UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. BHATT NIDHI	Order No	: 1000079106
UHID	: UHJA23021030	Registered On	: 23/03/2024 10:04:11 AM
Age/Sex	: 33/Years Female	Collected On	: 23/03/2024 12:09:52 PM
Ward / Bed No	:	Reported On	: 23/03/2024 09:38:36 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230026024
Station	: At Hospital	Mobile No	: 7579150476
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	100	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	130	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)	105.40	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.89	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.92	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	11.60	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)	167	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	105	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.5	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	98.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	21.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.5		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.0		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	119.5	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.5	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.69	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.51	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.41	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.09	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.20	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.27		2:1
SERUM SGOT (Method:IFCC without P5P)	28	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	25	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	137	U/L	46-122
GGT (Method:IFCC)	14	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) Remarks: Suggest iron profile. Kindly correlate clinically.	10.00	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	31.7	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7510	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	58.67	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	29.86	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.96	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.22	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.29	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.74	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	66.8	fL	78-100
MCH (Method: Calculated)	21.1	pg	27-31
MCHC (Method: Calculated)	31.5	g/dL	31-37
RDW - CV (Method: Calculated)	17.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.42	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)	11.26	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	33.2	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-20

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

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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	5.5		5.0-8.0
SPECIFIC GRAVITY	1.030		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)	Present (+)		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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DEPARTMENT OF LABORATORY MEDICINE

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Age/Sex	: 33/Years Female	Collected On	: 23/03/2024 12:09:52 PM
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Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230026024
Station	: At Hospital	Mobile No	: 7579150476
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	6-8	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
NAGARATNA

---End of Report---

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

*NABL renewal under process.

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. BHATT NIDHI	Order No	: 1000079109
UHID	: UHJA23021030 \	Registered On	: 23/03/2024 10:04:11 AM
Age/Sex	: 33/Years Female	Collected On	: 24/03/2024 11:43:46 AM
Ward / Bed No	:	Reported On	: 25/03/2024 12:59:13 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230026024
Station	: At Hospital	Mobile No	: 7579150476
Payer Name	: Mediwheel	Report Status	: Final Report

Samples

CERVICAL SMEAR - 24/03/2024 11:43 AM

Test Name :PAP SMEAR

NUMBER OF SLIDES RECEIVED: 02
TYPE OF THE SMEAR: Conventional
SOURCE OF THE SMEAR: Ecto and endocervix
CLINICAL DETAILS: Asymptomatic
L M P: 11/3/2024

SPECIMEN ADEQUACY:
Satisfactory for evaluation.
Transformation zone/ Endocervical cell component is absent.

MICROSCOPY:
Smears show predominantly superficial and intermediate squamous cells.
Background shows dense neutrophils.

IMPRESSION: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY (NILM)

