

## DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. S DANGIRAJ B	Order No : 1000079144
UHID : UHJ A23021038	Registered On : 23/03/2024 10:14:38 AM
Age/Sex : 46/Years Male	Collected On : 23/03/2024 11:14:13 AM
Ward / Bed No :	Reported On : 23/03/2024 06:43:06 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230026033
Station : At Hospital	Mobile No : 8652405877
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	104	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	100	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
<b>Estimated Average Glucose (eAG)</b> (Method: Calculated)	111.14	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method: CLIA)	1.12	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method: CLIA)	11.97	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method: CLIA: Ultra-sensitive)	7.84	μIU/mL	0.34-5.60
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method: CHOD-POD)	131	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method: Enzymatic GPO-POD)	165	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method: ENZYMATIC METHOD)	37.0	mg/dL	< 40 - Low ≥ 60 - High

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<b>LDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	67	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
<b>VLDL CHOLESTEROL</b> (Method: Calculated)	33.00	mg/dL	< 30
<b>TOTAL CHOLESTEROL : HDL RATIO</b> (Method: Calculated)	4.2		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
<b>LDL/HDL CHOLESTEROL RATIO</b> (Method: Calculated)	2.16		< 2.5 Optimal
<b>NON HDL CHOLESTEROL</b> (Method: Calculated)	100	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	6.3	mg/dL	3.5-7.2
<b>BUN/CREATININE RATIO</b>			Sample: Serum
<b>BLOOD UREA NITROGEN(BUN)</b> (Method:Urease GLDH - Kinetic)	14	mg/dL	7.93-20.07
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	0.99	mg/dL	0.9-1.3
<b>BUN/CRE-RATIO</b> (Method: Calculated)	12		12~20 : 1
<b>LIVER FUNCTION TEST</b>			Sample: Serum
<b>TOTAL BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.74	mg/dL	0.3-1.2
<b>DIRECT BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
<b>INDIRECT BILIRUBIN</b> (Method: Calculated)	0.57	mg/dL	0.2-1.0
<b>TOTAL PROTEIN</b> (Method:BIURET)	7.1	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.34	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.75	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.57		2:1
SERUM SGOT (Method:IFCC without P5P)	38	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	43	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	77	U/L	50-116
GGT (Method:IFCC)	17	U/L	< 55
<b>PROSTATE SPECIFIC ANTIGEN (PSA)</b> (Method:CLIA)	0.78	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.

<b>UREA</b> (Method:Urease GLDH - Kinetic)	31.0	mg/dL	17-43
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**Dr. Shobha Emmanuel**  
 MBBS, M.D(Pathology)  
 CONSULTANT PATHOLOGIST  
 KMC:66136

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HAEMATOLOGY

## COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.34	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.1	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6950	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
NEUTROPHILS (Method:Optical/Impedance)	56.06	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	22.06	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	12.72	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.79	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.37	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.21	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	82.7	fL	78-100
MCH (Method: Calculated)	27.5	pg	27-31
MCHC (Method: Calculated)	33.3	g/dL	31-37
RDW - CV (Method: Calculated)	14.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.79	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.81	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	21.1	fl	9-19
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	10	mm/hour	1-15
<b>BLOOD GROUPING &amp; RH TYPING</b>			
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



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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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

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Test Name	Result	Unit	Bio. Ref. Interval
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		
<b>URINE SUGAR, FASTING</b>	Absent		
(Method:GOD-POD)			

Verified By  
NAGARATNA

---End of Report---



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\*NABL renewal under process.

**EXERCISE STRESS TEST REPORT**

Patient Name: MR. RAJ DANGI,  
 Patient ID: 21038  
 Height: 166 cm  
 Weight: 70.2 kg

DOB: 27.05.1977  
 Age: 46yrs  
 Gender: Male  
 Race: Indian

Study Date: 23.03.2024  
 Test Type: Treadmill Stress Test  
 Protocol: BRUCE

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

**Medications:**

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**Medical History:**

NO H/O DM &amp; 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	00:02	0.00	0.00		120/80	
	STANDING	00:32	0.00	0.00	76	120/80	
	HYPERV.	00:02	0.00	0.00	77		
EXERCISE	WARM-UP	00:08	0.00	0.00	82	120/80	
	STAGE 1	03:00	1.70	10.00	112	120/80	
	STAGE 2	03:00	2.50	12.00	139	130/90	
	STAGE 3	02:04	3.40	14.00	164	140/100	
RECOVERY		03:15	0.00	0.00	100	140/100	

The patient exercised according to the BRUCE for 8:04 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 83 bpm rose to a maximal heart rate of 164 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 140/100 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 \_\_\_\_\_



