UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. KUMARI PREETI	Order No	: 1000078600
UHID	: UHJA23020864	Registered On	: 21/03/2024 09:58:25 AM
Age/Sex	: 34/Years Female	Collected On	: 21/03/2024 10:12:11 AM
Ward / Bed No	:	Reported On	: 21/03/2024 02:40:30 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230025821
Station	: At Hospital	Mobile No	: 9534334446
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	92	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	99.66	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.29	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.93	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.47	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)	182	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	66	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	40.0	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	128.8	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	13.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.5		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.2		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	142.0	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.0	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.56	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.59	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.48	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.4	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.23	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.16	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.33		2:1
SERUM SGOT (Method:IFCC without P5P)	25	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	17	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	75	U/L	46-122
GGT (Method:IFCC)	12	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)	9.58	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	30.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6210	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	54.17	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	32.10	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.35	%	0-6
MONOCYTES (Method:Optical/Impedance)	9.14	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.24	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.07	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram) Remarks: Suggest iron profile. Kindly correlate clinically.	74.8	fL	78-100
MCH (Method: Calculated)	23.5	pg	27-31
MCHC (Method: Calculated)	31.5	g/dL	31-37
RDW - CV (Method: Calculated)	17.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.69	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)	10.23	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	27.4	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	08	mm/hour	1-20

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	AB		
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	5.0		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	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
Rashmita

---End of Report---

Dr. Shobha Emmanuel
CONSULTANT PATHOLOGIST
KMC:66136

*NABL renewal under process.

NABH NABL No.1

UNITE HOSPITA
Care Par Excelle
Jayanagar, Bangal

Out Patient Record

Patient Name	**: Mrs.KUMARI PREETI**	**UHID**	**: UHJA23020864**
Age / Sex	: 34 Years / Female	OP NO/Reg Dt	: 21-03-2024 09:58 AM
Spouse / Father Name	: ASHUTOSH KUMAR	Department	:
Address	: JAYANAGAR SAI GUKUL APPARTMETNS, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Vaikad,

Complaints / Findings / Observations :

- Regular routine check.

HT - 160
Wt - 57
PR - 116
SpO2 - 99
BP - 121

Investigations:

Rlo - comorbidity

Rlo - Sp.

Treatment / Care of Plan / Provisional Diagnosis :

- All reports are in normal Range.

Follow Up Advice :

Adv

. Tab UEMCAL PLUS.

0-1-0

Signature of the Doctor

7 Days

ed Hospital

Kg / mmHg

34 years

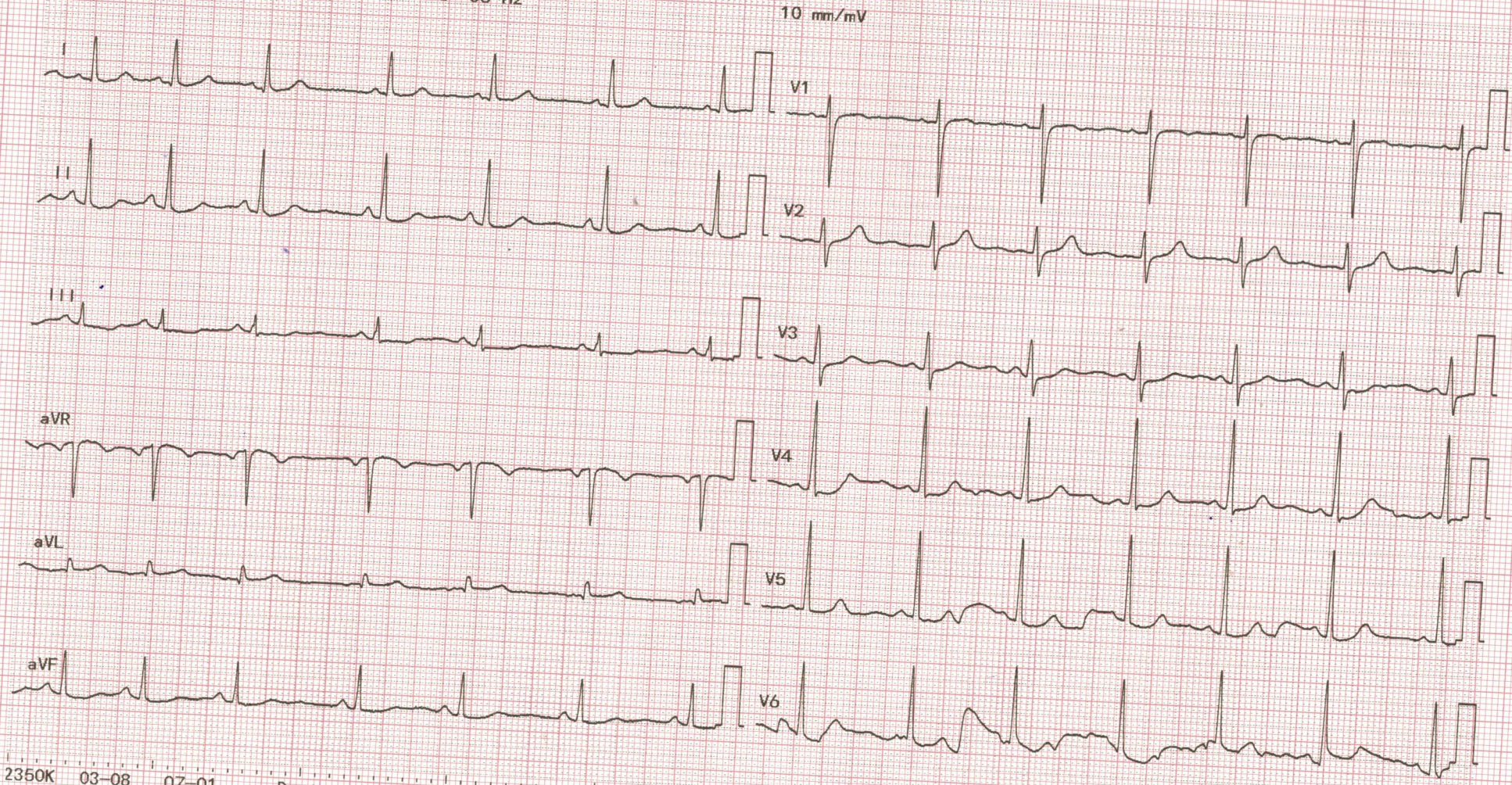
1100 Sinus rhythm
1102 Sinus arrhythmia [RR int. change over 20%]
4011 Minimal ST depression [0.025+ mV ST depression (V4, V6)]
9130 ** borderline ECG **

