UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. MRS. R SUGUNA	Order No	: 1000074723
UHID	: UHJA23019196	Registered On	: 27/02/2024 08:56:34 AM
Age/Sex	: 50/Years Female	Collected On	: 27/02/2024 08:59:40 AM
Ward / Bed No	:	Reported On	: 27/02/2024 03:31:45 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023746
Station	: At Hospital	Mobile No	: 9611579898
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	99	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	113	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)	1.23	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.37	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	7.81	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	175	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	102	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	50.5	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	104.1	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	20.39	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.4		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)	124.5	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.4	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.42	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.33	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.25	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.04	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.39		2:1
SERUM SGOT (Method:IFCC without P5P)	26	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	20	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	93	U/L	46-122
GGT (Method:IFCC)	22	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	12.8	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	6	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.78	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	7.6		12¯20 : 1

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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DEPARTMENT OF LABORATORY MEDICINE

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Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023746
Station	: At Hospital	Mobile No	: 9611579898
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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)	12.32	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	38.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4530	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	55.00	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.00	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.17	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.51	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.32	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.15	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	91.8	fL	78-100
MCH (Method: Calculated)	29.7	pg	27-31
MCHC (Method: Calculated)	32.3	g/dL	31-37
RDW - CV (Method: Calculated)	13.4	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.60	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)	6.89	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	8	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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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. MRS. R SUGUNA	Order No	: 1000074723
UHID	: UHJA23019196	Registered On	: 27/02/2024 08:56:34 AM
Age/Sex	: 50/Years Female	Collected On	: 27/02/2024 08:59:40 AM
Ward / Bed No	:	Reported On	: 27/02/2024 03:31:45 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023746
Station	: At Hospital	Mobile No	: 9611579898
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

PHYSICAL EXAMINATION

VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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)	Trace		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative

MICROSCOPIC EXAMINATION

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Age/Sex	: 50/Years Female	Collected On	: 27/02/2024 08:59:40 AM
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Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023746
Station	: At Hospital	Mobile No	: 9611579898
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	4-6	/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.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. MRS. R SUGUNA	Order No	: 1000074726
UHID	: UHJA23019196 \	Registered On	: 27/02/2024 08:56:34 AM
Age/Sex	: 50/Years Female	Collected On	: 27/02/2024 03:03:40 PM
Ward / Bed No	:	Reported On	: 27/02/2024 04:57:29 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023746
Station	: At Hospital	Mobile No	: 9611579898
Payer Name	: Mediwheel	Report Status	: Final Report

Samples

CERVICAL SMEAR - 27/02/2024 03:03 PM

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: Postmenopausal status

SPECIMEN ADEQUACY:
Satisfactory for evaluation.
Endocervical cell component is present.

MICROSCOPY:
Smears show predominantly intermediate squamous cells, intermedio-parabasal cells and parabasal cells.
Background shows dense neutrophilic infiltrate.
No trichomonads, candida, other parasites or non-specific microorganisms are present.

IMPRESSION: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY (NILM)
COMMENTS: Atrophy with Inflammation (Atrophic Vaginitis)

Nauceen.N

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. MRS. R SUGUNA	Order No	: 1000074728
UHID	: UHJA23019196	Registered On	: 27/02/2024 08:57:28 AM
Age/Sex	: 50/Years Female	Collected On	: 27/02/2024 09:03:45 AM
Ward / Bed No	:	Reported On	: 27/02/2024 11:18:22 AM
Reference	:	Bill No	: OOBJA23008269
Station	: At Hospital	Mobile No	: 9611579898
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
VITAMIN B12 (Method:CLIA)	257	pg/mL	75-807

Interpretation Notes

Vitamin B12 or Cobalamin assay helps to diagnose the cause of anemia or neuropathy; to evaluate nutritional status in some patients; to monitor effectiveness of treatment for B12 deficiency. Vitamin B12 is necessary for normal RBC formation, tissue and cellular repair, and DNA synthesis. Vitamin B12 is also important for nerve health; a deficiency in either B12 or Folate can lead to macrocytic anemia. Interpretation of the result should be considered in relation to clinical circumstances. The concentration of Vitamin B12 obtained with different assay methods cannot be used interchangeably due to differences in assay methods and reagent specificity.