23.03.2024  
2:57:25pm

Male 166 cm 70.2 kg  
46yrs Indian  
Meds:

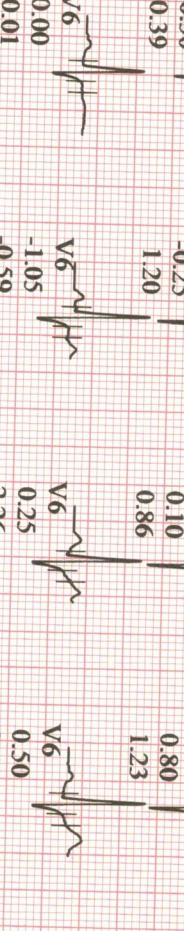
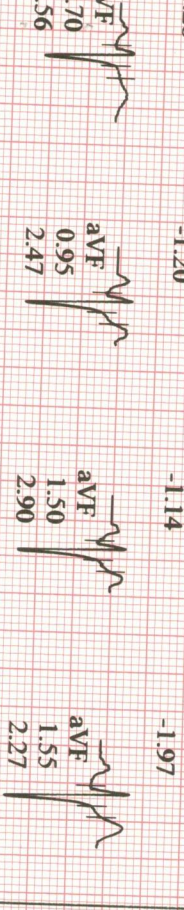
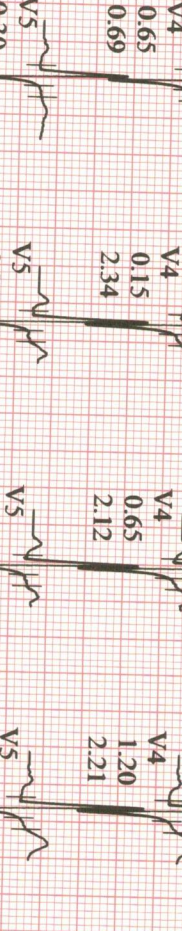
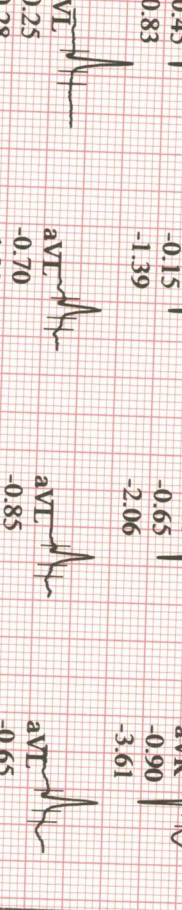
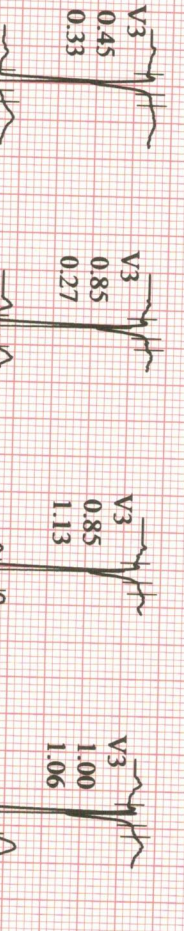
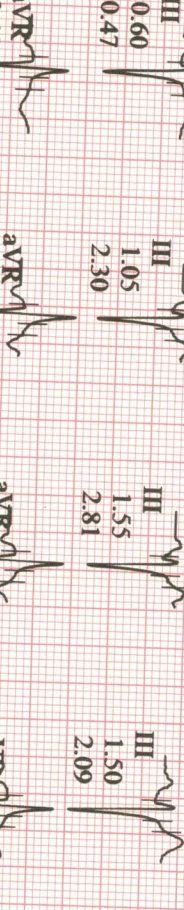
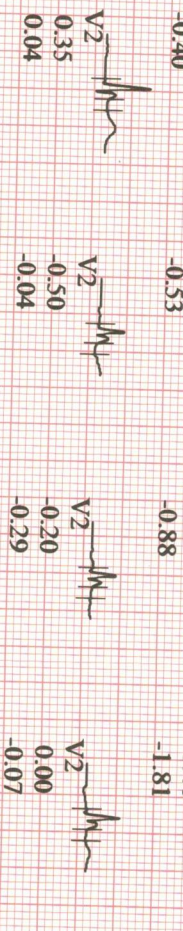
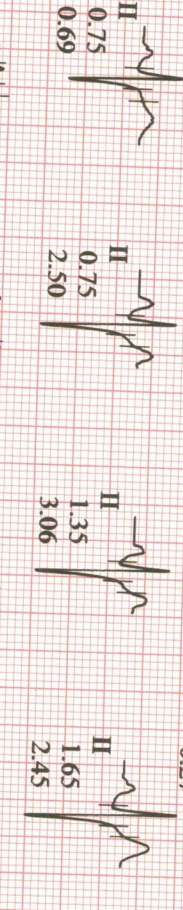
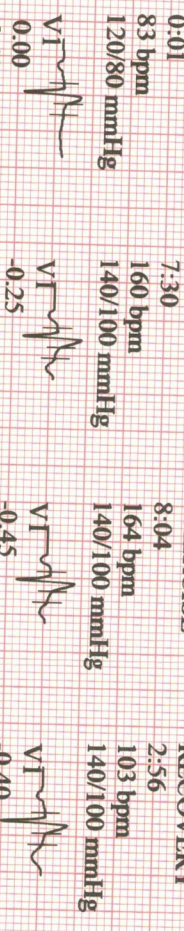
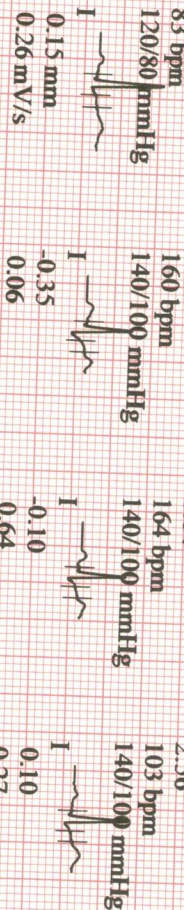
Test Reason: Screening for CAD  
Medical History: NO H/O DM & HTN

