

Name: *Rupa Kumari* Birth date: / / mmHg

years

1100 Sinus rhythm
4068 Nonspecific Twave abnormality
0102 ARTIFACT PRESENT
9130 ** borderline ECG **

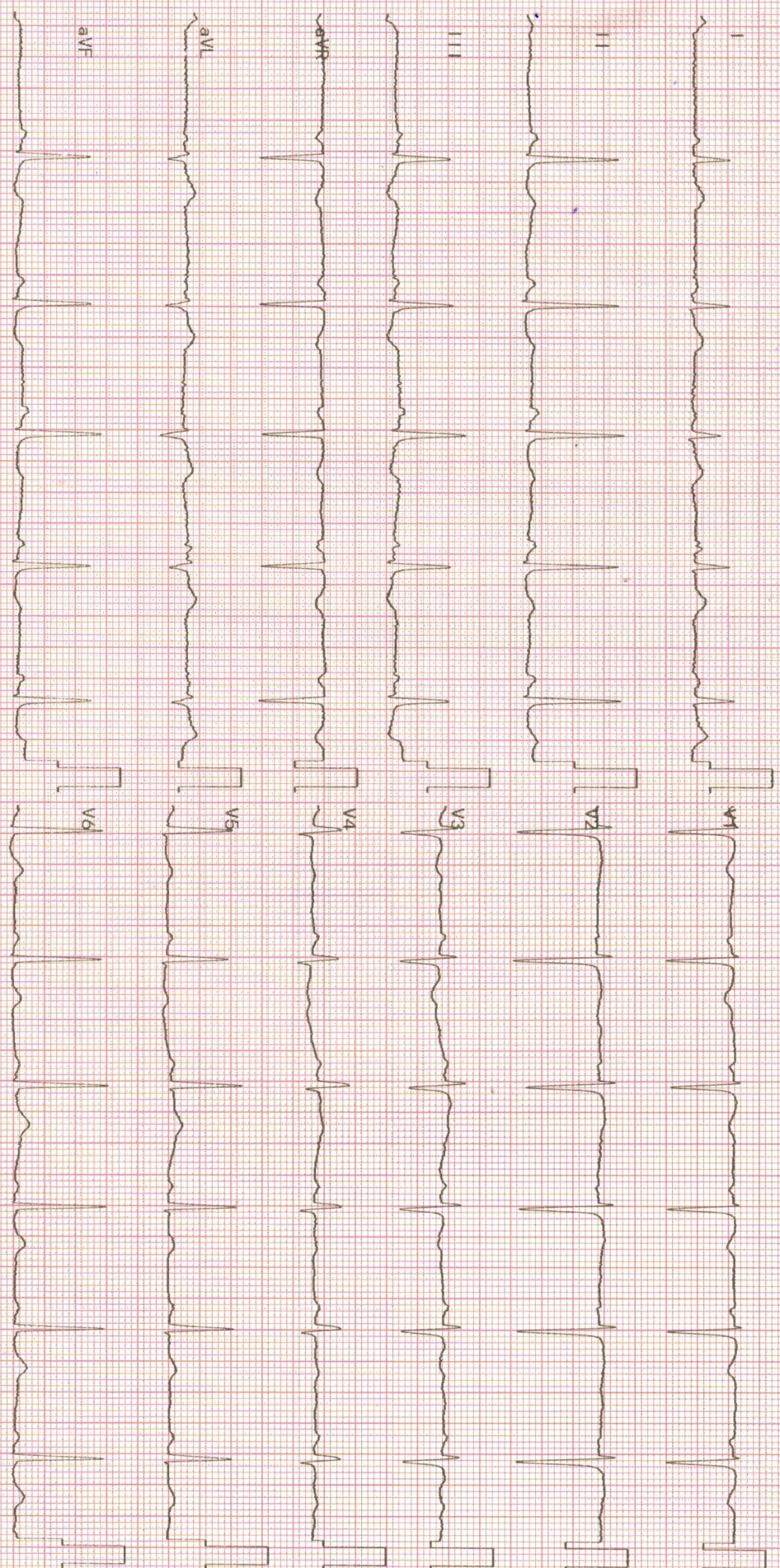
Sex: M
cm
kg
Birth date: / / mmHg
Symptoms:
Indication:
History:
Ient. rate
IR int
QRS dur
QT/QTc(E) int
T/QT axis
V5/SV1 amp
V5+SV1 amp

