UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KUMARESHAN	Order No	: 1000065307
UHID	: UHJA23014933	Registered On	: 05/01/2024 05:54:18 PM
Age/Sex	: 50/Years Male	Collected On	: 05/01/2024 05:57:01 PM
Ward / Bed No	:	Reported On	: 05/01/2024 09:06:11 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230018833
Station	: At Hospital	Mobile No	: 9591637003
Payer Name	:	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)	108	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	7.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	165.68	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.06	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.33	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.37	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	171	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)	39.7	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	107.1	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)	4.31		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.70		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	131.3	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.0	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	11	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.79	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	13.92		12˜20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.52	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.42	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.26	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.94	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.44		2:1
SERUM SGOT (Method:IFCC without P5P)	30	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	34	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	69	U/L	50-116
GGT (Method:IFCC)	34	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.64	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	23.3	mg/dL	17-43

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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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)	14.28	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)	8080	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	52.09	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	35.40	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	6.14	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.15	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.22	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.22	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	84.0	fL	78-100
MCH (Method: Calculated)	27.4	pg	27-31
MCHC (Method: Calculated)	32.6	g/dL	31-37
RDW - CV (Method: Calculated)	15.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	4.09	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)	8.54	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	22.2	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	08	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	25	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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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
PREETHI R

---End of Report---

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

ID:23014933
Name:Mr.Kumareshan
Birth date:

5-Jan-2024 AM10:44:24

50 years

1100 Sinus rhythm
9110 ** normal ECG **

kg / mmHg

tion:
ms:
y:

rate	89	bpm
	174	ms
r	88	ms
(E) int	348/ 395	ms
T axis	19/ -16/ 19	°
1 amp	0.81/ 0.73	mV
1 amp	1.54	mV

Unconfirmed Report
Reviewed by:

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

V1
V2
V3
V4
V5
V6

03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

Patient name :	Mr. KUMARESHAN	Date :	05/01/24
Age :	50 years GENDER: MALE	Patient ID :	14983
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.1 (2.5-3.7)	LVIDD : 5.1 (3.5-5.5)	MV EV : 67.4	AV : 80.0	MR : NORMAL
LA : 3.5 (1.9-4.0)	LVIDS : 3.3 (2.4-4.2)	AV : 96.4		AR : NORMAL
RA : 2.4 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 109		PR : NORMAL
RV : 2.1 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : GRADE 1 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:

NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE 1 LV DIASTOLIC DYSFUNCTION
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: **Mr.KUMARESHAN**	**UHID**	: **UHJA23014933**
Age / Sex	: 50 Years / Male	OP NO/Reg Dt	: OP230000017924 / 05-01-2024 05:54 PM
Father Name	:	Department	:
Spouse Name	: PALANISWAMY	Refered By	:
Address	: 259, SRI NANDA GOKULA, 10TH CROSS, 6TH MAIN, PIPETINE ROAD, MSR NAGAR MATH KARE, , Bengaluru Urban, Karnataka,	Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Dr. [illegible]

Vn < 6/6P, 6/6 } N.

(glass)

HTN - 5-6 yrs

Investigations:

M/S OU Nad

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (dilated) OU CD ratio 0.3:1 FR (+)

Follow Up Advice : Impr: OU Ref Err.
(Continue same glass)

Signature of the Doctor

EXERCISE STRESS TEST REPORT

Patient Name: MR. KUMARESHAN,
Patient ID: 14933
Height: 177 cm
Weight: 105 kg

DOB: 31.07.1973
Age: 50yrs
Gender: Male
Race: Indian

Study Date: 05.01.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

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

Medications:
--

Medical History:
H/O DM & HTN

Reason for Exercise Test:
reening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:02	0.00	0.00	109	120/80	
	STANDING	00:15	0.00	0.00	105		
	HYPERV.	00:02	0.00	0.00	105	120/80	
	WARM-UP	00:32	0.00	0.00	110	120/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	129	120/80	
	STAGE 2	03:00	2.50	12.00	134	130/80	
	STAGE 3	02:03	3.40	14.00	157	140/90	
RECOVERY		05:17	0.00	0.00	116	140/90	

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 107 bpm rose to a maximal heart rate of 160 bpm. This value represents 94 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg , rose to a maximum blood pressure of 140/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

terpretation
ummary: 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 TOLERENCE
NORMAL HR AND BP RESPONSE
NO ANGINA OR ARRYTHMIAS
NO SIGNIFICANT ST-T CHANGES DURING EXERCISE AND RECOVERY

IMPRESSION: STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician _____ **Technician** _____

DEPARTMENT OF RADIODIAGNOSIS

Name	Kumareshan	**Date**	05/01/24
Age	50 years	**Hospital ID**	UHJA23014933
Sex	Male	**Ref.**	Healthcheck

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size15.7 cms measuring 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 measuring 7.4 cms, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (9.5 x 5.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (9.8 x 5.8 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 calculus / mobile echoes.

Prostate is normal in echopattern and size, measures ~ 18 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. Manu Srinivas H, MD, RD
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Kumareshan	**Date**	05/01/24
Age	50 years	**Hospital ID**	UHJA23014933
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. Manu Srinivas H, MD, RD
Consultant Radiologist