Medication:
Symptoms:
History:

Vent. rate	83	bpm
PR int	122	ms
QRS dur	76	ms
QT/QTc(E) int	340/ 380	ms
P/QRS/T axis	65/ 51/ 22	°
RV5/SV1 amp	1.59/ 1.33	mV
RV5+SV1 amp	2.92	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

Out Patient Record

Patient Name	**: Mrs.KUMARI PREETI**	**UHID**	**: UHJA23020864**
Age / Sex	: 34 Years / Female	OP NO/Reg Dt	: 21-03-2024 09:58 AM
Spouse / Father Name	: ASHUTOSH KUMAR	Department	:
Address	: JAYANAGAR SAI GUKUL APPARTMETNS, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

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

Complaints / Findings / Observations :

for health check up

HT - 160 cm
Wt - 57.6 kg
PR - 116 bpm
SpO2 - 99%
BP - 121/95

Investigations:

No fruitful coitus..

No h/o DM, HTN, Thyroid

M/c - reg
Nulligravida
LMP - 7/3/24
PMC - regular

Treatment / Care of Plan / Provisional Diagnosis :

No h/o any surgery

No h/o any family cancer

Follow Up Advice :

P/A - Soft

P/S - Cervix Vagina

Mild Moderate [illegible]

VAGINISMUS

Signature of the Doctor

Delpri

√ T-Flocen 1309 — 9

Three Thorn Thorn Fire

Carebil. V6 Vqid puij — 6d

Cubri gl — jt before Interview

No interview — 1 week

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

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Address	: JAYANAGAR SAI GUKUL APPARTMETNS, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

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

Complaints / Findings / Observations :

for health check up

HT - 160 cm
Wt - 57.6 kg
PR - 116 b/m
SPO2 - 99 %
BP - 121/95

Investigations:

No fruitful coitus

No h/o DM, HTN, thyroid

Treatment / Care of Plan / Provisional Diagnosis :

No h/o any surgery
No h/o any genetic con

ML - [illegible]
Nulligravida
LMP - 7/3/24
PMC - regular

Follow Up Advice :

P/A - soft

P/S - EC vagina
Mild - moderate [illegible]

VAGINISMUS

Signature of the Doctor

NABH NABL No.1

HOSPITAL
Care Par Excellence
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Address	: JAYANAGAR SAI GUKUL APPARTMETNS, , Bengaluru Urban, Karnataka, INDIA,	Refered By	: Op Ahal
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha

Complaints / Findings / Observations :

Vn 6/18. PH 6/6
6/24. PH 6/6

Investigations:

A/S OU Nml

Treatment / Care of Plan / Provisional Diagnosis :

Fundus OU C/D 0.3:1
Mac

Follow Up Advice :

Ix: REF err

To R/v with glass

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Kumari Preethi	**Date**	21/03/24
Age	34 years	**Hospital ID**	UHJA23020864
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 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 (10.8 x 3.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.5 x 3.5 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 6.7 x 3.5 x 4.5 cms. Myometrial and endometrial echoes are normal. Endometrium measures 10.1 mm.
Right ovary is normal in size and echopattern, measures 1.6 cc.
Left ovary is normal in size and echopattern, measures 3.9 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:

- **No definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Kumari Preethi	**Date**	21/03/24
Age	34 years	**Hospital ID**	UHJA23020864
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