9-Mar-2024 PM12:31:01

ID:
Name:mrs.roopa devi
ex:F Birth date: 39 years
cm kg / mmHg
edication:
ymptoms:
istory:

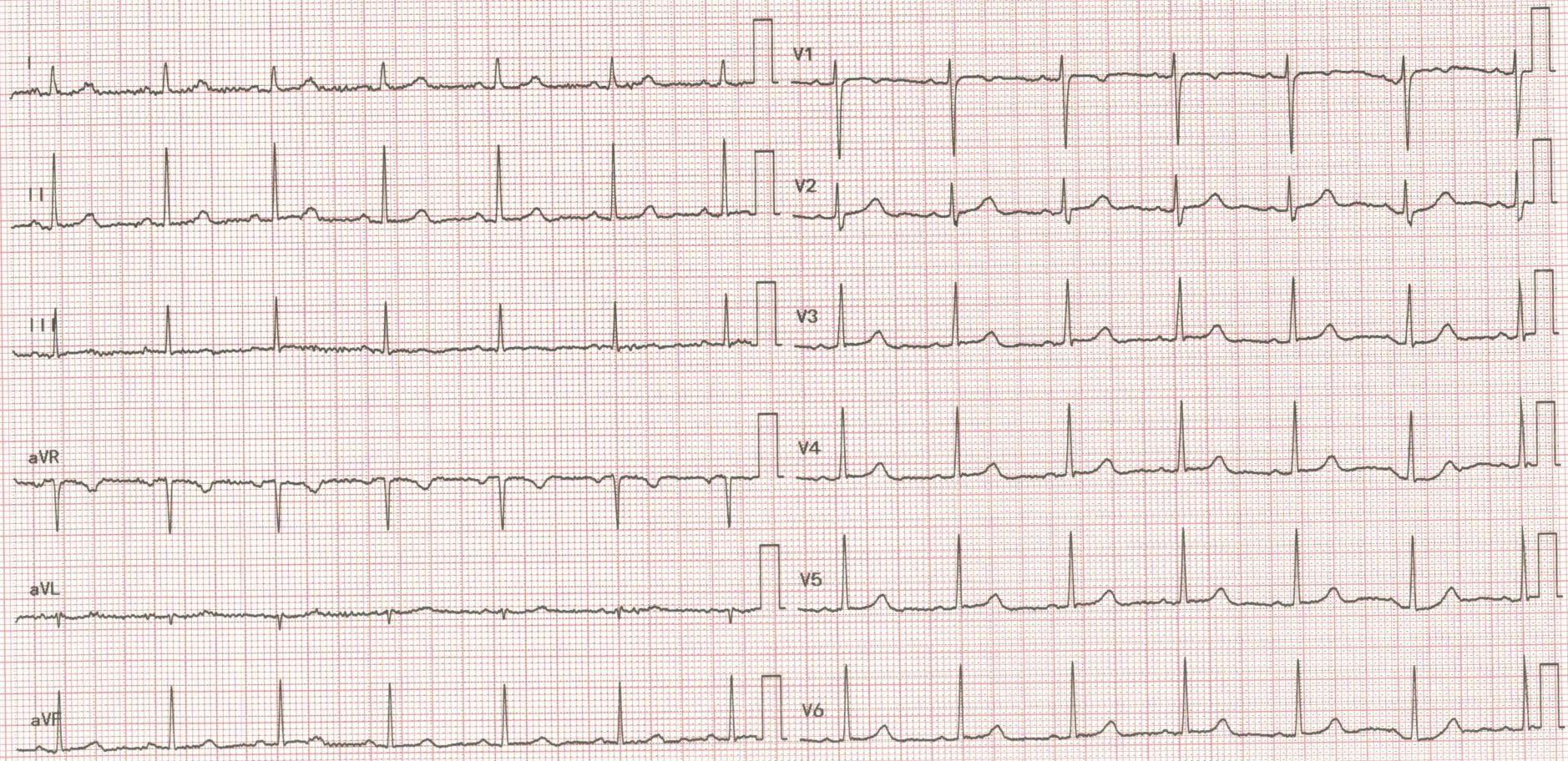
1100 Sinus rhythm
9110 ** normal ECG **

ent. rate	82	bpm
R int	142	ms
RS dur	66	ms
T/QTc(E) int	344/ 383	ms
/QRS/T axis	47/ 68/ 34	°
V5/SV1 amp	1.33/ 1.27	mV
V5+SV1 amp	2.61	mV

Unconfirmed Report
Reviewed by:

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

10 mm/mV



3250K 03-08 07-01 Dept:

Exam:UNITED HOSPITAL

DEPARTMENT OF RADIODIAGNOSIS

Name	G Roopa Devi	**Date**	09/03/24
Age	39 years	**Hospital ID**	UHJA23020009
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

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.G ROOPA DEVI**	**UHID**	**: UHJA23020009**
Age / Sex	: 39 Years / Female	OP NO/Reg Dt	: 09-03-2024 09:56 AM
Spouse / Father Name	: NAVARANG BABU	Department	:
Address	: KENGERI, , Bengaluru Urban, Karnataka, INDIA,	Refered By	: Opthal
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

VA < 6/6 } N.
6/6

Investigations:

As per OU

Treatment / Care of Plan / Provisional Diagnosis :

Tab OU Cpt 0-3-1
1 week

Follow Up Advice : Lubrex eyedrops 4 times
x 1 week

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	G Roopa Devi	**Date**	09/03/24
Age	39 years	**Hospital ID**	UHJA23020009
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:b

Liver is normal in size 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, shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (8.7 x 2.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.5 x 3.8 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 ***mildly bulky in size, measures 10.1 x 3.4 x 5.1 cms***. Myometrial and endometrial echoes are normal. Endometrium measures 12 mm.
Right ovary is normal in size and echopattern, measures 2.6 cc.
Left ovary is normal in size and echopattern, measures 4.4 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 bulky uterus.**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

Patient name :	**Mrs. ROOPA DEVI G**	**Date :**	**09/03/24**
Age :	**39 years GENDER: FEMALE**	**Patient ID :**	**20009**
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 : 75.6	AV : 62.9	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 66.6		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

Out Patient Record

Patient Name	**: Mrs.G ROOPA DEVI**	**UHID**	**: UHJA23020009**
Age / Sex	: 39 Years / Female	OP NO/Reg Dt	: 09-03-2024 09:56 AM
Spouse / Father Name	: NAVARANG BABU	Department	:
Address	: KENGERI, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

WJ · 88.7
HT · 157 CM
BP - 86/62
PR - 80bpm
SPO2 - 99%

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

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. G ROOPA DEVI	Order No	: 1000076330
UHID	: UHJA23020009	Registered On	: 09/03/2024 09:56:34 AM
Age/Sex	: 39/Years Female	Collected On	: 09/03/2024 10:45:33 AM
Ward / Bed No	:	Reported On	: 09/03/2024 04:39:37 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230024712
Station	: At Hospital	Mobile No	: 9916307876
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	94	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	96	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	122.63	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.16	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	12.67	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.67	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)	114	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	35	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	38.5	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	68.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	7.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	2.96		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.77		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	75.5	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.1	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	12	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.62	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.35	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.08	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.27	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.11	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.98	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.37		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	11	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	49	U/L	46-122
GGT (Method:IFCC)	14	U/L	< 38

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)	8.96	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	29.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6770	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	66.07	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	24.44	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.36	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.77	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.36	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.27	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	68.2	fL	78-100
MCH (Method: Calculated)	21.0	pg	27-31
MCHC (Method: Calculated)	30.8	g/dL	31-37
RDW - CV (Method: Calculated)	18.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.61	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)	8.08	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	35.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	30	mm/hour	1-20

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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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

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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	1.005		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	6-8	/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.M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418