Verified By
PRAVEEN T

---End of Report---

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

lex:F
Birth date:
50 years

cm kg / mmHg

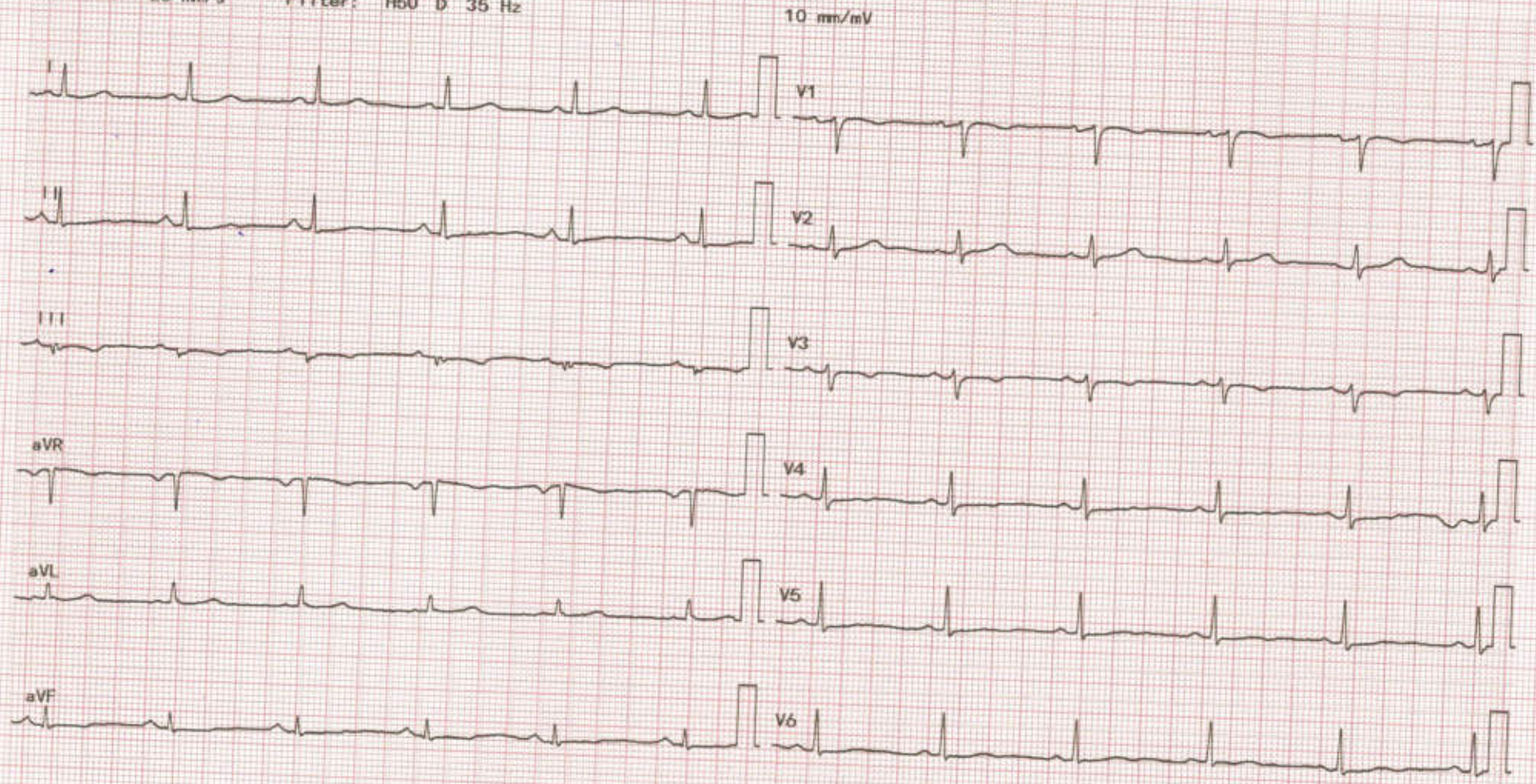
ledication:
lymptoms:
listory:

lent. rate	69	bpm
R int	152	ms
RS dur	72	ms
IT/QTc(E) int	374/ 393	ms
I/QRS/T axis	65/ 28/ -43	°
V5/SV1 amp	0.79/ 0.62	mV
V5+SV1 amp	1.42	mV

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (II, V4, V5, V6)]
8102 Low QRS voltage in chest leads [QRS deflection < 1.0 mV in chest leads]
9130 ** borderline ECG **

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

Out Patient Record

Patient Name	**: Mrs.MRS. R SUGUNA**	**UHID**	**: UHJA23019196**
Age / Sex	: 50 Years / Female	OP NO/Reg Dt	: 27-02-2024 08:56 AM
Spouse / Father Name	: RANGAN A K	Department	:
Address	: no 12 1st a main 2nd cross chlour palya magadi road , , Bengaluru Urban, Karnataka,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. vivala [gynic]

Complaints / Findings / Observations :

Routine health check

Investigations: o/H P2L2

MHI - Attained Menopause 2yrs ago

Treatment / Care of Plan / Provisional Diagnosis :

part h/o - N.S

Family h/o - No Malignancy

O/E BL Breast S/L NAD

Follow Up Advice :

P.A - S/L

P/S - Cx vagino reading

PAP Smear taken

Signature of the Doctor

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.MRS. R SUGUNA**	**UHID**	**: UHJA23019196**
Age / Sex	: 50 Years / Female	OP NO/Reg Dt	: 27-02-2024 08:56 AM
Spouse / Father Name	: RANGAN A K	Department	:
Address	: no 12 1st a main 2nd cross chlour palya magadi road , , Bengaluru Urban, Karnataka,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Ashwitha Padma

Complaints / Findings / Observations :

Wt-72.7
Hypothy - T Thyronorm 75 mcg. HT-159
BP-99/6
Has missed tablets for a wk. SpO2-99
PR-76b
no. Symptoms.

Investigations:

TSH. 7.8.
B_{12} - 257.

Treatment / Care of Plan / Provisional Diagnosis :

After 4 wks
TSH | FT_3 | FT_4.

℞ (30)
Cap. Neurobion forte
0-1-0

Cap. D-Rise 60K.0
Once a wk - 8 wks.

Follow Up Advice :

Signature of the Doctor

EXERCISE STRESS TEST REPORT

Patient Name: MRS. SUGUNA,
Patient ID: 23019196
Height: 159 cm
Weight: 72.7 kg

DOB: 22.02.1974
Age: 50yrs
Gender: Female
Race: Indian

Study Date: 27.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: DR. RAHUL PATIL
Attending Physician: DR. RAHUL PATIL
Technician: YAMINI/THABITHA

Medications:
--

Medical History:
NO H/O DM & HTN

Reason for Exercise Test:
Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:13	0.00	0.00	85	100/70	
	STANDING	00:12	0.00	0.00	80	100/70	
	HYPERV.	00:03	0.00	0.00	80	100/70	
	WARM-UP	00:37	0.00	0.00	77	100/70	
EXERCISE	STAGE 1	03:00	1.70	10.00	104	100/70	
	STAGE 2	03:00	2.50	12.00	133	110/80	
	STAGE 3	02:09	3.40	14.00	166	120/90	
RECOVERY		06:09	0.00	0.00	90	120/90	

The patient exercised according to the BRUCE for 8:08 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 86 bpm rose to a maximal heart rate of 166 bpm. This value represents 97 % of the maximal, age-predicted heart rate. The resting blood pressure of 100/70 mmHg , rose to a maximum blood pressure of 120/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation
Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions
GOOD EFFORT TOLERANCE
NORMAL HR AND BP RESPONSE
NO ANGINA OR ARRHYTHMIAS NOTED
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician _____ **Technician** _____

