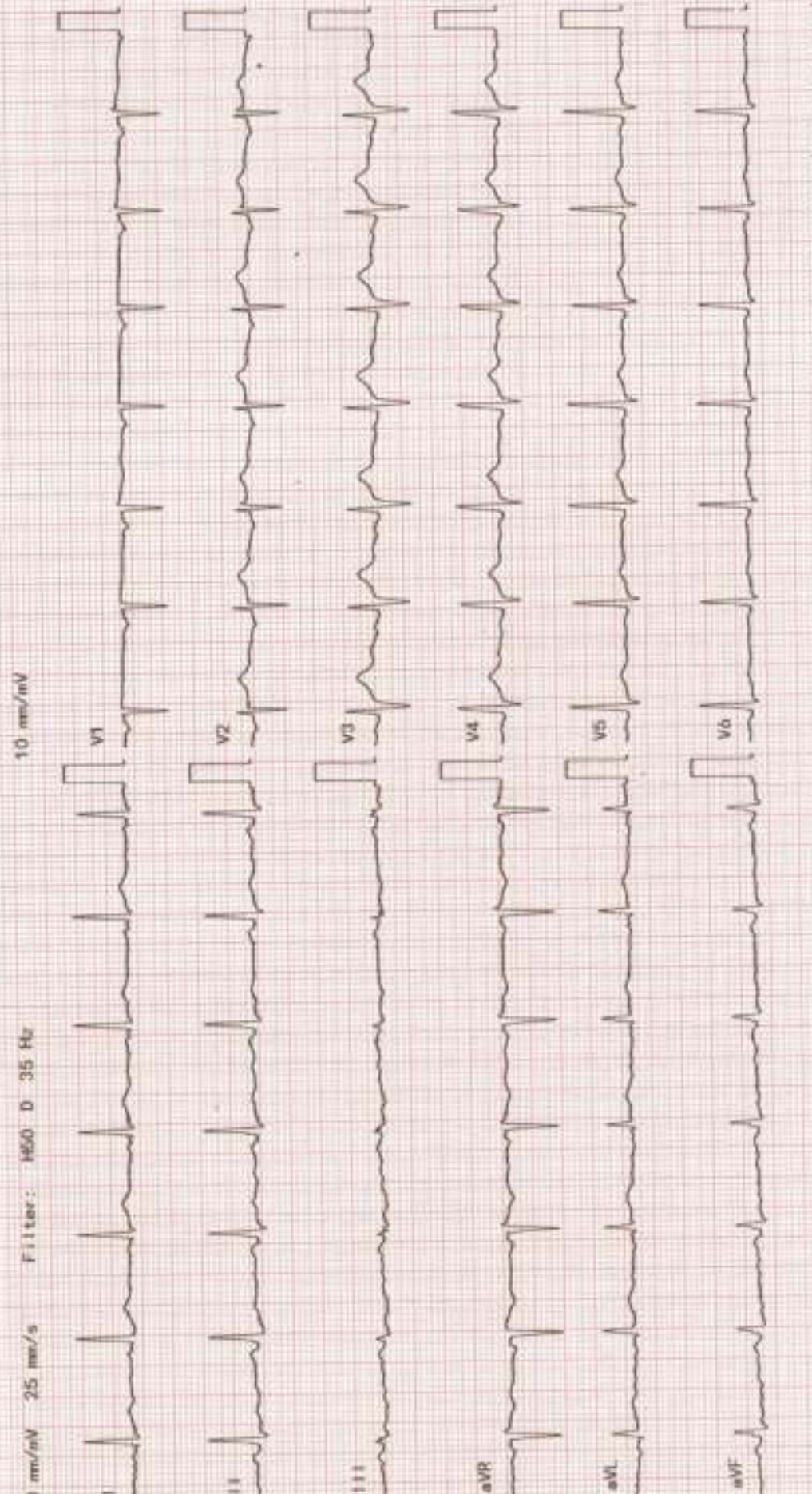
R
 high fibre diet

Signature of the Doctor

1100 Sinus rhythm
 4068 Nonspecific Twave abnormality [flat T or negative T (I, aVL, aVF, V6)]
 9130 ** borderline ECG **

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

Unconfirmed Report
 Reviewed by:



EXERCISE STRESS TEST REPORT

Patient Name: MR. SANDEEP,
Patient ID: 19199
Height: 179 cm
Weight: 88 kg

DOB: 07.07.1988
Age: 35yrs
Gender: Male
Race: Indian

Study Date: 27.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: DR. RAHUL PATIL
Attending Physician: DR. RAHUL PATIL
Technician: YAMINI/THABITHA

Medications:

Medical History:

NO H/O DM & HTN

Reason for Exercise Test:

Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:05	0.00	0.00	82	120/80	
	STANDING	00:36	0.00	0.00	80	120/80	
	HYPERV.	00:02	0.00	0.00	82	120/80	
	WARM-UP	00:36	0.00	0.00	76	120/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	110	120/80	
	STAGE 2	03:00	2.50	12.00	114	130/90	
	STAGE 3	02:03	3.40	14.00	133	140/100	
RECOVERY		05:20	0.00	0.00	81	140/100	

The patient exercised according to the BRUCE for 8:03 mins, achieving a work level of Max. METS: 10.10. The resting heart rate of 82 bpm rose to a maximal heart rate of 134 bpm. This value represents 72 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 140/100 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.

