DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SAKSHI	Order No	: 1000092984
UHID	: UHJA24004414	Registered On	: 10/08/2024 08:13:48 AM
Age/Sex	: 33/Years Female	Collected On	: 10/08/2024 08:27:56 AM
Ward / Bed No	:	Reported On	: 10/08/2024 12:41:10 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240006160
Station	: At Hospital	Mobile No	: 9113310180
Payer Name	: Mediwheel	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval
FASTING GLUCOSE (Method: Hexokinase)	112	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	164	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.19	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	14.39	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	6.05	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)	200	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	121	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	50.2	mg/dL	< 40 - Low ≥ 60 - High

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DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	125.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	24.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.98		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.50		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	149.80	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.4	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)	0.80	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.19	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.62	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.36	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.04	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.43		2:1
SERUM SGOT (Method:IFCC without P5P)	50	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	57	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	106	U/L	46-122
GGT (Method:IFCC)	127	U/L	< 38

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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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)	11.80	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9130	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	77.13	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	15.26	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.83	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.54	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.24	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.18	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	88.4	fL	78-100
MCH (Method: Calculated)	28.2	pg	27-31
MCHC (Method: Calculated)	31.9	g/dL	31-37
RDW - CV (Method: Calculated)	14.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.21	Lakhs/Cum	1.5-4.5

DEPARTMENT OF LABORATORY MEDICINE

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Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	9.41	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	21.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	30	mm/hour	1-20

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
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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Station	: At Hospital	Mobile No	: 9113310180
Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SAKSHI	Order No	: 1000092984
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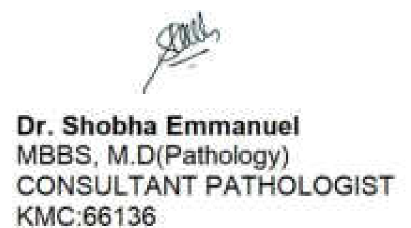
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240006160
Station	: At Hospital	Mobile No	: 9113310180
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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)	Present (1.0%)		

Verified By
Dr Shobha Emmanuel

---End of Report---



Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

(1)

NABH No.1

Jayanagar, Bangalore

Out Patient Record

Patient Name	: **Mrs.SAKSHI**	**UHID**	: **UHJA24004414**
Age / Sex	: 33 Years / Female	OP NO/Reg Dt	: 10-08-2024 08:13 AM
Spouse / Father Name	: RAJEEV RANJAN	Department	:
Address	: JP NAGAR 8TH PHASE, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

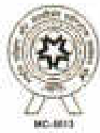
BP - 150/100 mmHg
SpO2 - 97 %
P - 76 b/m
Ht - 165 cm
Wt - 97.3 kg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor



NABH NABL No.1

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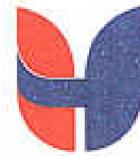

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Care For Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SAKSHI**	**UHID**	**: UHJA24004414**
Age / Sex	: 33 Years / Female	OP NO/Reg Dt	: 10-08-2024 08:13 AM
Spouse / Father Name	: RAJEEV RANJAN	Department	: Ophthal
Address	: JP NAGAR 8TH PHASE, , Bengaluru Urban, Karnataka, INDIA,	Refered By	: Medi Wheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Seema.

Complaints / Findings / Observations : c/o difficulty while reading.

Borderline DM/HTN
Not on Rx.

Investigations:

Vn (glass) — 6/18 PH nil. / 6/18 PH nil.

A/S OU Normal.

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (undilated) OU CDR 0.3:1, disc margins - Ⓝ
? Disc Pallor (+)

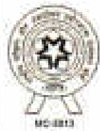
Dry AR.
Ⓡ -0.75 / -2.25 x 180
Ⓛ -0.75 / -1.25 x 170

Follow Up Advice :

If - OU Ref Error.

Adv: Dilated fundus Examination.

Signature of the Doctor
10/8/24.