UNITED HOSPITAL

MRS. SUGUNA,
Patient ID 23019196
27.02.2024 Female 159 cm 72.7 kg
10:30:09am 50yrs Indian
Meds:

Test Reason: Screening for CAD
Medical History: NO H/O DM & HTN

Ref. MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL
Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test
Comment:

BRUCE: Total Exercise Time 08:08
Max HR: 166 bpm 97% of max predicted 170 bpm HR at rest: 86
Max BP: 120/90 mmHg BP at rest: 100/70 Max RPP: 19920 mmHg*bpm
Maximum Workload: 10.10 METS
Max. ST: -1.65 mm, 0.00 mV/s in V5; EXERCISE STAGE 1 01:00
Arrhythmia: A:485, VBIG:2, PVC:7, PSVC:9
ST/HR index: 0.43 µV/bpm
Reasons for Termination: Target heart rate achieved
Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall ...

	BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
	0:01	1:00	8:09	5:52
	77 bpm	101 bpm	166 bpm	88 bpm
	100/70 mmHg		120/90 mmHg	
I	-0.05 mm	-0.15	-0.30	-0.05
	-0.09 mV/s	-0.28	-0.08	0.10
II	-0.35	-0.70	-0.60	-0.35
	0.22	-0.19	1.29	0.41
III	-0.35	-0.50	-0.35	-0.35
	-0.01	-0.60	1.37	0.19
aVR	0.20	0.45	0.45	0.20
	-0.22	-0.29	-0.56	-0.47
aVL	0.15	0.15	0.00	0.10
	-0.14	-0.27	-0.77	-0.23
aVF	-0.35	-0.55	-0.50	-0.35
	0.12	-0.41	1.26	0.30

	BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
	0:01	1:00	8:09	5:52
	77 bpm	101 bpm	166 bpm	88 bpm
	100/70 mmHg		120/90 mmHg	
V1	0.15	0.10	0.40	0.15
	-0.30	-0.41	-1.28	-0.47
V2	0.15	0.15	0.05	0.05
	0.13	0.10	-0.17	-0.04
V3	-0.20	-0.25	0.20	-0.05
	0.14	0.04	1.27	0.07
V4	-0.25	-0.40	-0.45	-0.25
	0.09	-0.13	1.14	0.20
V5	-0.25	-1.65	-0.55	-0.30
	-0.19	-0.83	1.30	0.24
V6	-0.20	0.05	-0.60	-0.25
	0.10	-0.15	1.19	0.24

GE CASE V6.73 (2)
10mm/mV 60Hz 0.01-20Hz S+ HEART V5.4

Unconfirmed

Attending MD: DR. RAHUL PATIL

MRS. SUGUNA,
Patient ID 23019196
27.02.2024
10:30:09am

Female 159 cm 72.7 kg
50yrs Indian
Meds:

Test Reason: Screening for CAD
Medical History: NO H/O DM & HTN

Ref. MD: DR. RAHUL PATIL Ordering MD: DR. RAHUL PATIL
Technician: YAMINI/THABITHA Test Type: Treadmill Stress Test
Comment:

UNITED HOSPITAL

BRUCE: Total Exercise Time 08:08
Max HR: 166 bpm 97% of max predicted 170 bpm HR at rest: 86
Max BP: 120/90 mmHg BP at rest: 100/70 Max RPP: 19920 mmHg*bpm
Maximum Workload: 10.10 METS
Max. ST: -1.65 mm, 0.00 mV/s in V5; EXERCISE STAGE 1 01:00
Arrhythmia: A:485, VBIG:2, PVC:7, PSVC:9
ST/HR index: 0.43 µV/bpm
Reasons for Termination: Target heart rate achieved
Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall impression: Normal stress test.
Conclusion: GOOD EFFORT TOLERANCE
NORMAL HR AND BP RESPONSE
NO ANGINA OR ARRHYTHMIAS NOTED
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA
Location Number: * 0 *