Functional Capacity: normal.

HR Response to Exercise: appropriate.

BP Response to Exercise: normal resting BP - appropriate response.

Chest Pain: none.

Arrhythmias: none.

ST Changes: none.

Overall impression: Normal stress test.

Conclusions

GOOD EFFORT TOLERANCE

NORMAL HR AND BP RESPONSE

NO ANGINA OR ARRHYTHMIAS NOTED

NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician

Technician

DR SANDER P.
Patient ID 19199
02/2024
19:20am

Male 179 cm 88 kg
35yrs Indian
Medcs:

Test Reason: Screening for CAD
Medical History: NO H/O DM & HTN

Ref MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL
Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test
Comment:

BRUCE: Total Exercise Time 08:03
Max HR: 134 bpm 72% of max predicted 185 bpm HR at rest: 82
Max BP: 140/100 mmHg BP at rest: 120/80 Max RPP: 18760 mmHg*bpm
Maximum Workload: 10.10 METS
Max ST: -0.65 mm, 0.00 mV/s in III; RECOVERY 01:50
Arhythmias: A-13, ASYSTO-3
ST/HR index: 0.92 μ V/bpm

Reasons for Termination: Target heart rate achieved
Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
6 bpm	101 bpm	133 bpm	81 bpm
20/80 mmHg	140/100 mmHg	140/100 mmHg	140/100 mmHg

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.25 mm	0.20	0.50	0.15
0.15 mV/s	0.12	0.72	0.36

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.45	-0.45	-0.10	0.05
0.72	0.82	1.12	0.66

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.15	-0.65	-0.50	-0.10
0.14	0.52	0.59	0.17

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.40	0.15	-0.20	-0.10
0.73	-1.23	-1.20	-0.68

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.10	0.45	0.50	0.15
0.29	-0.28	-0.04	-0.04

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.30	-0.50	-0.35	-0.05
0.45	0.67	0.78	0.46

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
76 bpm	101 bpm	133 bpm	81 bpm
120/80 mmHg	140/100 mmHg	140/100 mmHg	140/100 mmHg

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.05	0.30	0.25	0.10
-0.41	-0.60	-0.14	-0.34

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
1.00	0.60	0.75	0.65
0.73	0.57	0.97	0.44

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
1.10	0.25	0.50	0.60
1.00	1.13	1.13	0.69

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.65	-0.45	-0.15	0.45
0.85	0.79	0.68	0.72

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.40	-0.50	0.00	0.20
0.56	0.62	0.59	0.47

BASELINE EXERCISE	MAX ST RECOVERY	PEAK EXERCISE EXERCISE	TEST END RECOVERY
0.15	-0.40	0.00	0.00
0.27	0.46	0.81	0.29

Unconfirmed

Attending MD: DR. RAHUL PATIL

R. SANDEEP,

Patient ID: 19199

02/02/2024

19:20am

Male 179 cm 88 kg

35yrs Indian

Medic:

Test Reason: Screening for CAD

Medical History: NO H/O DM & HTN

Ref. MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL
 Technician: VAMINI/THABITHA Test Type: Treadmill Stress Test
 Comment:

BRUCE: Total Exercise Time 08:03

Max HR: 134 bpm 72% of max predicted 185 bpm HR at rest: 82

Max BP: 140/100 mmHg BP at rest: 120/80 Max RPP: 18760 mmHg* bpm

Maximum Workload: 10.10 METS

Max. ST: -0.65 mm, 0.00 mV/s in III; RECOVERY 01:50

Arrhythmic: A-13, ASYSTO:3

ST/HR index: 0.92 μ V/bpm

Reasons for Termination: Target heart rate achieved

Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to

Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate

response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall

Impression: Normal stress test

Conclusion: GOOD EFFORT TOLERANCE

NORMAL HR AND BP RESPONSE

NO ANGINA OR ARRHYTHMIAS NOTED

NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND

RECOVERY

IMPRESSION: STRESS TEST IS NEGATIVE FOR INDICIBLE ISCHEMIA

Location Number: * 0 *

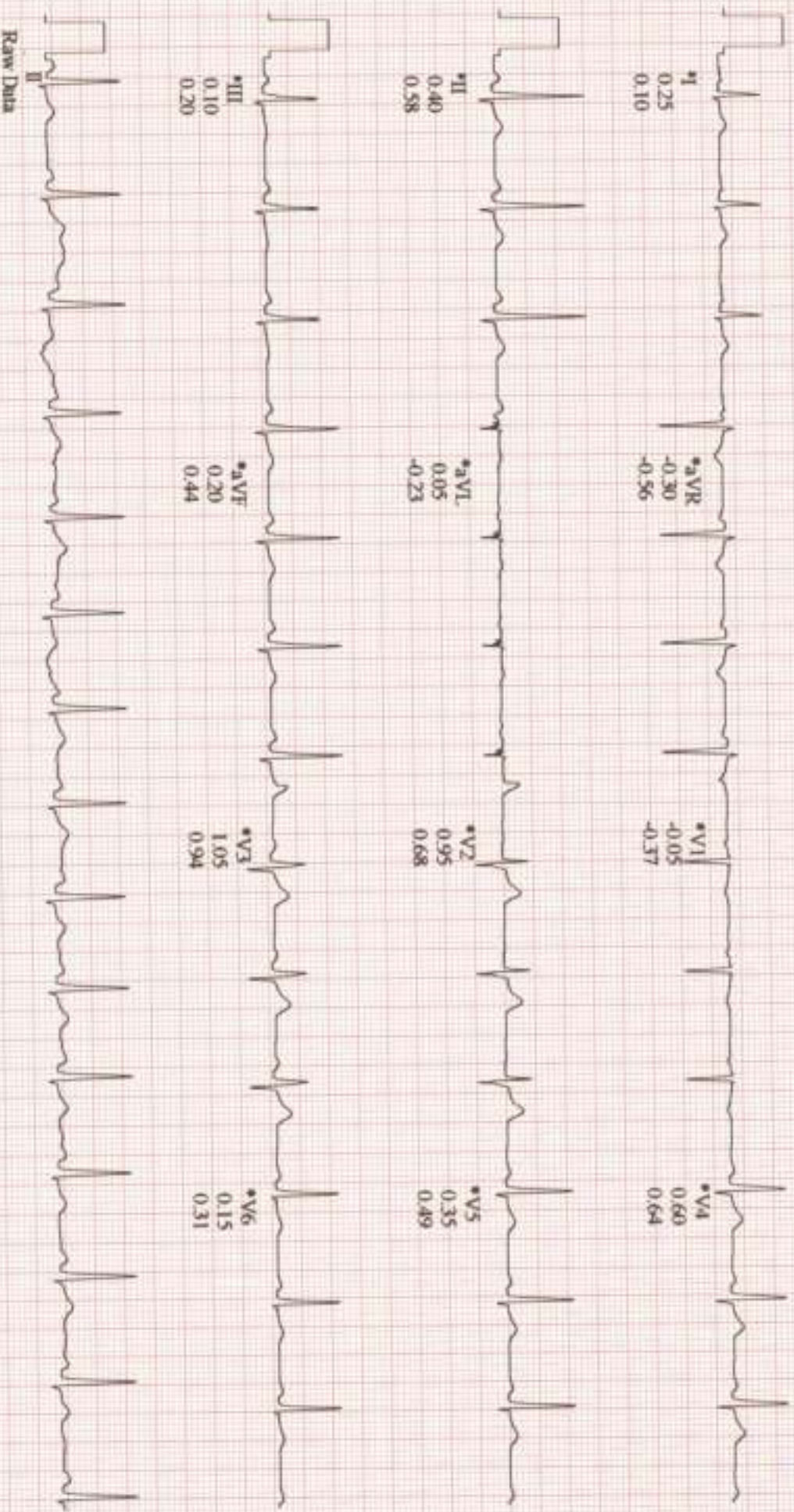
79 bpm
120/80 mmHg

PRETEST
STANDING
00:39

BRUCE
0.0 mph
0.0 %

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



*Computer Synthesized Rhythms

78 bpm
120/80 mmHg

PRETEST
WARM-UP
01:15

BRUCE
0.0 mph
0.0 %

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)