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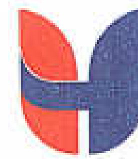

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Out Patient Record

Patient Name	**: Mrs.SAKSHI**	**UHID**	**: UHJA24004414**
Age / Sex	: 33 Years / Female	OP NO/Reg Dt	: 10-08-2024 08:13 AM
Spouse / Father Name	: RAJEEV RANJAN	Department	: ENT
Address	: JP NAGAR 8TH PHASE, , Bengaluru Urban, Karnataka, INDIA,	Refered By	: Mediwheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Vignesh. J

Complaints / Findings / Observations :

B/L Ears, Nose, oral Cavity, oropharynx Neck } Within Normal limits.

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

DR. VIGNESH J
MBBS, DLO, DNB, FHNS
ENT, HEAD AND NECK CANCER SURGEON
REG. NO: 92095

Signature of the Doctor

Name:sakshi

10-Aug-2024 AM8:54:30

SCHILLER

ex:F Birth date: 33 years

cm kg / mmHg

edication:

ymptoms:

istory:

ent. rate	77	bpm
R int	130	ms
RS dur	82	ms
T/QTc(E) int	374/ 406	ms
/QRS/T axis	26/ 12/ 10	°
V5/SV1 amp	0.79/ 1.06	mV
V5+SV1 amp	1.86	mV

