

ID:

Name: parul

Birth date: /

mmHg

34 years

1100 Sinus rhythm

9110 \*\* normal ECG \*\*

23-Mar-2024 13:11:42

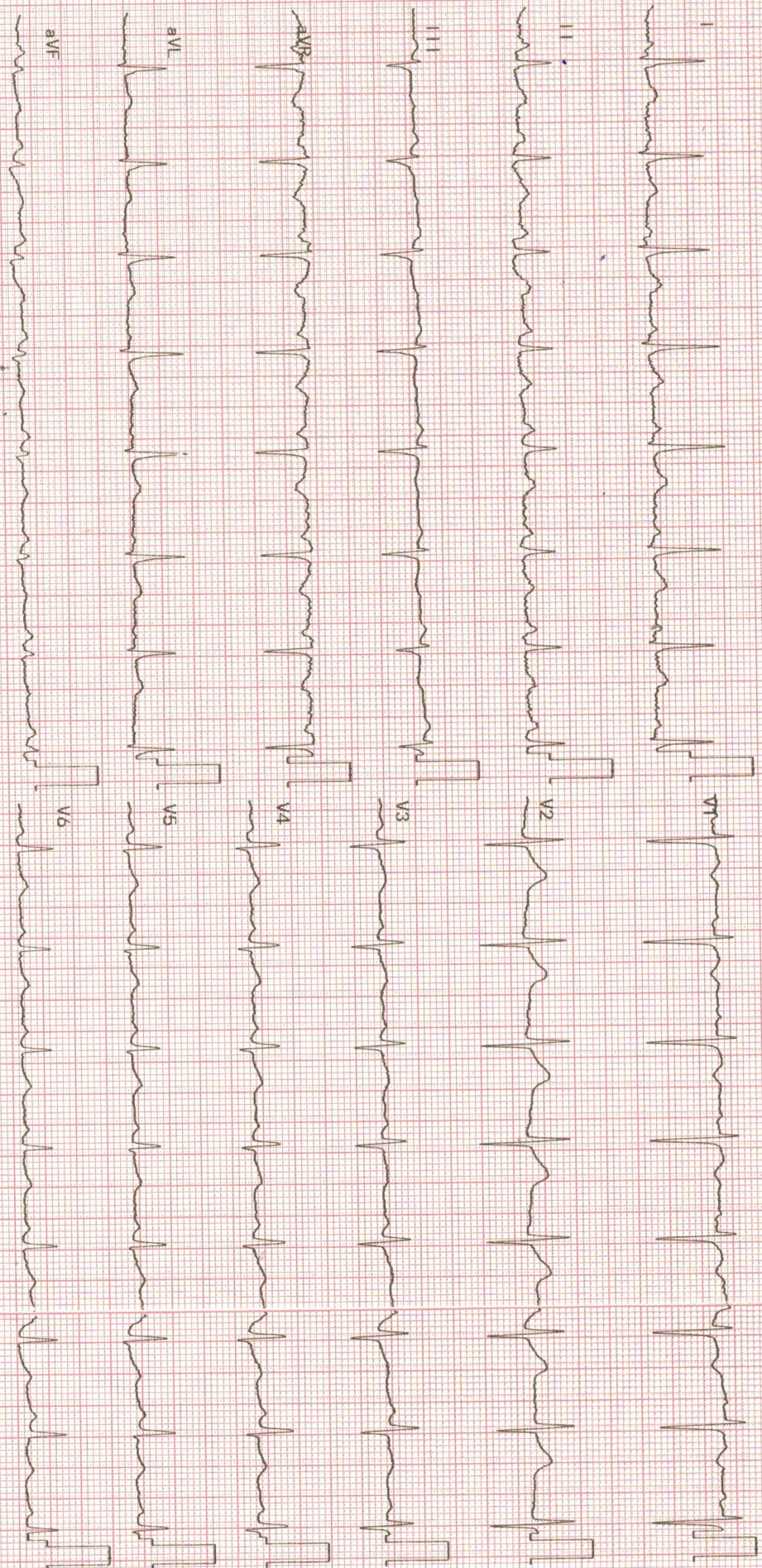
Sex: F  
cm  
kg  
Medications:  
Symptoms:  
History:  
Kent. rate

96 bpm  
138 ms  
76 ms  
QRS dur 332/385 ms  
P/QRS/T axis 53/13/32  
RV5/SV1 amp 0.58/1.17 mV  
RV5+SV1 amp 1.75 mV

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

10 mm/mV

Unconfirmed Report  
Reviewed by:



2350K 03-08 07-01

Dept:

Part No.2.157017M C 0123

M80

SCHILLER





NABH



NABL



No.1

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

Patient name :	Mrs. GUPTA PRAJAPATI PARUL	Date :	23/03/24
Age :	34 years GENDER: FEMALE	Patient ID :	21023
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 : 76.9	AV : 61.8	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 100		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



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No.1



Care Par Excellence  
Jayanagar, Bangalore

Mrs. Gopita Prayagati  
parent

3/24

23/3/24

In labor Chery

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

BP - 114/82

PR - 102b/min

SpO2 - 97%

HT - 148cm

WT - 62kg

no 2/1. 24 AM, 6h  
Dy

no 2/1. 24 Dy

no 2/1. 24 care

DA -  
Hb -  
pt not  
Cdk fr  
Hb -

M - Dy  
Dy  
Cdk 1/2  
out - 1/2  
Cdk - 26/4/24  
one - 2/4  
Brest - 9

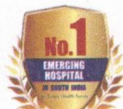




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No.1

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

<b>Name</b>	Gupta Prajapati Parul	<b>Date</b>	23/03/24
<b>Age</b>	34 years	<b>Hospital ID</b>	UHJA23021023
<b>Sex</b>	Female	<b>Ref.</b>	Health check

**ULTRASOUND ABDOMEN AND PELVIS****FINDINGS:**

**Liver** is normal in size and *shows mildly increased 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 (8.6 x 3.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

**Left Kidney** is normal in size (9.8 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 normal in size, measures 7.4 x 2.7 x 4.4 cms. Myometrial and endometrial echoes are normal. Endometrium measures 7.3 mm.

**Right ovary** is normal in size and echopattern, measures 3.5 cc.

**Left ovary** is normal in size and echopattern, measures 6.1 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 fatty infiltration of liver (Grade I).**
- **No other definite sonological abnormality detected.**



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Care Par Excellence  
Jayanagar, Bangalore

## DEPARTMENT OF RADIODIAGNOSIS

<b>Name</b>	Gupta Prajapati Parul	<b>Date</b>	23/03/24
<b>Age</b>	34 years	<b>Hospital ID</b>	UHJA23021023
<b>Sex</b>	Female	<b>Ref.</b>	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. GUPTA PRAJ APATI PARUL	Order No	: 1000079085
UHID	: UHJ A23021023	Registered On	: 23/03/2024 09:56:44 AM
Age/Sex	: 34/Years Female	Collected On	: 23/03/2024 12:32:10 PM
Ward / Bed No	:	Reported On	: 23/03/2024 06:42:48 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230026017
Station	: At Hospital	Mobile No	: 7905933587
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)	108	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<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)	1.22	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method: CLIA)	11.95	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method: CLIA: Ultra-sensitive)	1.42	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)
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method: CHOD-POD)	252	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method: Enzymatic GPO-POD)	77	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method: ENZYMATIC METHOD)	51.6	mg/dL	< 40 - Low ≥ 60 - High

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<b>LDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	185.0	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)	15.40	mg/dL	< 30
<b>TOTAL CHOLESTEROL : HDL RATIO</b> (Method: Calculated)	4.8		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)	3.5		< 2.5 Optimal
<b>NON HDL CHOLESTEROL</b> (Method: Calculated)	200.4	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	4.5	mg/dL	2.6-6.0
<b>BLOOD UREA NITROGEN(BUN)</b> (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	0.62	mg/dL	0.6-1.1
<b>LIVER FUNCTION TEST</b>			
<b>TOTAL BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.42	mg/dL	0.3-1.2
<b>DIRECT BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
<b>INDIRECT BILIRUBIN</b> (Method: Calculated)	0.33	mg/dL	0.2-1.0
<b>TOTAL PROTEIN</b> (Method:BIURET)	7.5	g/dL	6.6-8.3
<b>ALBUMIN</b> (Method:BCG)	4.04	g/dL	3.5-5.2
<b>GLOBULIN</b> (Method: Calculated)	3.45	g/dL	2.3-3.5

Sample: Serum

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.16		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	19	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	88	U/L	46-122
GGT (Method:IFCC)	17	U/L	< 38



**Dr. Shobha Emmanuel**  
MBBS, M.D(Pathology)  
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)	12.32	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.7	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	8850	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
NEUTROPHILS (Method:Optical/Impedance)	65.07	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	25.45	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.85	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.34	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.29	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.52	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	83.3	fL	78-100
MCH (Method: Calculated)	27.3	pg	27-31
MCHC (Method: Calculated)	32.7	g/dL	31-37
RDW - CV (Method: Calculated)	15.3	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.04	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)	9.51	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	21.3	fl	9-19
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	12	mm/hour	1-20
<b>BLOOD GROUPING &amp; RH TYPING</b>			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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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	6.0		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	0-2	/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>	<b>Absent</b>		
(Method:GOD-POD)			

Verified By  
Rashmita

---End of Report---



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\*NABL renewal under process.