MRS. SUGUNA
Patient ID: 23019196
27.02.2024
10:30:31am

LINKED MEDIANS

81 bpm
100/70 mmHg

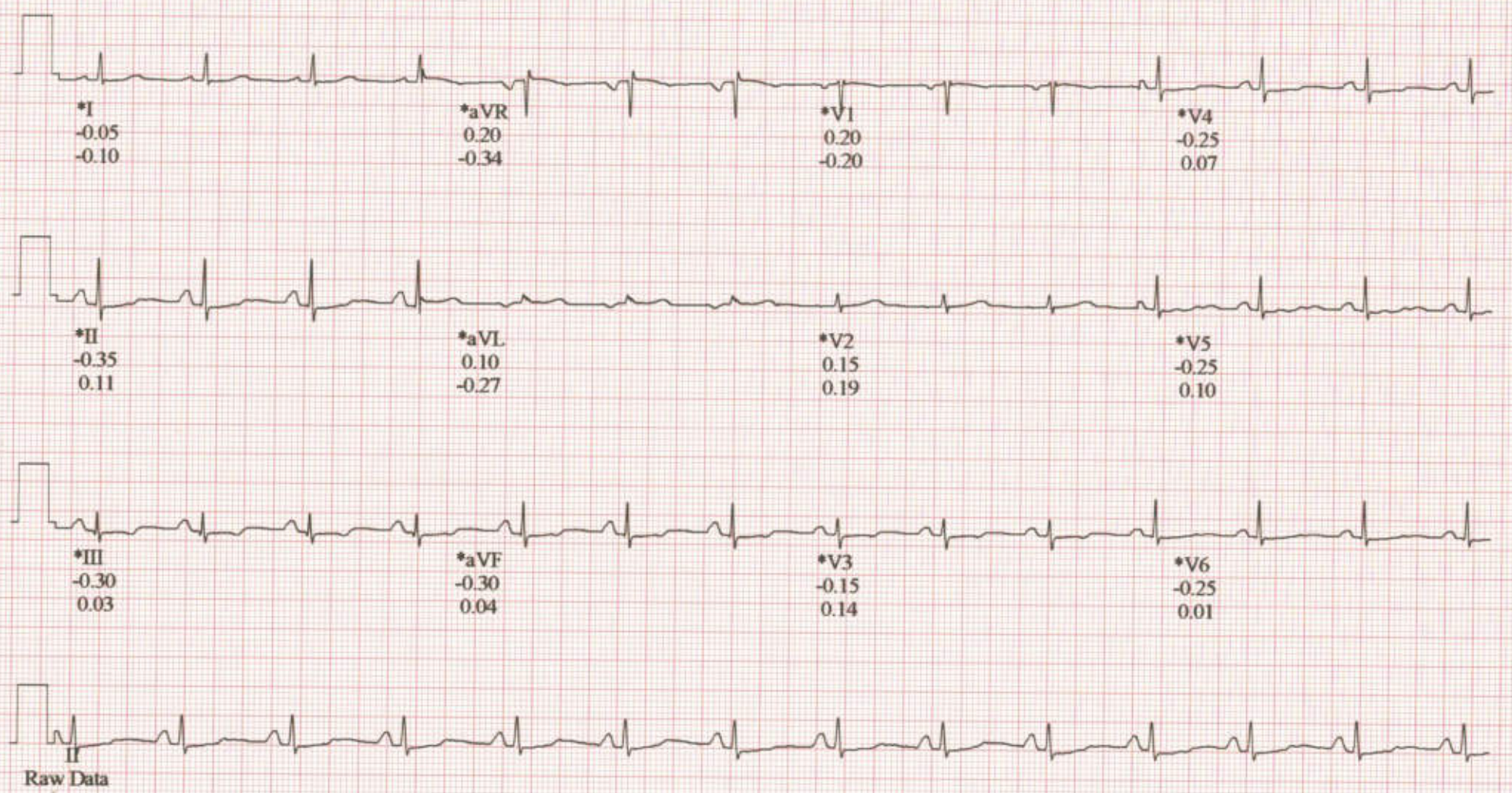
PRETEST
STANDING
00:22

BRUCE
0.0 mph
0.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



Raw Data

*Computer Synthesized Rhythms

GE
CASE V6.73

25 mm/s 10 mm/mV 60Hz 0.01 - 20Hz S+ HR(II,V4)

Start of Test: 10:30:09am

LINKED MEDIANS

MRS. SUGUNA
Patient ID: 23019196
27.02.2024
10:31:09am

77 bpm
100/70 mmHg

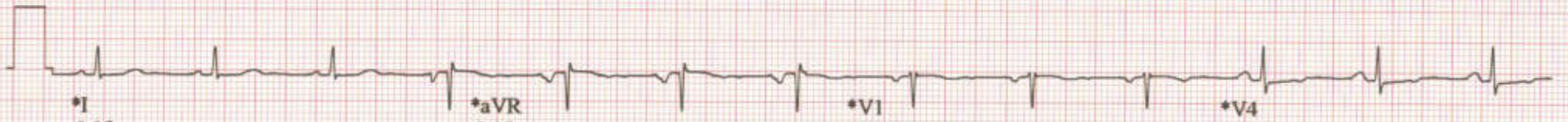
PRETEST
WARM-UP
01:00

BRUCE
0.0 mph
0.0 %

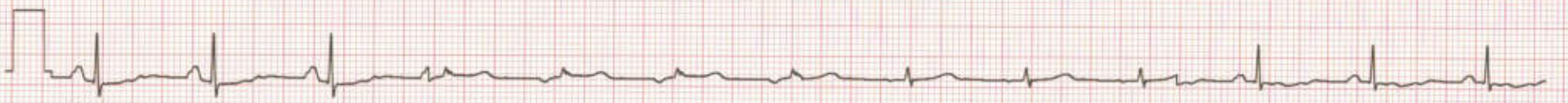
UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

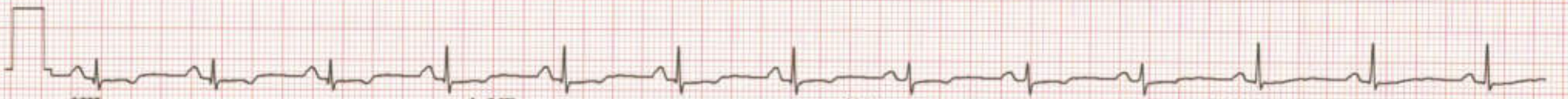
ST @ 10mm/mV
60 ms post J



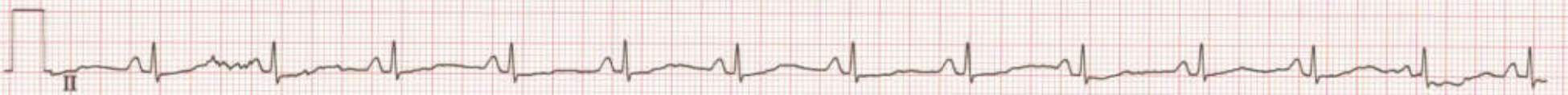
*I	*aVR	*V1	*V4
0.05	0.15	0.10	-0.25
-0.10	-0.33	-0.25	0.07



*II	*aVL	*V2	*V5
-0.30	0.15	0.15	-0.35
0.14	-0.14	0.14	-0.14



*III	*aVF	*V3	*V6
-0.35	-0.30	-0.20	-0.15
0.04	0.14	0.10	0.13



II
Raw Data

*Computer Synthesized Rhythms

GE
CASE V6.73

25 mm/s 10 mm/mV 60Hz 0.01 - 20Hz S+ HR(II,V4)