1100 Sinus rhythm

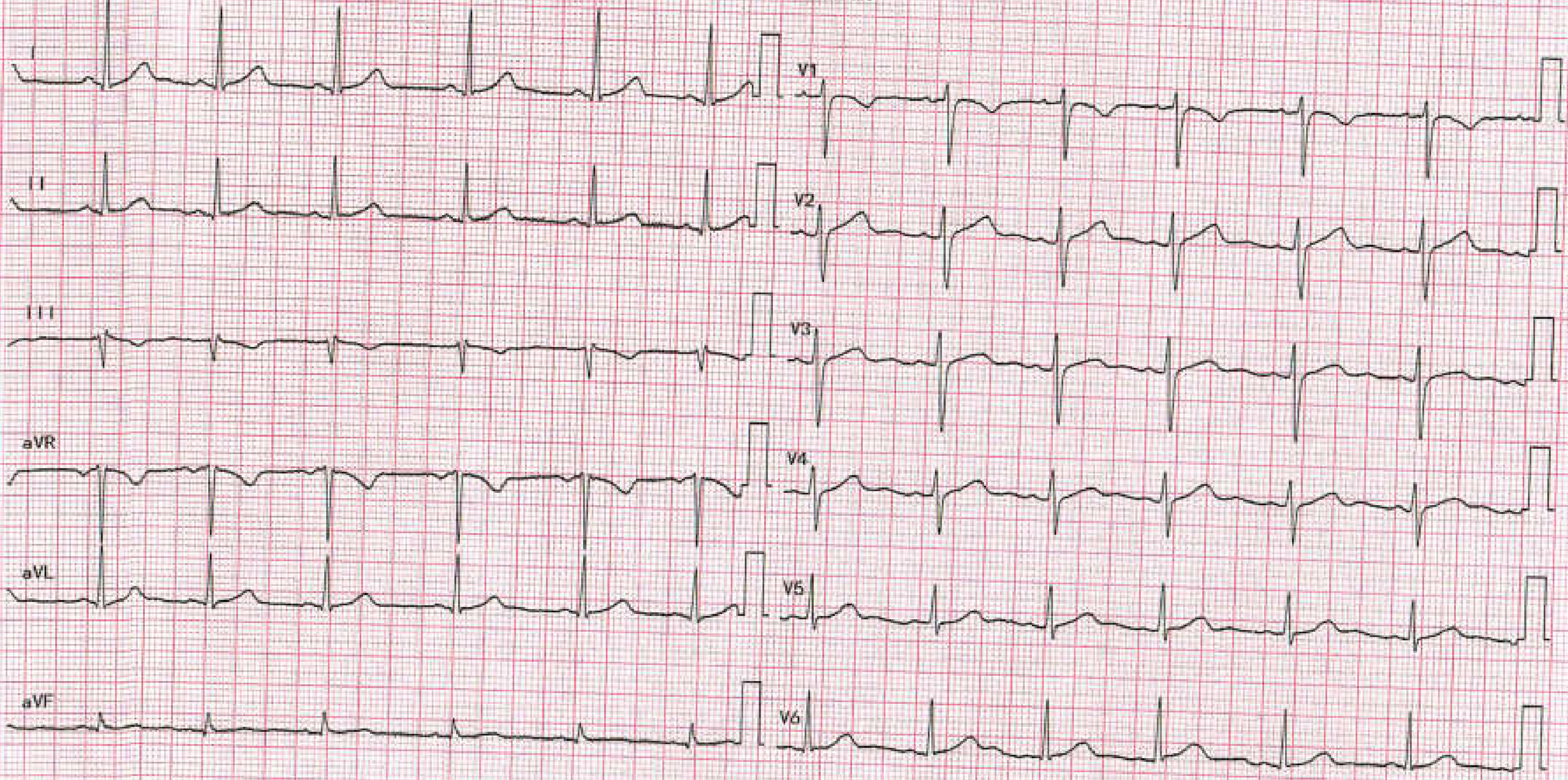
9110 ** normal ECG **

Unconfirmed Report

Reviewed by:

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

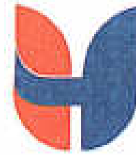
10 mm/mV



2350K 03-08 07-01 Dept.:

Exam: UNITED HOSPITAL

Part No.2.157017M



NABH No.1

DEPARTMENT OF RADIODIAGNOSIS

Jayanagar, Bangalore

Name	Sakshi	**Date**	10/08/24
Age	33 years	**Hospital ID**	UHJA24004414
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (18 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 (11.6 cms), shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (11.9 x 5.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (12.1 x 4.9 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 distended, normal in contour and wall thickness. No evidence of calculi.

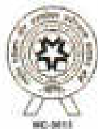
Uterus is anteverted and normal in size, measures 8.3 x 4.5 x 4.9 cms. Myometrial and endometrial echoes are normal. Endometrium measures 14 mm.
Right ovary is normal in size and echopattern, measures 2.9 x 2.8 cms.
Left ovary is normal in size and echopattern, measures 2.9 x 2.8 cms.
Both adnexa: Normal. 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 III).**
- **No other definite sonological abnormality detected.**

Dr. Manu Srinivas H, MD, RD
Consultant Radiologist



NABH NABL No.1

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Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SAKSHI**	**UHID**	**: UHJA24004414**
Age / Sex	: 33 Years / Female	OP NO/Reg Dt	: 10-08-2024 08:13 AM
Spouse / Father Name	: RAJEEV RANJAN	Department	: Gynec
Address	: JP NAGAR 8TH PHASE, , Bengaluru Urban, Karnataka, INDIA,	Refered By	: Mediwheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Yogalakshmi S.K.

Complaints / Findings / Observations :

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH NABL No.1

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PATIENT NAME :	Mrs. SAKSHI	DATE :	10/08/24
AGE :	33 YEARS GENDER : FEMALE	PATIENT ID :	24004414
REF BY :	CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(cm)	(cm)	(cm/sec)		
AO : 2.8 (2.5-3.7)	LVIDD : 4.4 (3.5-5.5)	MV EV : 1.0	AV : 0.8	MR : NORMAL
LA : 3.5 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 1.4		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 1.1		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.3 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO 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:

TACHYCARDIA OBSERVED DURING THE STUDY (HR – 101 bpm)
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 S PATIL
CONSULTANT CARDIOLOGIST

NABH No.1

Out Patient Record

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Spouse / Father Name	: RAJEEV RANJAN	Department	:
Address	: JP NAGAR 8TH PHASE, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

BP - 150/100 mmHg
SpO_2 - 97 %
P - 76 b/m
Ht - 165 cm
Wt - 97.3 kg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor