UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. MR. NARER LACHAMAPPA R	Order No	: 1000076034
UHID	: UHJA23019920	Registered On	: 08/03/2024 09:09:34 AM
Age/Sex	: 39/Years Male	Collected On	: 08/03/2024 09:19:28 AM
Ward / Bed No	:	Reported On	: 08/03/2024 01:38:15 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230024604
Station	: At Hospital	Mobile No	: 9986695637
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	128	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	151	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	6.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	134.11	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)	8.42	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.94	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	166	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	230	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	41.4	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	78.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	46.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.0		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.89		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	124.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.3	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.96	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.85	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.68	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.64	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.56	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.81		2:1

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SERUM SGOT (Method:IFCC without P5P)	22	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	29	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	62	U/L	50-116
GGT (Method:IFCC)	39	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)	14.67	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.8	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9130	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.84	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	23.45	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.02	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.41	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.28	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.75	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	92.2	fL	78-100
MCH (Method: Calculated)	30.9	pg	27-31
MCHC (Method: Calculated)	33.5	g/dL	31-37
RDW - CV (Method: Calculated)	13.4	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.75	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)	6.55	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

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	1.020		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			

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EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	2-4	/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

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mr. NARER LACHAMAPPA R	Date :	08/03/24
Age :	39 years GENDER: MALE	Patient ID :	19920
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 : 3.5 (3.5-5.5)	MV EV : 69.4	AV : 59.7	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 93.7		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 95.1		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 1.2 (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

Mr. Naveen lachappa 60yrs/M.

8/March/20..

Dr. Shwetha

DM - 2yrs
HTN - 2-3yrs

V_A < 6/6P, 6/6P } N6

A/S: OU Normal

Fundus (undilated): OU C Disc 0.3:1 (Stuffy)

I/S: Mild Ref Error

Adv: Dilated fundus examination

[signature]

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DEPARTMENT OF RADIODIAGNOSIS

Name	Narer Lachamappa R	**Date**	08/03/24
Age	39 years	**Hospital ID**	UHJA23019920
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and ***shows mildly 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 (9.9 x 4.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (8.7 x 3.7 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 ~ 9.8 cc.

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

IMPRESSION:

- **Mild fatty infiltration of liver (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	Narer Lachamappa R	**Date**	08/03/24
Age	39 years	**Hospital ID**	UHJA23019920
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

Please bring this report

NABH NABL No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.MR. NARER LACHAMAPPA R**	**UHID**	**: UHJA23019920**
Age / Sex	: 39 Years / Male	OP NO/Reg Dt	: 08-03-2024 09:09 AM
Spouse / Father Name	: RANGAPPA NARER	Department	:
Address	: vidyaranya puram, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Soujanya Shetty

Complaints / Findings / Observations :

no complaints.

Ht - 165 cm.
Wt - 67.8 kg.
BP - 128/90
PR - 80bpm
SPO2 - 99.

Investigations:

Reports Enclosed.

Treatment / Care of Plan / Provisional Diagnosis :

Lifestyle management.

Follow Up Advice :

RTA - 6 monthly

Signature of the Doctor