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

BRUCE: Total Exercise Time 08:04  
Max HR: 164 bpm 94% of max predicted 174 bpm HR at rest: 83  
Max BP: 140/100 mmHg BP at rest: 120/80 Max RPP: 22680 mmHg\*bpm  
Maximum Workload: 10.10 METS  
Max ST: -1.05 mm, 0.00 mV/s in V6; EXERCISE STAGE 3 07:30  
Arhythmia: A:120  
ST/HR index: 0.24  $\mu$ 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 EXERCISE	PEAK EXERCISE	TEST END RECOVERY
83 bpm	160 bpm	164 bpm	103 bpm
120/80 mmHg	140/100 mmHg	140/100 mmHg	140/100 mmHg

BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE	TEST END RECOVERY
83 bpm	160 bpm	164 bpm	103 bpm
120/80 mmHg	140/100 mmHg	140/100 mmHg	140/100 mmHg



GE CASE V6.73 (2)  
100mm/m V 50Hz 0.01-20Hz S+ HEART V5.4

Unconfirmed  
Attending MD: DR. RAHUL PATIL

MR. RAJ DANGI,

Patient ID 21038

23.03.2024

2:57:25pm

Male 166 cm 70.2 kg  
46yrs Indian

Meds:

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Medical History: NO H/O DM & HTN

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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 ARRRHYTHMIAS NOTED  
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND  
RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA  
Location Number: \* 0 \*

**DEPARTMENT OF RADIODIAGNOSIS**

<b>Name</b>	S Dangi Raj B	<b>Date</b>	23/03/24
<b>Age</b>	46 years	<b>Hospital ID</b>	UHJA23021038
<b>Sex</b>	Male	<b>Ref.</b>	Healthcheck

**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**

**Disclaimer for Radiology Scans and Procedures :**

- 1) Radiology results should be correlated and interpreted by qualified medical professionals only. In case of any clarification, the referring doctors or patients can contact the reception/respective department/doctor.
- 2) Radiology results are affected by patient body habitus, food consumption, bowel contents, hydration status, foreign bodies and artifacts.
- 3) Small renal/ureteric stones, some of the pathologies of bowel, peritoneum and retroperitoneum may not be detected on ultrasound study.
- 4) Antenatal ultrasound: Maternal body variables, gestational age, fetal position at the time of the scan affects the scanning. Patient should come for review scan if and when recommended. Chromosomal anomalies cannot be diagnosed on ultrasound only. If ultrasound markers indicate high risk for chromosomal anomalies, further evaluation including karyotyping may be needed.
- 5) Duplicate reports can be provided only upto 30 days from the date of scan/procedure.
- 6) X-ray is a screening modality and not a diagnostic test. It should be correlated clinically and complemented by other requisite imaging modalities and lab tests. X-ray cannot detect soft tissue injuries (like tendon/ ligament injuries) and small renal/ ureteric stones.
- 7) All disputes relating to the reports are subject to jurisdiction of courts at Bengaluru city only.