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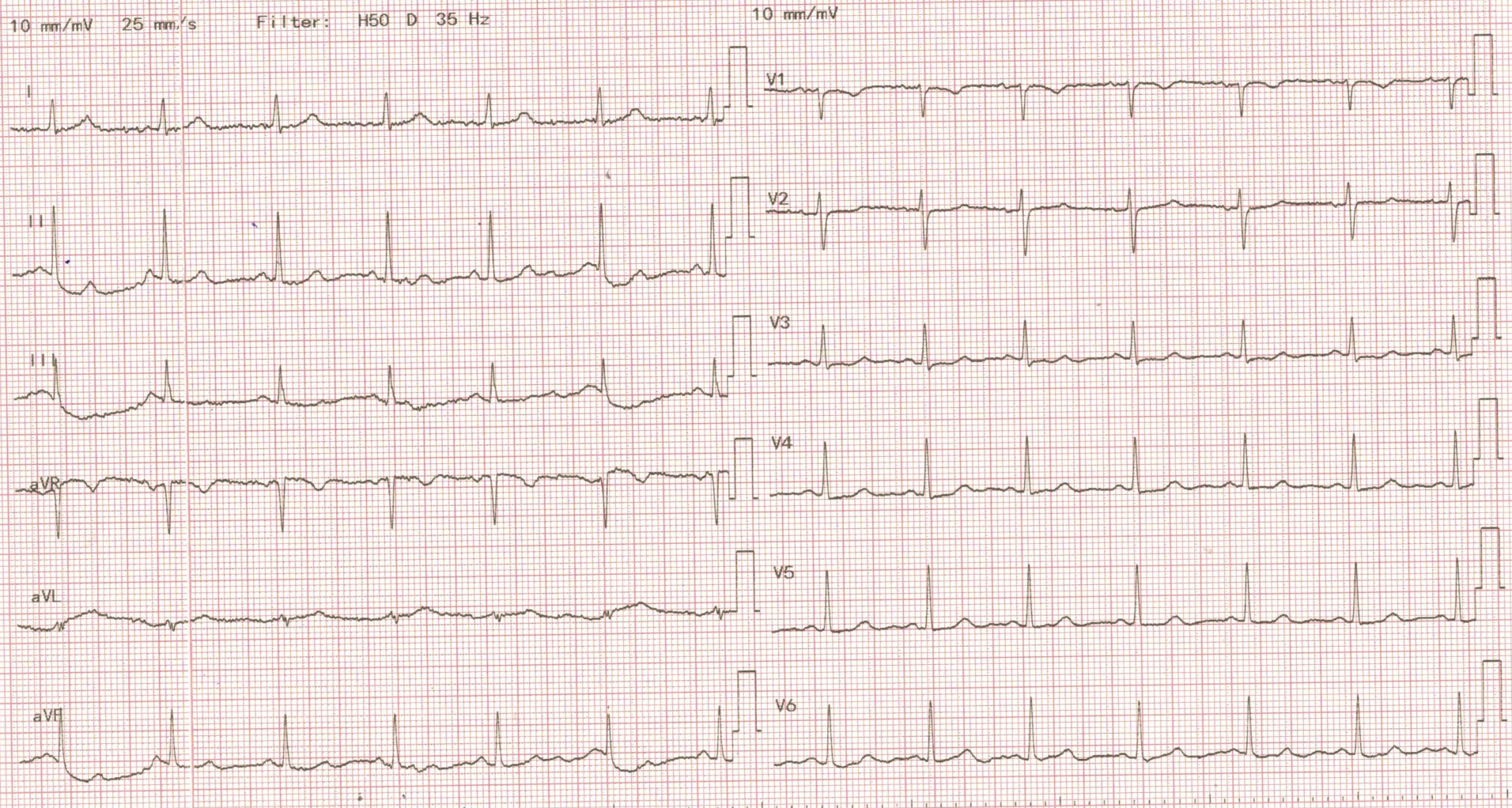
ID:
Name: bhatt nidhi
Sex: F
Birth date:
33 years
1100 Sinus rhythm
9110 ** normal ECG **
cm kg / mmHg
Medication:
Symptoms:
History:

Vent. rate	83	bpm
PR int	134	ms
QRS dur	68	ms
QT/QTc(E) int	342/ 381	ms
P/QRS/T axis	76/ 71/ 27	°
RV5/SV1 amp	1.10/ 0.56	mV
RV5+SV1 amp	1.66	mV

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:
Exam: UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mrs. BHATT NIDHI**	**Date :**	**23/03/24**
Age :	**33 years GENDER: FEMALE**	**Patient ID :**	**21030**
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 : 75.3	AV : 62.9	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 78.4		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 : NORMAL
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
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

NORMAL CHAMBER DIMENSIONS
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

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.BHATT NIDHI**	**UHID**	**: UHJA23021030**
Age / Sex	: 33 Years / Female	OP NO/Reg Dt	: 23-03-2024 10:04 AM
Spouse / Father Name	: .	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and Gynecologist, Laparoscopy and IVF Specialist
KMC Reg. No. 90384

Hb - 68
Ht - 15
PR - 94
SpO2 - 98
BP - 108/

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Bhatt Nidhi	**Date**	23/03/24
Age	33 years	**Hospital ID**	UHJA23021030
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is **enlarged in size (15.8 cms) and shows mild increased echopattern.** No intra or extra hepatic biliary duct dilatation. *Few calcific foci are seen in segment VI.* 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 evidence of mass or focal lesions.

Right Kidney is normal in size (10 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.5 x 4.0 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 well distended. Wall thickness is normal. No evidence of calculi, mass or mural lesion.
Uterus is anteverted and normal in size, measures 8.1 x 2.4 x 3.8 cms. Myometrial and endometrial echoes are normal. Endometrium measures 7.3 mm.
Right ovary is normal in size and echopattern, measures 7.3 cc. Dominant follicle is seen.
Left ovary is normal in size and echopattern, measures 1.9 cc.
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 I).**
- No **other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Bhatt Nidhi	**Date**	23/03/24
Age	33 years	**Hospital ID**	UHJA23021030
Sex	Female	**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