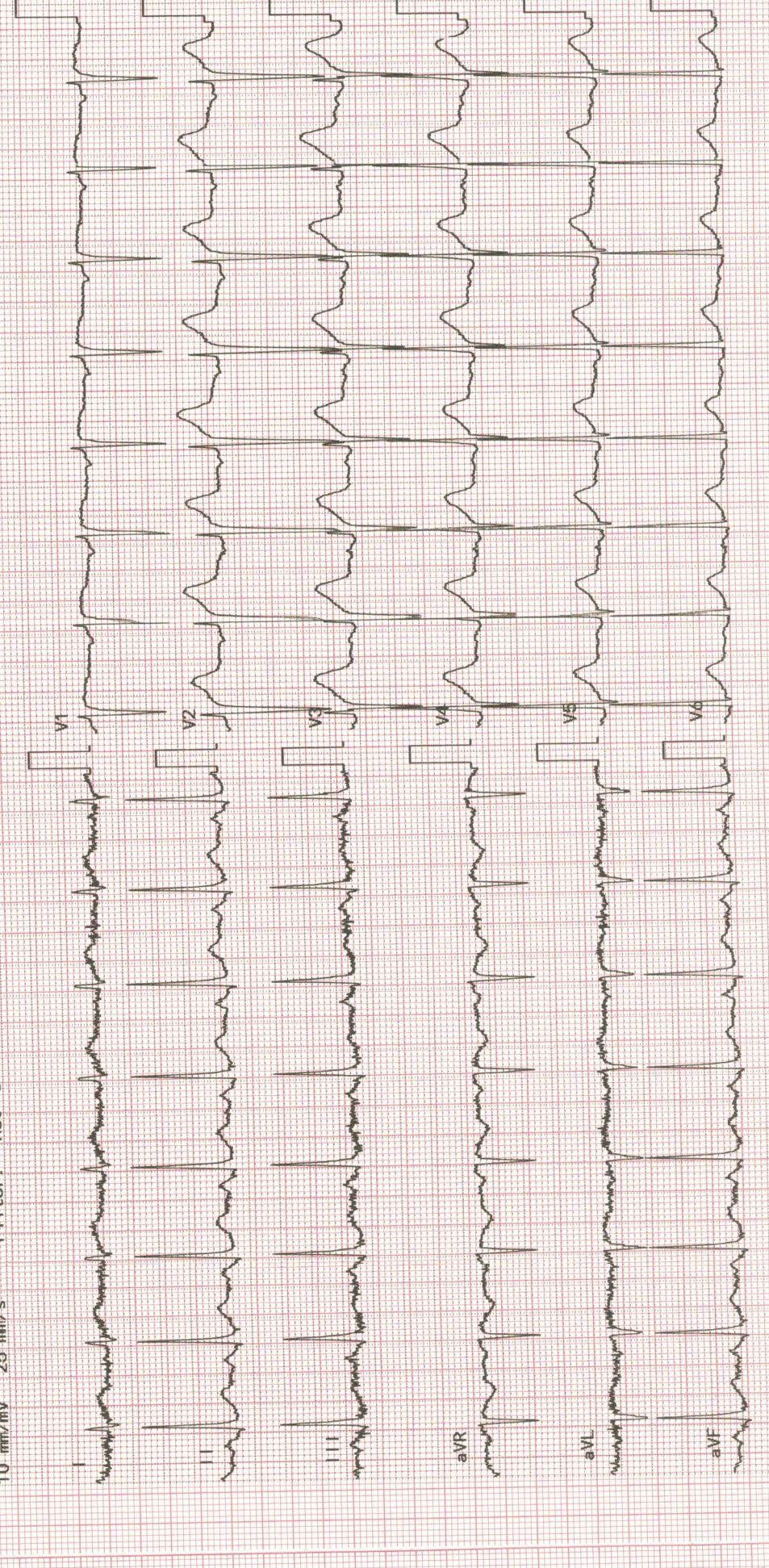


ID: Name: mr. tadas Birth date: / Weight: kg Blood pressure: mmHg Age: 47 years

1100 Sinus rhythm
4038 Nonspecific ST elevation [ST elevation (V3, V4)]
0102 ARTIFACT PRESENT
9130 ** borderline ECG **

Indication: R int 99 bpm
Symptoms: RS dur 344/ 400 ms
History: T/QTc(E) int 73/ 83/ 48 °
Ent. rate V5/SV1 amp 2.04/ 1.32 mV
R int V5+SV1 amp 3.36 mV

10 mm/mV 25 mm/s Filter: H50 D 100 Hz 10 mm/mV



Unconfirmed Report
Reviewed by:



NABH



NABL



No.1

Out Patient Record

Patient Name	: Mr.TADAS NAVEEN KUMAR VASANT	UHID	: UHJA23019975
Age / Sex	: 47 Years / Male	OP NO/Reg Dt	: 09-03-2024 08:15 AM
Spouse / Father Name	: BHAGYA SHREE	Department	:
Address	: 286, 21st main 2nd stage btm layout, Bengaluru Urban, Karnataka, INDIA,	Referred By	: op thal
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Handwritten notes: V_n (gluc) } 6/6 } 6/6 } 4.

