NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: **Mrs.M SANGEETHA**	**UHID**	: **UHJA23018356**
Age / Sex	: 33 Years / Female	OP NO/Reg Dt	: 14-02-2024 08:20 AM
Spouse / Father Name	: SHARATH KUMAR A	Department	:
Address	: magdi road, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Amulekhe.

Complaints / Findings / Observations :

. Regular health check up

Wt-62.4
HT-159
Bp-101/72
Spo2-98
PR-84b/

Investigations:

Treatment / Care of Plan / Provisional Diagnosis : Adv

. physical activity
. Lots of fluids

Follow Up Advice :

Medically fit.

Signature of the Doctor

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		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Anuleekha.

Complaints / Findings / Observations :

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HT - 159
Bp - 101/72
Spo2 - 98
PR - 84b/

Investigations:

Treatment / Care of Plan / Provisional Diagnosis : Adv

physical activity
Lots of fluids

Follow Up Advice :

Medically fit.

Signature of the Doctor

SCHILLER

ID: 23018356
Name: Mrs. M. Sangeetha

14-Feb-2024 AM10:10:40

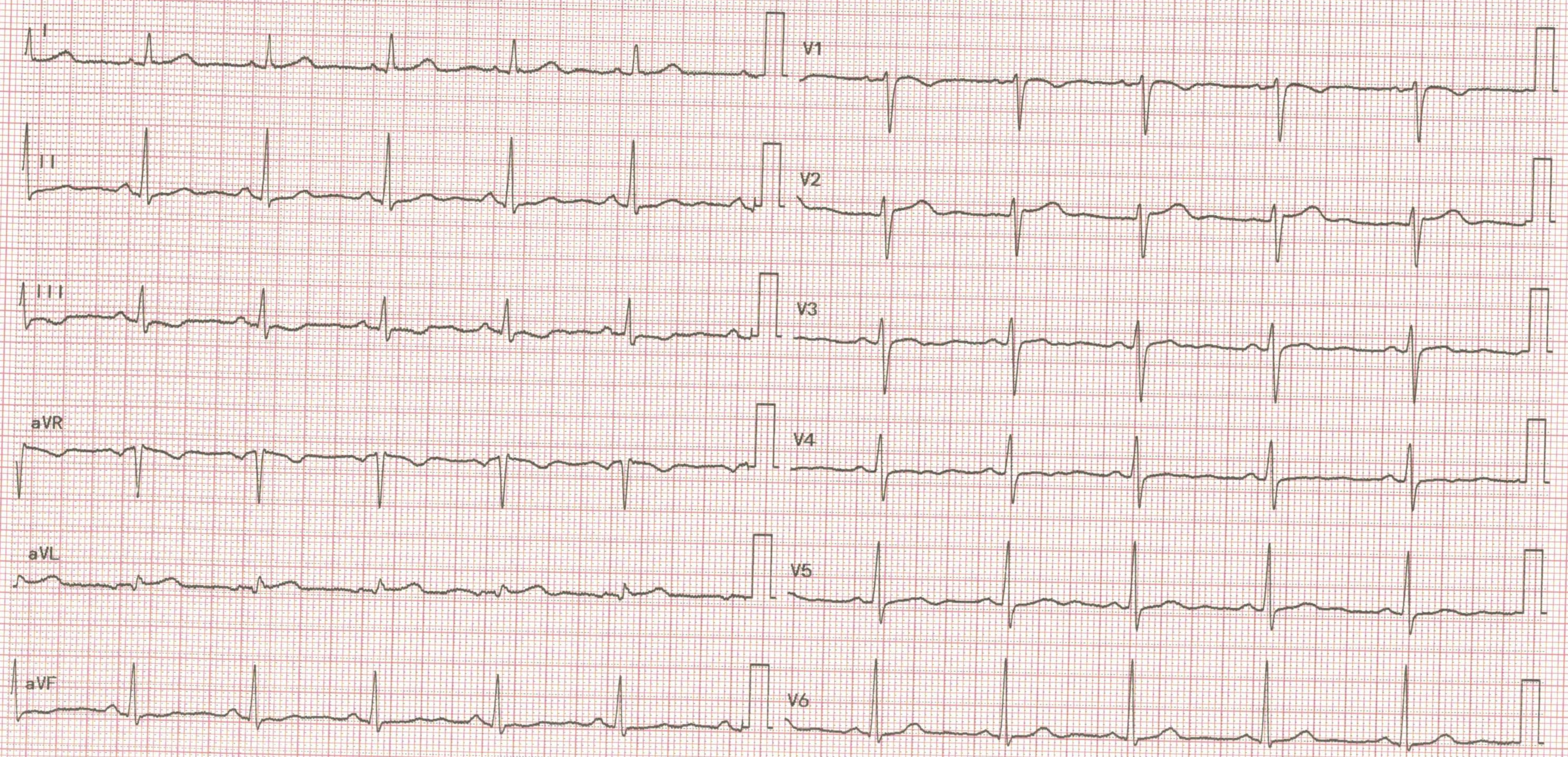
lex: F
Birth date: 33 years
cm kg / mmHg
ledication:
lymptoms:
listory:

lent. rate	72	bpm
IR int	144	ms
RS dur	92	ms
T/QTc(E) int	366/ 390	ms
/QRS/T axis	55/ 59/ 14	°
V5/SV1 amp	1.09/ 0.87	mV
V5+SV1 amp	1.96	mV

1100 Sinus rhythm
4068 Nonspecific Twave abnormality [flat T or negative T (aVF, V4)]
9130 ** borderline ECG **

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: UNITED HOSPITAL

Part No.2.157017M CE 0123 M.BD

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	M Sangeetha	**Date**	14/02/24
Age	33 years	**Hospital ID**	UHJA23018356
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 RADIODIAGNOSIS

Name	M Sangeetha	Date	14/02/24
Age	33 years	Hospital ID	UHJA23018356
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (16.6 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 ***lumen shows a shadowing calculus measuring 6 mm.*** There is no evidence of 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 (9.2 x 3.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.8 x 4.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

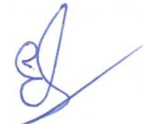
Retroperitoneum- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

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 8.8 x 5.5 x 3.5 cms. Myometrial and endometrial echoes are normal. Endometrium measures 7.1 mm.
Both ovaries ***show polycystic morphology.***
Right ovary measures 9.6 cc. **Left ovary** measures 16.4 cc.

There is no ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **Cholelithiasis. No evidence of cholecystitis.**
- **Bilateral polycystic ovaries.**
- **Mild hepatomegaly with mild fatty infiltration (Grade I).**



Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH NABL No.1

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Patient name :	Mrs. M SANGEETHA	Date :	14/02/24
Age :	33 years GENDER: FEMALE	Patient ID :	18356
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 3.8 (3.5-5.5)	MV EV : 73.2	AV : 61.1	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 109		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 93.1		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.7 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 0.9 (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, TRIVIAL TR, PASP-15mmHg
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. M SANGEETHA	Order No	: 1000072960
UHID	: UHJA23018356	Registered On	: 14/02/2024 08:20:46 AM
Age/Sex	: 33/Years Female	Collected On	: 14/02/2024 08:28:18 AM
Ward / Bed No	:	Reported On	: 14/02/2024 04:11:57 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022717
Station	: At Hospital	Mobile No	: 8971400724
Payer Name	: Mediwheel	Report Status	: Final Report

BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval
FASTING GLUCOSE (Method: Hexokinase)	98	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	117	mg/dL	70-140
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)	1.33	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	6.55	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.70	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)	201	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	143	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	42.6	mg/dL	< 40 - Low ≥ 60 - High

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	129.8	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	28.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.7		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.0		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	158.4	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.2	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)	0.58	mg/dL	0.6-1.1

LIVER FUNCTION TEST — Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.51	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.43	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.30	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.89	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.10		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	19	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	84	U/L	46-122
GGT (Method:IFCC)	17	U/L	< 38

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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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)	11.73	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	35.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6110	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	53.29	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	35.01	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.46	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.88	%	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)	83.0	fL	78-100
MCH (Method: Calculated)	27.5	pg	27-31
MCHC (Method: Calculated)	33.1	g/dL	31-37
RDW - CV (Method: Calculated)	15.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.07	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)	6.95	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	9	mm/hour	1-20

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
ABO Group (Method:Agglutination Gel Method)	A
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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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Cloudy		
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)	Present (+)		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	4-6	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		

Verified By
Rashmita

---End of Report---

Naveen.N
Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418