Start of Test: 10:30:09am

LINKED MEDIANS

MRS. SUGUNA
Patient ID: 23019196
27.02.2024
10:37:00am

131 bpm
110/80 mmHg

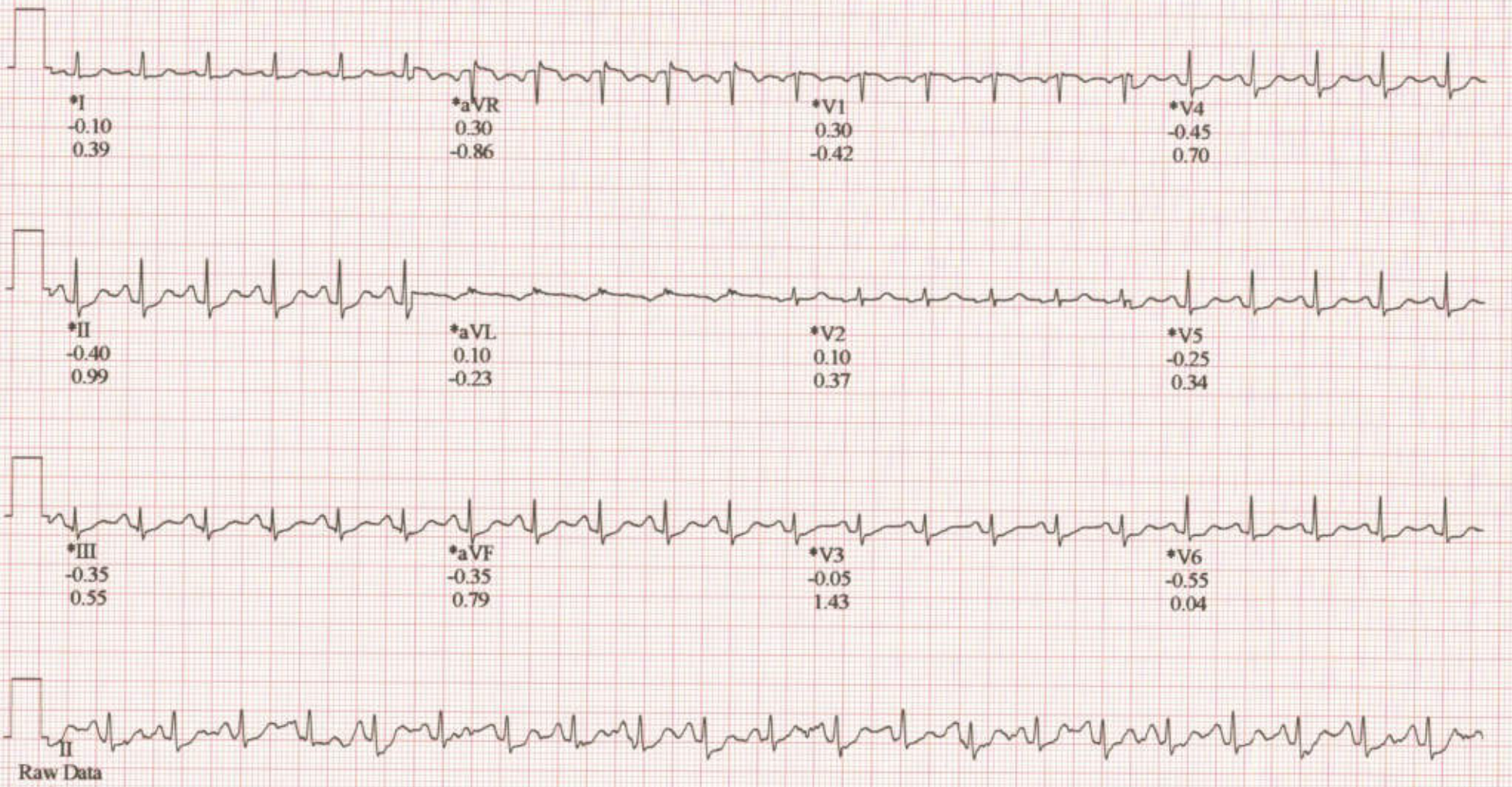
EXERCISE
STAGE 2
05:50

BRUCE
2.5 mph
12.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



*I	*aVR	*V1	*V4
-0.10	0.30	0.30	-0.45
0.39	-0.86	-0.42	0.70
*II	*aVL	*V2	*V5
-0.40	0.10	0.10	-0.25
0.99	-0.23	0.37	0.34
*III	*aVF	*V3	*V6
-0.35	-0.35	-0.05	-0.55
0.55	0.79	1.43	0.04

II
Raw Data

*Computer Synthesized Rhythms

GE
CASE V6.73

25 mm/s 10 mm/mV 60Hz 0.01 - 20Hz S+ HR(II,V4)