*I
0.30
-0.02

*aVR
-0.35
-0.76

*V1
0.05
-0.36

*V4
0.70
0.81

*II
0.45
0.67

*aVL
0.10
-0.38

*V2
1.00
0.77

*V5
0.40
0.60

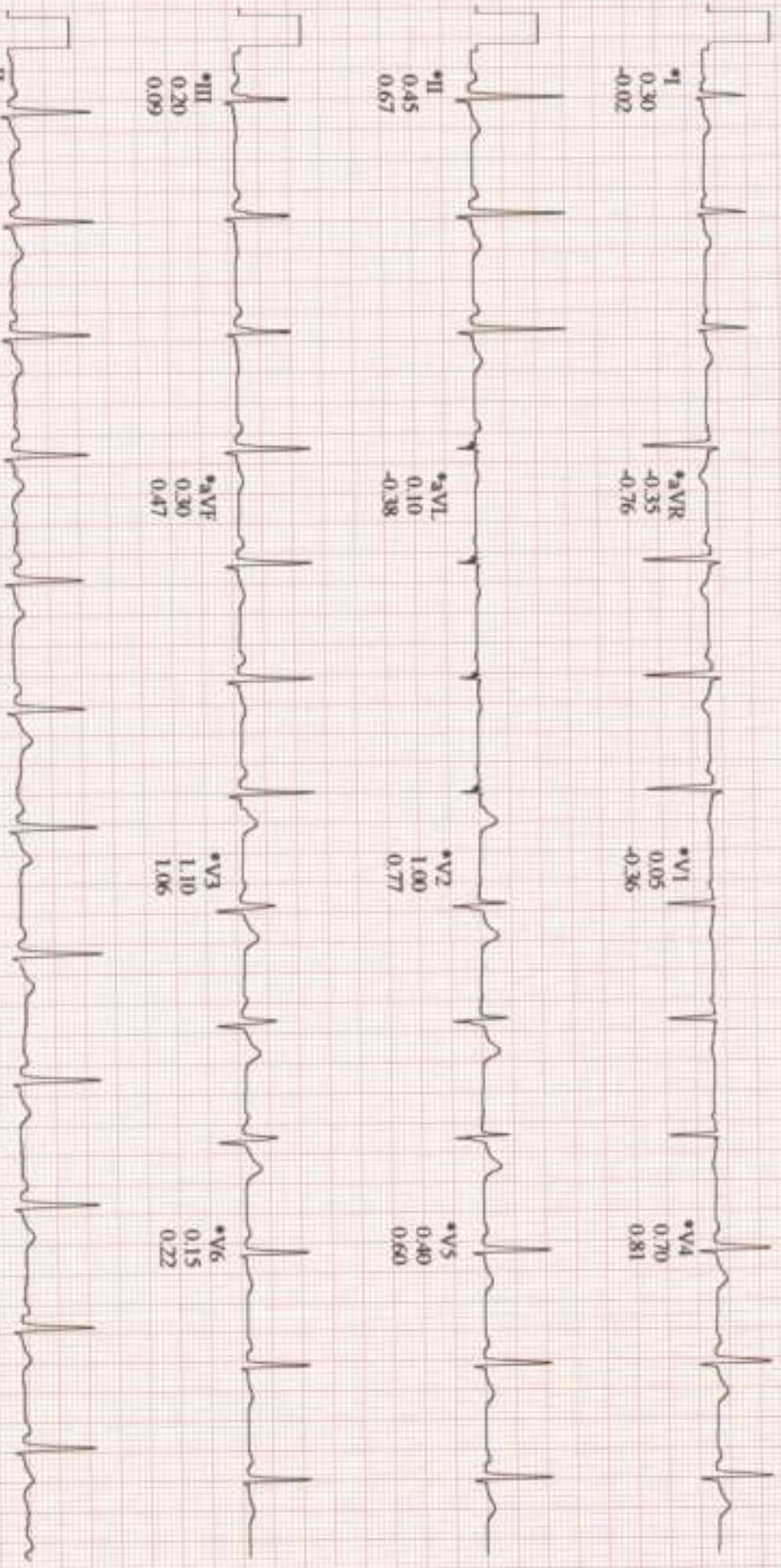
*III
0.20
0.09

*aVF
0.30
0.47

*V3
1.10
1.06

*V6
0.15
0.22

Raw Data



*Computer Synthesized Rhythms

Start of Test: 11:19:20am