Investigations:

Handwritten note: H₂ O₂ level

Treatment / Care of Plan / Provisional Diagnosis :

Handwritten note: F₂ O₂ level

Handwritten note: If: Ref. Care.

Follow Up Advice :

Signature of the Doctor





NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mr.TADAS NAVEEN KUMAR VASANT UHID : UHJA23019975
 Age / Sex : 47 Years / Male OP NO/Reg Dt : 09-03-2024 08:15 AM
 Spouse / Father Name : BHAGYA SHREE Department :
 Address : 286, 21st imain 2nd stage btm laayout , Referred By :
 Bengaluru Urban, Karnataka, INDIA, Consultant : Dr.Preventive Health Check Up
 KMC No. :

Complaints / Findings / Observations :

SIB physician Team

Reports received.

CP & palpitations in morning

2DEcho - Tachycardia noted

HT 167cm
 wt 59kg
 BP - 117/76
 SpO₂ - 99%
 PR - 96b/min

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Cardiac Screening Package

Adv :

Cardiologist opinion
Continue Annual health check up.

Follow Up Advice :

Treadmill test

Signature of the Doctor



NABH



NABL



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Tadas Naveen Kumar Vasant	Date	09/03/24
Age	47 years	Hospital ID	UHJA23019975
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**



NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore**DEPARTMENT OF RADIODIAGNOSIS**

Name	Tadas Naveen Kumar Vasant	Date	09/03/24
Age	47 years	Hospital ID	UHJA23019975
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS**FINDINGS:**

Liver is normal in size measuring 12 cms and 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 9 cms, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (8.5 x 4.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (8.6 x 4.6 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.

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

IMPRESSION:

- No definite sonological abnormality detected.

Manu H
Dr. Manu Srinivas H, MD, RD
Consultant Radiologist



NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mr. TADAS NAVEEN KUMAR	Date :	09/03/24
Age :	47 years GENDER: MALE	Patient ID :	19975
Ref by :	DR.CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY**M - MODE AND DOPPLER MEASUREMENTS**

(c.m)	(c.m)	(cm/sec)		
AO : 2.9 (2.5-3.7)	LVIDD : 4.6 (3.5-5.5)	MV EV : 62.1	AV : 51.3	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 85.2		AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 100		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : -----	AV : -----	TR : TRIVIAL TR
TAPSE: 1.7 (>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, TRIVIAL TR, PASP-20mmHg
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :**TACHYCARDIA OBSERVED DURING THE STUDY (105bpm)**

NORMAL LV SYSTOLIC FUNCTION EF : 60%

NORMAL LV DIASTOLIC FUNCTION

NO PULMONARY HYPERTENSION

NO REGIONAL WALL MOTION ABNORMALITIES

NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. TADAS NAVEEN KUMAR VASANT	Order No	: 1000076188
UHID	: UHJ A23019975	Registered On	: 09/03/2024 08:15:59 AM
Age/Sex	: 47/Years Male	Collected On	: 09/03/2024 08:35:50 AM
Ward / Bed No	:	Reported On	: 09/03/2024 01:50:32 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230024672
Station	: At Hospital	Mobile No	: 9741415141
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	95	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	100	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	4.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	82.45	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.47	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	8.00	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	2.09	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	160	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	56	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	41.8	mg/dL	< 40 - Low ≥ 60 - High

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	107.0	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	11.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.8		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.5		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	118.2	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.1	mg/dL	3.5-7.2
BUN/CREATININE RATIO			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.75	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	17.3		12~20 : 1
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.61	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.34	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.28	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.6	g/dL	6.6-8.3

Sample: Serum

Sample: Serum

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.77	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.83	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.68		2:1
SERUM SGOT (Method:IFCC without P5P)	31	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	26	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	51	U/L	50-116
GGT (Method:IFCC)	14	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.58	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)	28.0	mg/dL	17-43
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Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. TADAS NAVEEN KUMAR VASANT	Order No	: 1000076188
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Test Name	Result	Unit	Bio. Ref. Interval
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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.75	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	46.2	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4630	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	54.67	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	36.57	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.24	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.28	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.24	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.35	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	86.3	fL	78-100
MCH (Method: Calculated)	29.4	pg	27-31
MCHC (Method: Calculated)	34.1	g/dL	31-37
RDW - CV (Method: Calculated)	14.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.03	Lakhs/Cum	1.5-4.5

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.19	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.1	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)	A		
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

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. TADAS NAVEEN KUMAR VASANT	Order No	: 1000076188
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Test Name	Result	Unit	Bio. Ref. Interval
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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	7.5		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	: Mr. TADAS NAVEEN KUMAR VASANT	Order No	: 1000076188
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Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230024672
Station	: At Hospital	Mobile No	: 9741415141
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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		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---

Naveen M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418