Start of Test: 10:30:09am

MRS. SUGUNA
Patient ID: 23019196
27.02.2024
10:39:16am

LINKED MEDIANS

166 bpm
120/90 mmHg

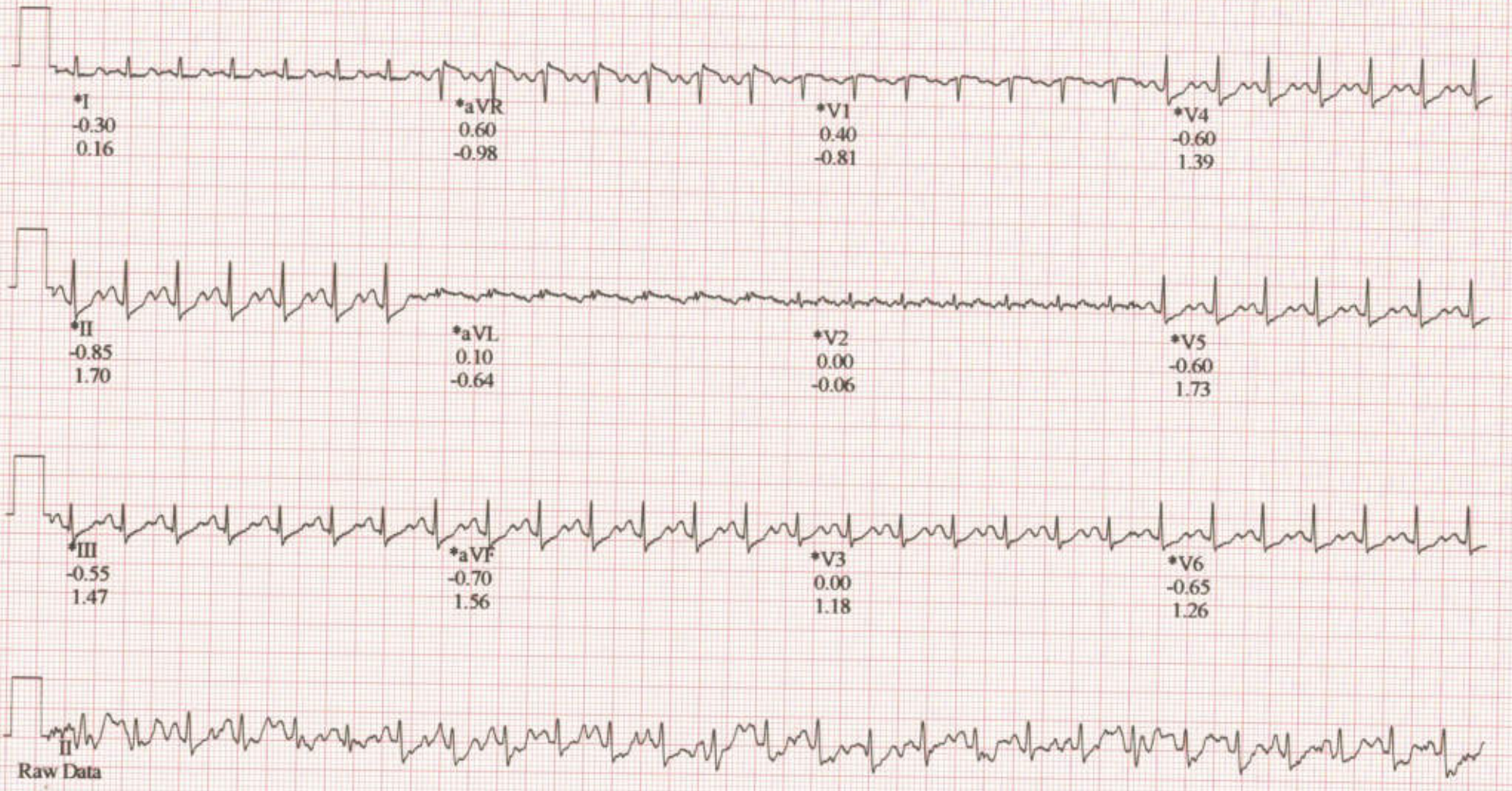
EXERCISE
STAGE 3
08:06

BRUCE
3.4 mph
14.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



*Computer Synthesized Rhythms

GE
CASE V6.73

25 mm/s 10 mm/mV 60Hz 0.01 - 20Hz S+ HR(II,V4)