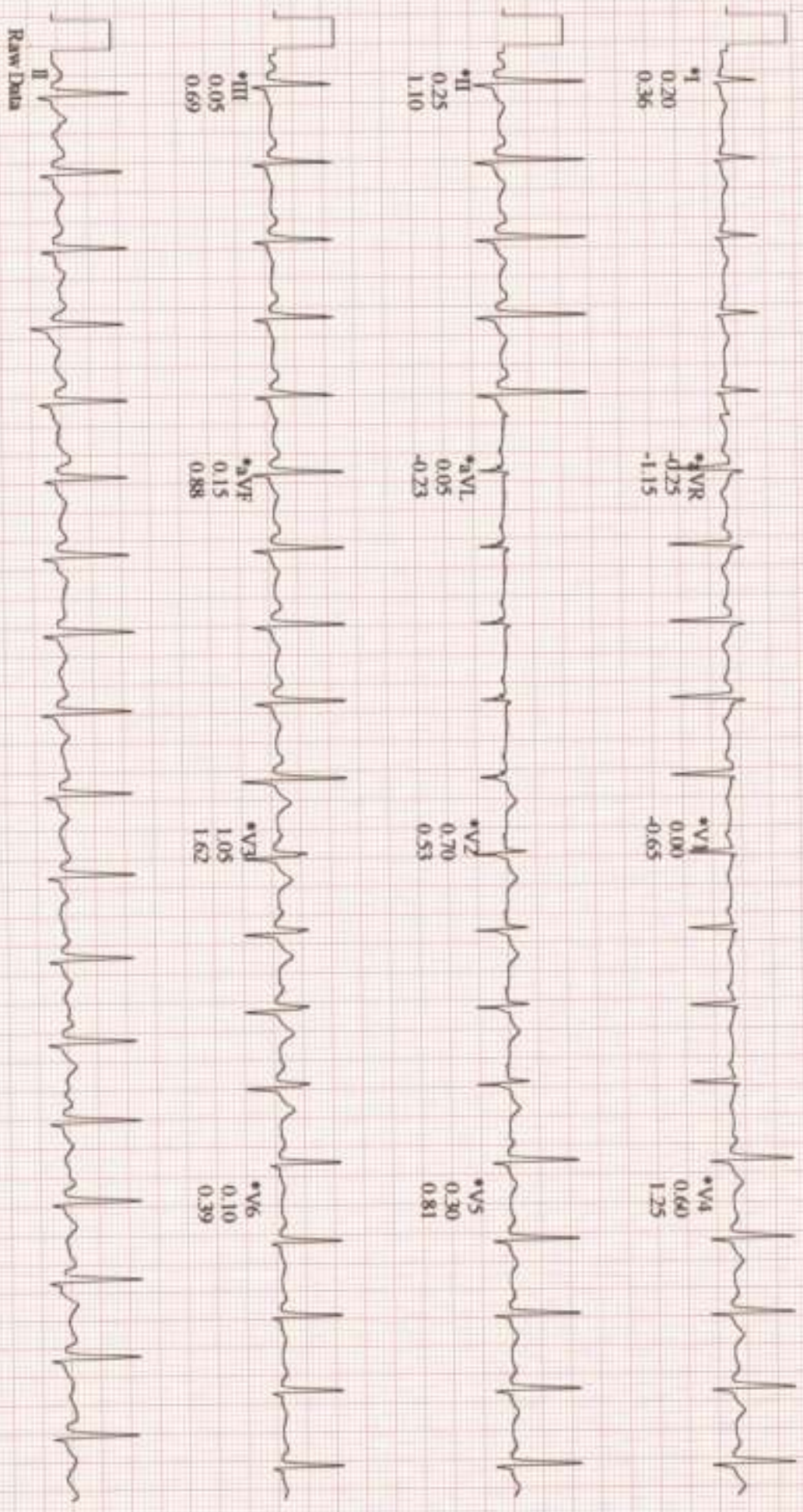
113 bpm
120.80 mmHg

EXERCISE
STAGE 1
02-50

BRUCE
1.7 mph
10.0 %

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



Raw Data

*Computer Synthesized Rhythms

Start of Test: 11:19:20am

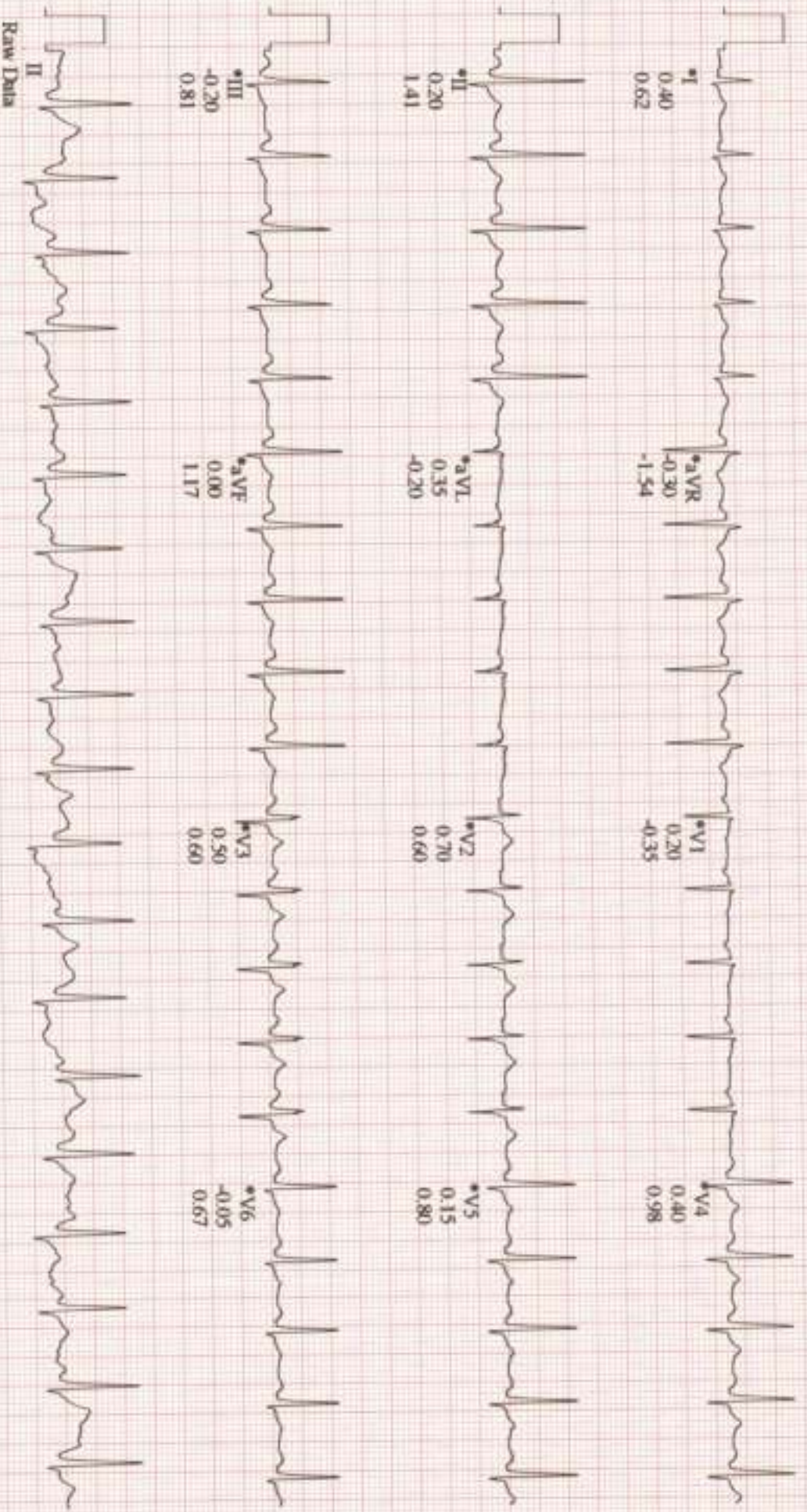
118 bpm
130/90 mmHg

EXERCISE
STAGE 2
05:50

BRUCE
2.5 mph
12.0 %

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



Raw Data

*Computer Synthesized Rhythms

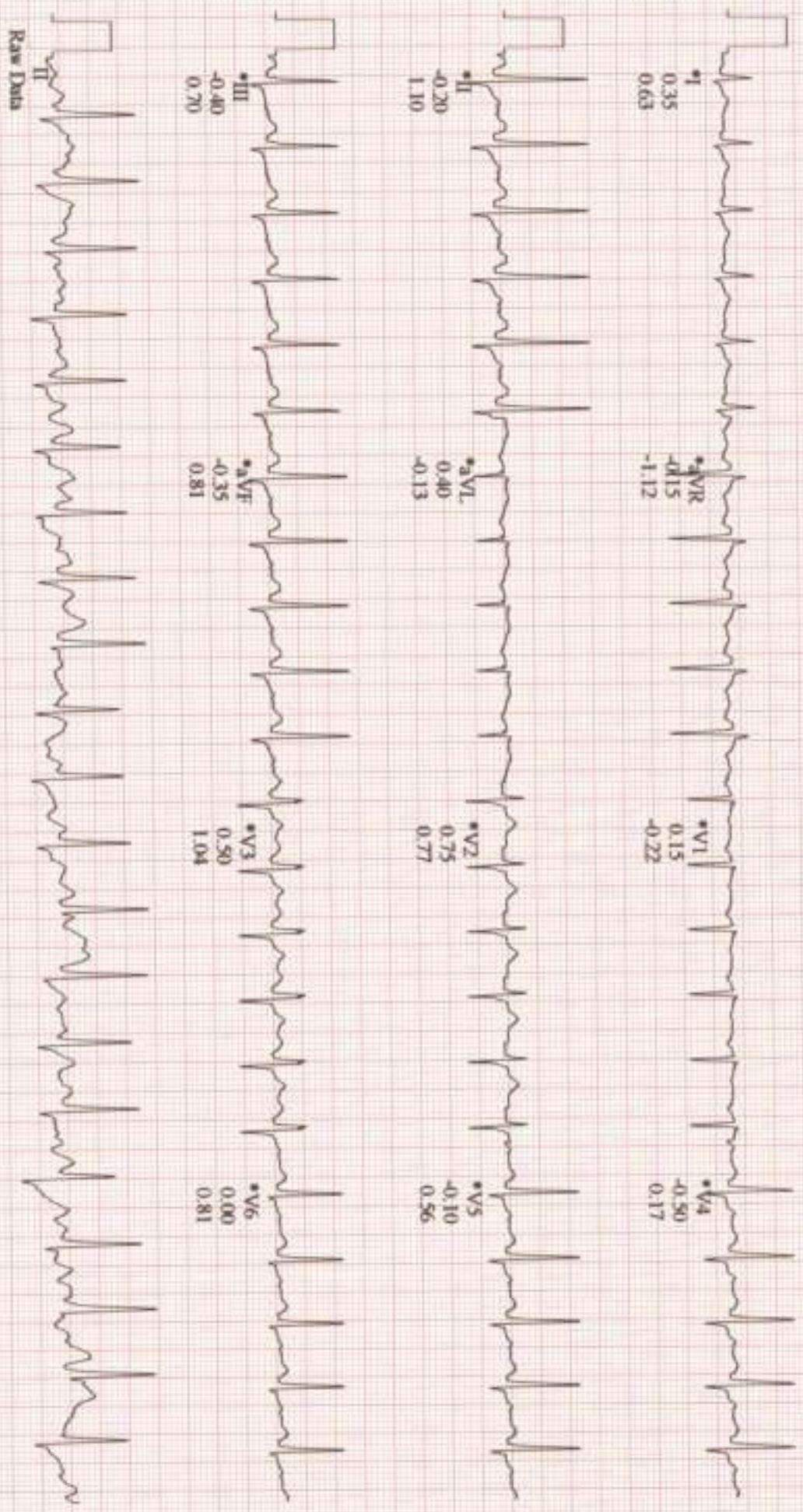
131 bpm
140/100 mmHg

EXERCISE
STAGE 3
08:01

BRUCE
3.4 mph
14.0 %

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)