71 bpm
148 ms
80 ms
362/375 ms
52/67/9 ms
1.13/1.11 mV
2.24 mV

Unconfirmed Report
Reviewed by:

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

10 mm/mV



2350K 03-08 07-01 Dept.:

Exam: UN TED HOSPITAL



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mrs.RUPA KUMARI UHID : UHJA23019999
 Age / Sex : 47 Years / Female OP NO/Reg Dt : 09-03-2024 09:25 AM
 Spouse / Father Name : KUMAR DEEPAK Department :
 Address : flat no 122a doddlekanahalli off banargatta, Referred By : *Op thal*
 , Bengaluru Urban, Karnataka, INDIA, Consultant : Dr.Preventive Health Check Up
 KMC No. :

Complaints / Findings / Observations :

VA $\left\{ \begin{array}{l} 6/8 \\ 6/18 \end{array} \right. N_{12}$

nil system

Investigations:

Al: ov red

Treatment / Care of Plan / Provisional Diagnosis :

Early ov cont ovi
(all) *PNFFJ*

Follow Up Advice :

2f: ov of cont

[Signature]
Signature of the Doctor



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mrs.RUPA KUMARI

UHID : UHJA23020019

Age / Sex : 35 Years / Female

OP NO/Reg Dt : 09-03-2024 10:30 AM

Spouse / Father Name : PRAKASH PRIYA RANJAN

Department :

Address : Near Padmanabha Nagar Bsk, , Bengaluru
Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

BP - 125/68 mmHg

SpO2 - 99 %

P - 79 bpm

H - 150 cm

W - 66.6 kg

VA $\left\{ \begin{array}{l} 6/9 P \\ 6/9 P' \end{array} \right.$

Investigations:

Alig ov Congenital Cataract

Treatment / Care of Plan / Provisional Diagnosis :

Refills All

Prescri ov CDat 0.4%
Actg

Follow Up Advice :

Advice: Complete Examination

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Rupa Kumari	Date	09/03/24
Age	35 years	Hospital ID	UHJA23020019
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

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 (8.3 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (11.1 x 4.2 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 8.0 x 4.0 x 4.1 cms. Myometrial and endometrial echoes are normal. Endometrium measures 6 mm.

Right ovary is normal in size and echopattern, measures 4.7 cc.

Left ovary is normal in size and echopattern, measures 3.4 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:

- No definite sonological abnormality detected.



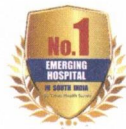
Dr. Elluru Santosh Kumar
Consultant Radiologist



NABH



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No.1



UNITED HOSPITAL

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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Rupa Kumari	Date	09/03/24
Age	47 years	Hospital ID	UHJA23019999
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

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. RUPA KUMARI	Order No	: 1000076370
UHID	: UHJ A23020019	Registered On	: 09/03/2024 10:30:16 AM
Age/Sex	: 35/Years Female	Collected On	: 09/03/2024 10:39:39 AM
Ward / Bed No	:	Reported On	: 09/03/2024 05:44:01 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230024724
Station	: At Hospital	Mobile No	: 9712998330
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	89	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)	4.8	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	91.05	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	0.81	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	7.00	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	1.67	μIU/mL	0.34 - 5.60 μIU/mL (Non Pregnant) 0.3 - 4.5 μIU/mL (I trimester) 0.5 - 5.2 μIU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	181	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	61	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	58.7	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	110.1	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	12.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.0		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.8		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	122.3	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.0	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	11	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.54	mg/dL	0.6-1.1
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.88	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.71	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.99	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.10	g/dL	2.3-3.5

Sample: Serum

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.28		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)	82	U/L	46-122
GGT (Method:IFCC)	12	U/L	< 38



Dr. Shobha Emmanuel
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CONSULTANT PATHOLOGIST
KMC:66136

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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)	10.10	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	32.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5620	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	64.92	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	25.13	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.69	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.01	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.25	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	3.95	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	81.2	fL	78-100
MCH (Method: Calculated)	25.6	pg	27-31
MCHC (Method: Calculated)	31.5	g/dL	31-37
RDW - CV (Method: Calculated)	15.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.36	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)	11.86	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	21.4	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)	B		
Rh Factor (Method:Agglutination Gel Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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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	20	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	4-6	/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	Absent		
(Method:GOD-POD)			

Verified By
NAGARATNA

---End of Report---



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*NABL renewal under process.