Start of Test: 10:30:09am

MRS. SUGUNA
Patient ID: 23019196
27.02.2024
10:40:18am

LINKED MEDIANS

133 bpm
120/90 mmHg

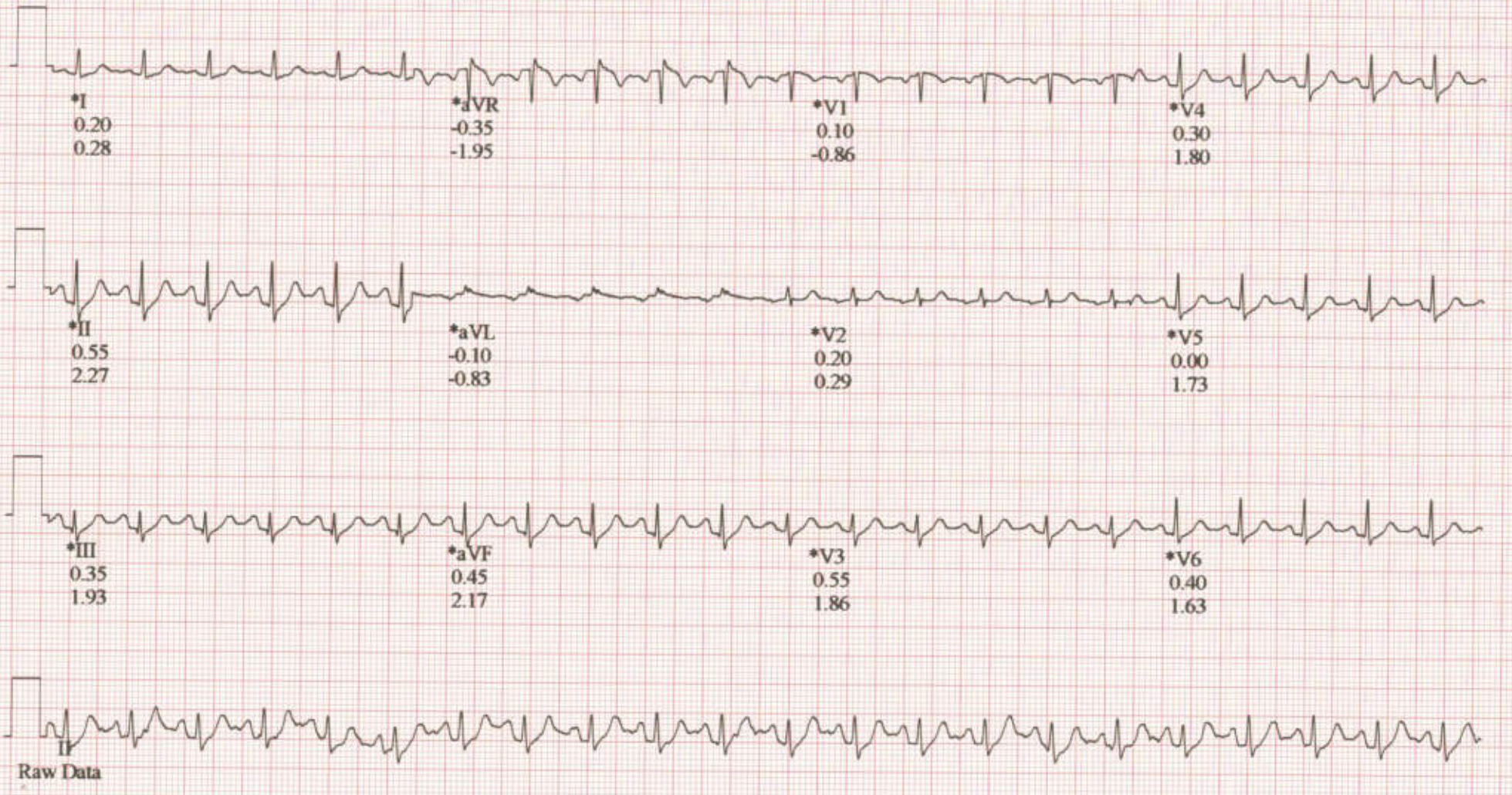
RECOVERY
#1
01:00

BRUCE
1.5 mph
0.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



*I	*aVR	*V1	*V4
0.20	-0.35	0.10	0.30
0.28	-1.95	-0.86	1.80
*II	*aVL	*V2	*V5
0.55	-0.10	0.20	0.00
2.27	-0.83	0.29	1.73
*III	*aVF	*V3	*V6
0.35	0.45	0.55	0.40
1.93	2.17	1.86	1.63

II
Raw Data

*Computer Synthesized Rhythms

GE
CASE V6.73

25 mm/s 10 mm/mV 60Hz 0.01 - 20Hz S+ HR(II,V4)

Start of Test: 10:30:09am

MRS. SUGUNA
Patient ID: 23019196
27.02.2024
10:42:18am

LINKED MEDIANS

97 bpm
120/90 mmHg

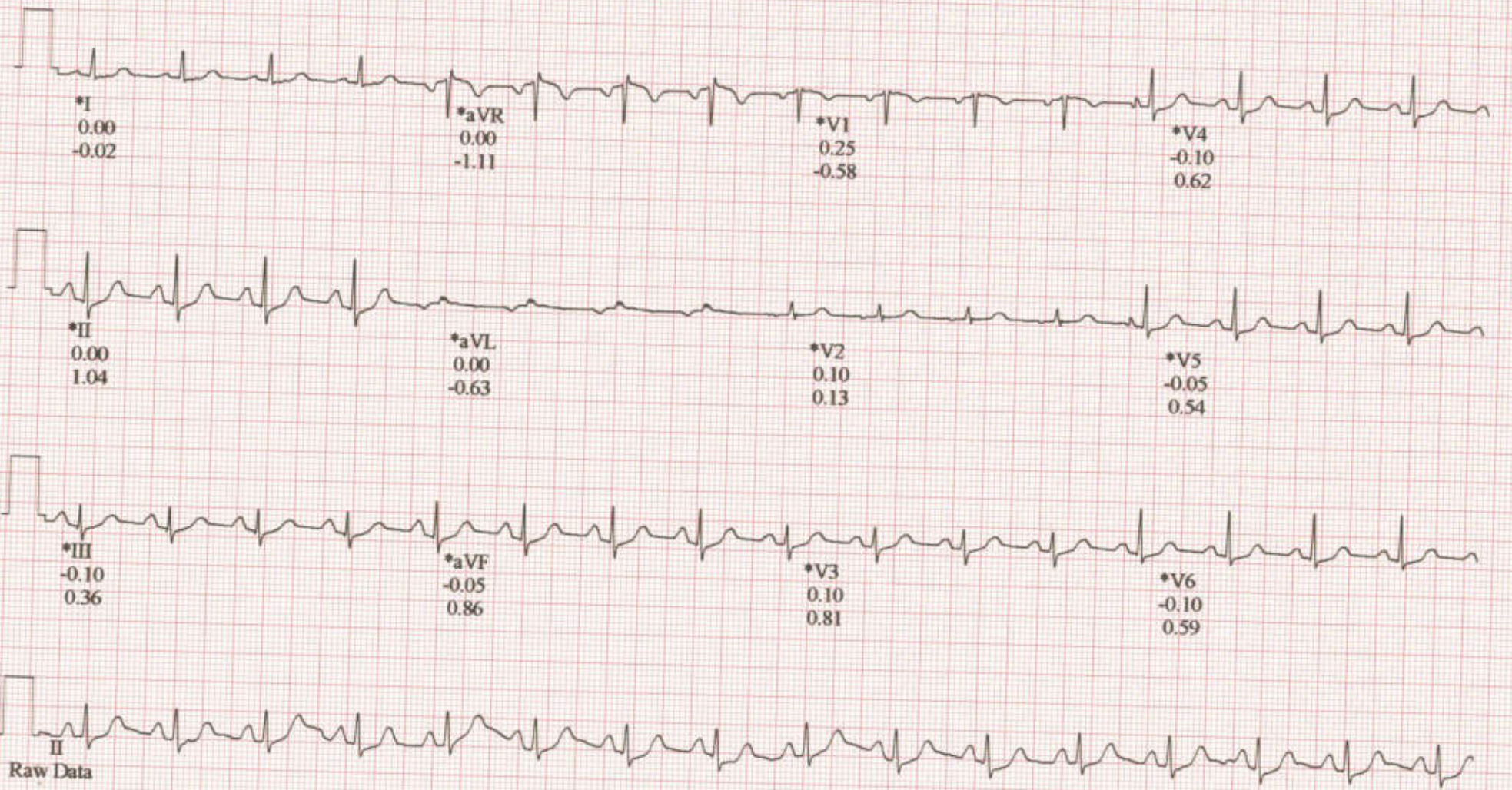
RECOVERY
#1
03:00

BRUCE
0.0 mph
0.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



*I
0.00
-0.02

*aVR
0.00
-1.11

*V1
0.25
-0.58

*V4
-0.10
0.62

*II
0.00
1.04

*aVL
0.00
-0.63

*V2
0.10
0.13

*V5
-0.05
0.54

*III
-0.10
0.36

*aVF
-0.05
0.86

*V3
0.10
0.81

*V6
-0.10
0.59

II
Raw Data

*Computer Synthesized Rhythms

E
ASE V6.73

25 mm/s 10 mm/mV 60Hz 0.01 - 20Hz S+ HR(II,V4)

Start of Test: 10:30:09am

MRS. SUGUNA
Patient ID: 23019196
27.02.2024
10:44:18am

LINKED MEDIANS

93 bpm
120/90 mmHg

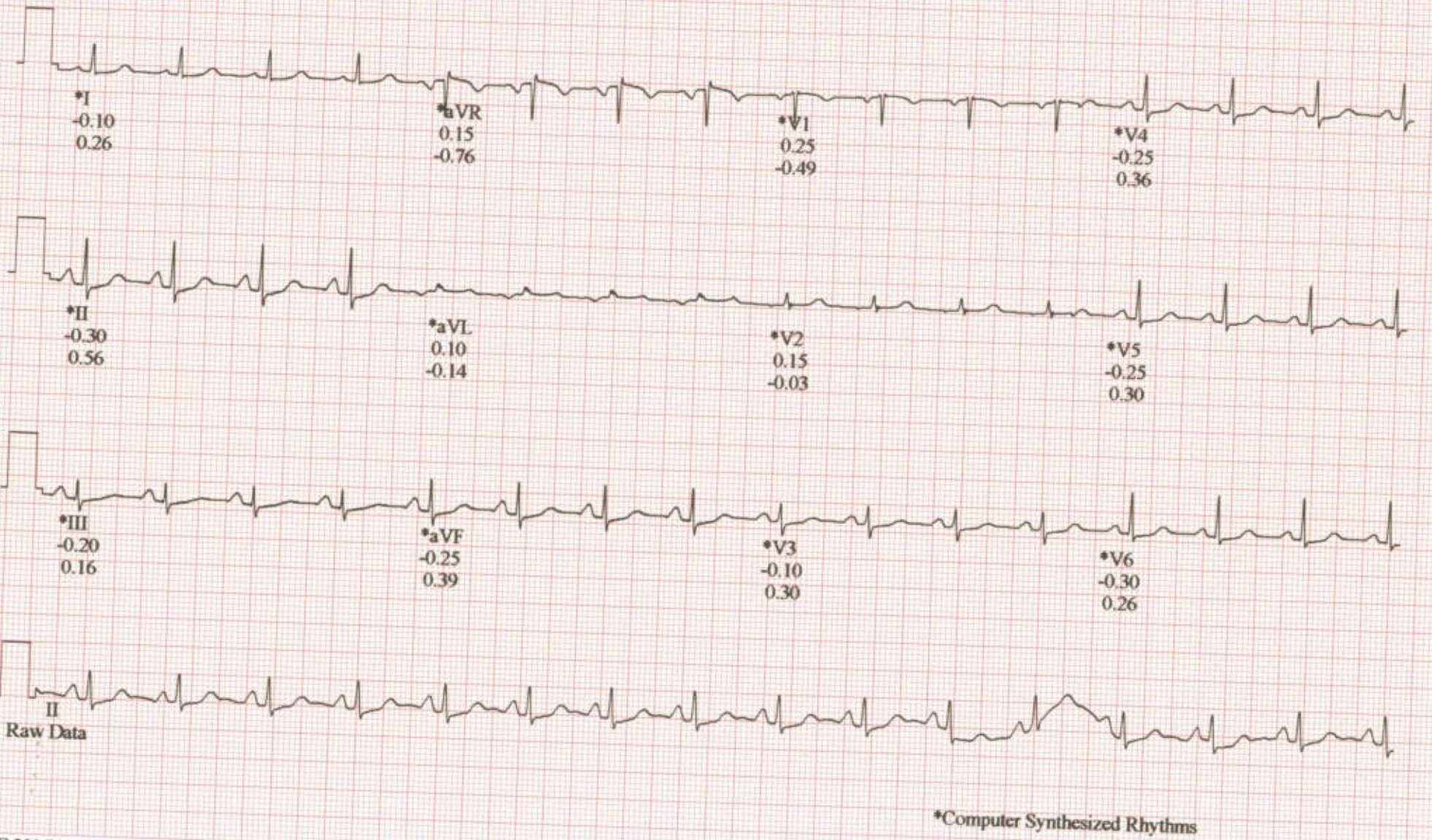
RECOVERY
#1
05:00

BRUCE
0.0 mph
0.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



Raw Data

*Computer Synthesized Rhythms

ASE V6.73

25 mm/s 10 mm/mV 60Hz 0.01 - 20Hz S+ HR(V6,V4)

Start of Test: 10:30:09am

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	R Suguna	**Date**	27/02/24
Age	50 years	**Hospital ID**	UHJA23019196
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (15.6 cms) and shows mild 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 (9.9 x 3.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (8.9 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 atrophic, measures 6.7 x 2.7 x 3.5 cms. Endometrium measures 4.4 mm.
Both ovaries could not be visualized – likely atrophic.

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

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	R Suguna	**Date**	27/02/24
Age	50 years	**Hospital ID**	UHJA23019196
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **No significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	R Suguna	**Date**	27/02/24
Age	50 years	**Hospital ID**	UHJA23019196
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