*Computer Synthesized Rhythms

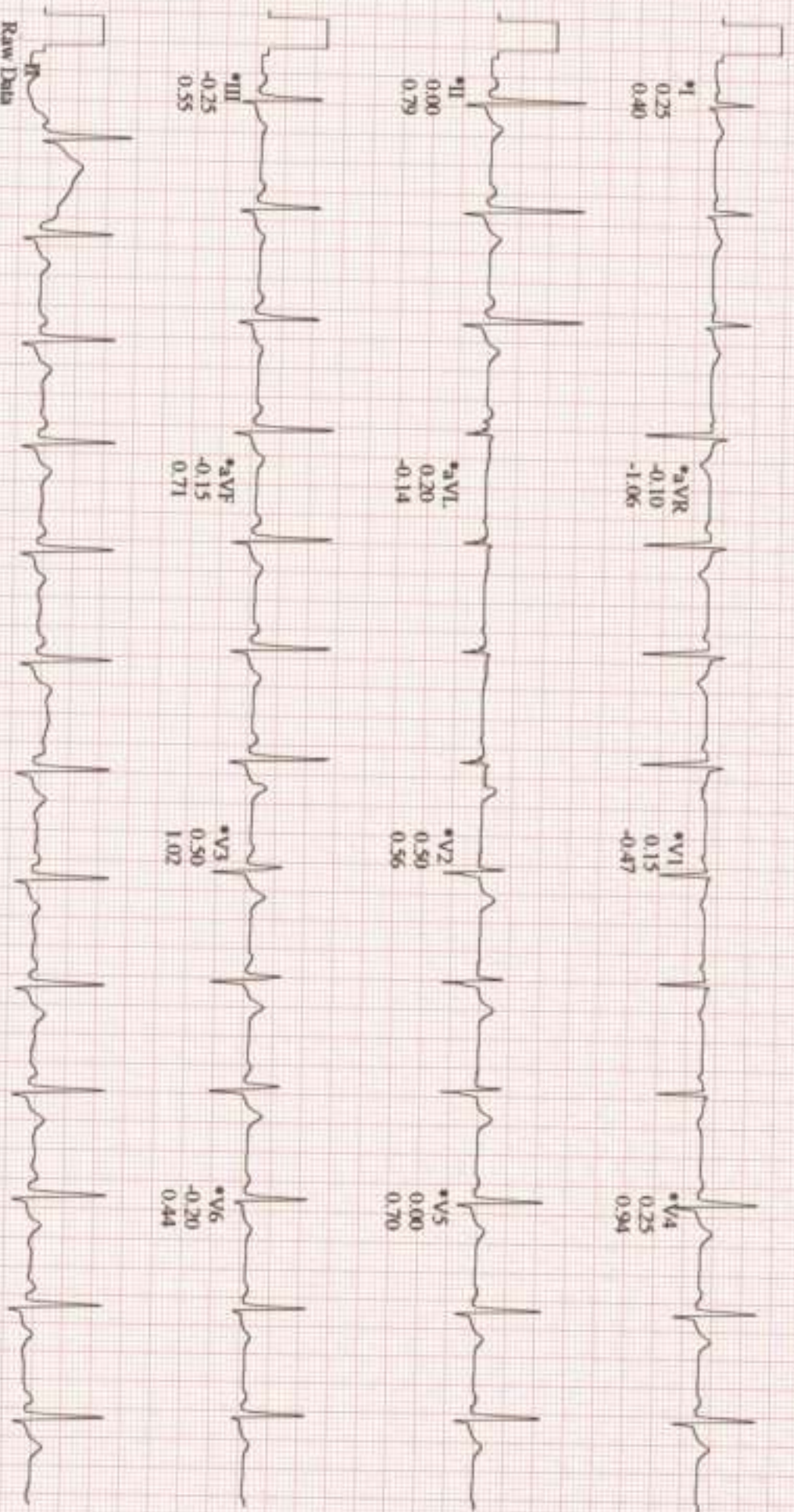
79 bpm

RECOVERY
#1
03:00

BROCC
0.0 mph
0.0 %

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm mV
60 ms post J



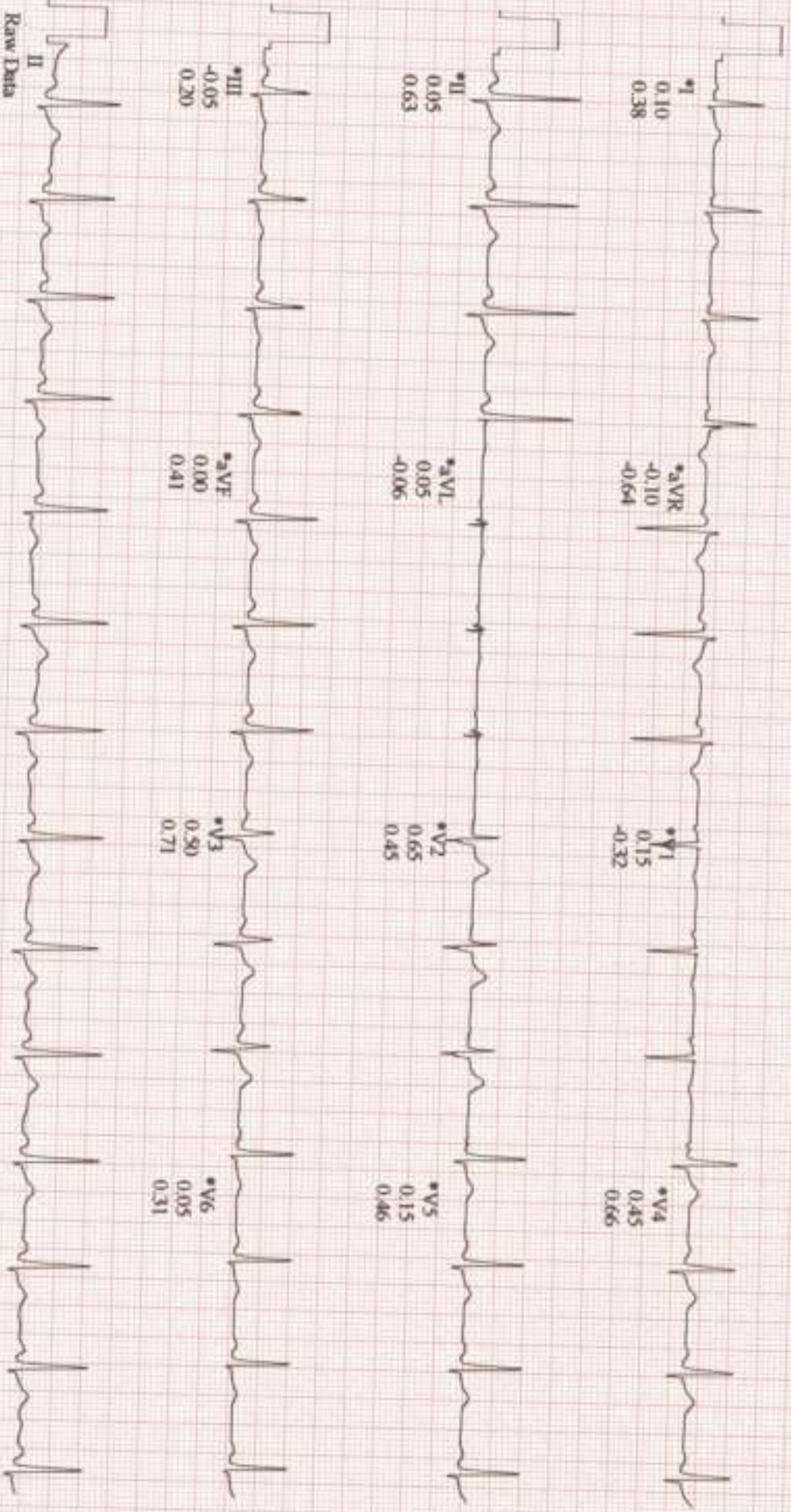
Raw Data

*Computer Synthesized Rhythms

82 bpm
140/100 mmHg
RECOVERY #1
05:00
BRUCE
0.0 mph
0.0 %

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)



Raw Data

*Computer Synthesized Rhythms

DEPARTMENT OF RADIO DIAGNOSIS

Name	Sandeep	Date	27/02/24
Age	35 years	Hospital ID	UHJA23019199
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is enlarged in size (15.2 cms) and shows moderately 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 (10.1 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.6 x 3.9 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 ~ 17.4 cc.

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.**





NABH



NABL



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sandeep	Date	27/02/24
Age	35 years	Hospital ID	UHJA23019199
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