ID:16581

Name:kiran r

Birth date: 30 years

kg / mmHg

tion:

oms:

y:

rate	57	bpm
	148	ms
r	94	ms
(E) int	420/ 414	ms
T axis	55/ 69/ 52	°
1 amp	1.96/ 0.97	mV
1 amp	2.93	mV

26-Jan-2024 AM10:09:30

1100 Sinus rhythm

2420 RSR (QR) in lead V1/V2, consistent with right ventricular conduction delay [RSR pattern (V1)]

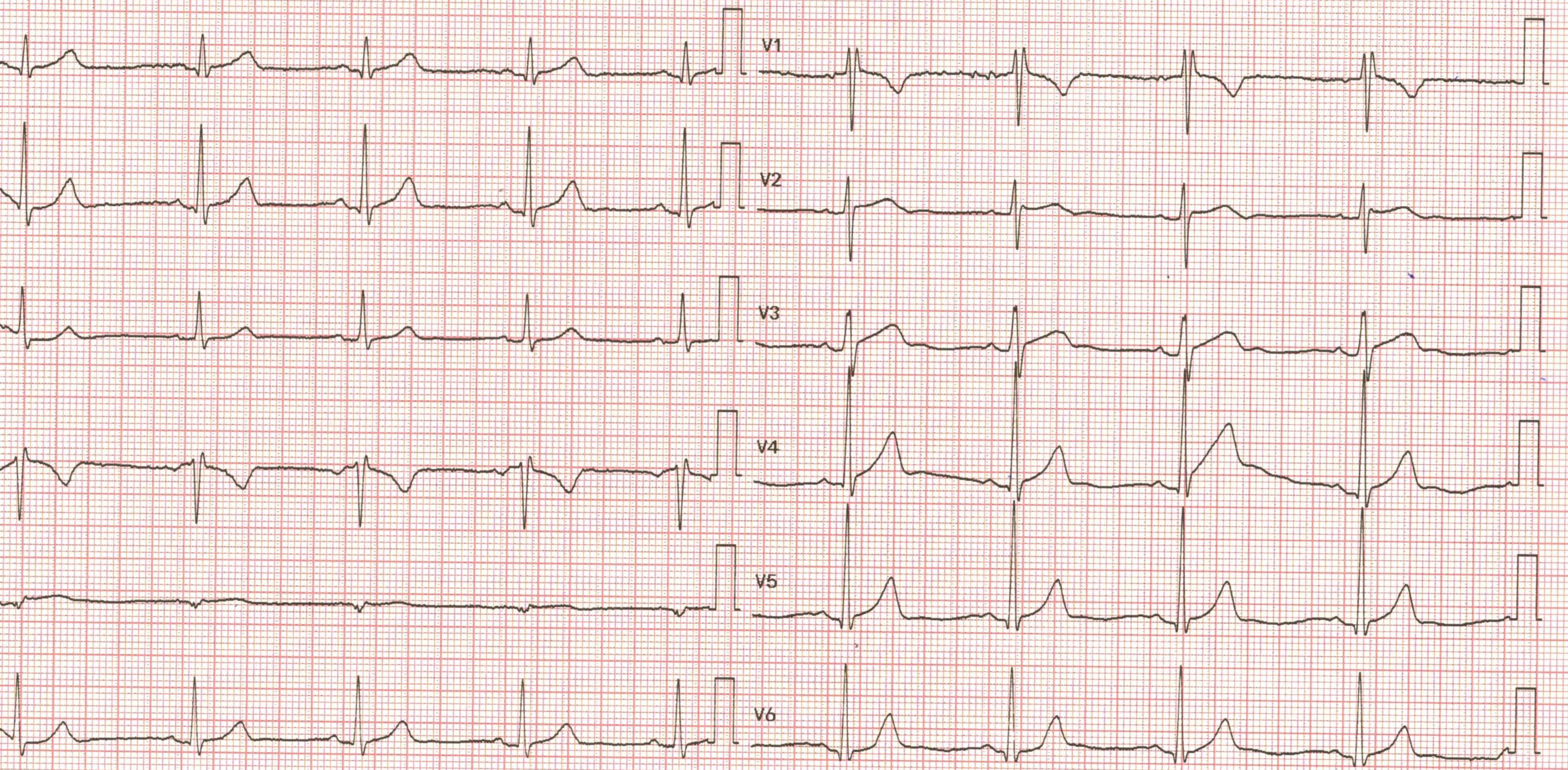
9130 ** borderline ECG **

Unconfirmed Report

Reviewed by:

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

10 mm/mV



03-08 07-01 Dept.:

Exam: UNITED HOSPITAL

MICRO MED CHARTS

Out Patient Record

Patient Name	: Mr.KIRAN R	UHID	: UHJA23016531
Age / Sex	: 30 Years / Male	OP NO/Reg Dt	: OP230000019653 / 26-01-2024 09:47 AM
Father Name	:	Department	:
Spouse Name	: RAMACHANDRA	Refered By	:
Address	: Tumkur, BANGALORE CITY H O, Bengaluru Urban, Karnataka, INDIA, 560002	Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

HT: 177cm.
WT: 80.3kg.
SpO2: 99%.
PR: 56bpm
BP: 100/60. mmHg.

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Patient name	Mr. Kiran R	Patient ID	UHJA23016531
Age	30 years	Sex	Male
Referring doctor	Health check	Date	26/01/24

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(10 cms, PT – 1.3cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size(10 cms, PT – 1.3cms) position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum – Visualized part of the 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.
Prostate is normal in echopattern and size.
Fluid - There is no ascites or pleural effusion.
Appendix could not be localized, obscured by bowel gas. No mass / collection in RIF /LIF.

IMPRESSION:

No definite sonological abnormality detected.

Dr. GIRIDHAR VS
Consultant Radiologist

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

NABH NABL No.1

A Unit of United Brothers Healthcare Services Private Limited
No. 110(30), Madhavan Park Circle, 10th Main Road, 3rd Block, Jayanagar, Bangalore - 560 011. T: 080 4566 6666 E: appointment@unitedhospital.in W: www.unitedhospital.com

DEPARTMENT OF RADIODIAGNOSIS

Name	Mr. Kiran R	**Date**	26/01/24
Age	30 years	**Hospital ID**	UHJA23016531
Sex	Male	**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. Giridhar V S
Consultant Radiologist

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KIRAN R	Order No	: 1000068666
UHID	: UHJA23016531	Registered On	: 26/01/2024 09:47:06 AM
Age/Sex	: 30/Years Male	Collected On	: 26/01/2024 09:59:29 AM
Ward / Bed No	:	Reported On	: 26/01/2024 01:39:25 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230020602
Station	: At Hospital	Mobile No	: 8050336513
Payer Name	:	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
POST PRANDIAL GLUCOSE (Method: Hexokinase)	94	mg/dL	70-140
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.89	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.25	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.29	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	184	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	46	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	60.4	mg/dL	< 40 - Low ≥ 60 - High
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	114.4	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	9.19	mg/dL	< 30

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KIRAN R	Order No	: 1000068666
UHID	: UHJA23016531	Registered On	: 26/01/2024 09:47:06 AM
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Station	: At Hospital	Mobile No	: 8050336513
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.05		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.89		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	123.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.2	mg/dL	3.5-7.2
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	14	mg/dL	7.93-20.07

LIVER FUNCTION TEST

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.18	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.24	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.94	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.51	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.49	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.81		2:1
SERUM SGOT (Method:IFCC without P5P)	28	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	26	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	80	U/L	50-116

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KIRAN R	Order No	: 1000068666
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Station	: At Hospital	Mobile No	: 8050336513
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
GGT (Method:IFCC)	15	U/L	< 55
CREATININE (Method:Modified Jaffe, Kinetic)	0.88	mg/dL	0.9-1.3

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KIRAN R	Order No	: 1000068666
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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)	15.38	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.3	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4780	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	55.88	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	34.69	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.90	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.91	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.62	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.30	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	85.4	fL	78-100
MCH (Method: Calculated)	29.0	pg	27-31
MCHC (Method: Calculated)	34.0	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.81	Lakhs/Cum	1.5-4.5

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KIRAN R	Order No	: 1000068666
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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.91	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.2	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-15

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
ABO Group (Method:Agglutination Gel Method)	B		
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

DEPARTMENT OF LABORATORY MEDICINE

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		5.0-8.0
SPECIFIC GRAVITY	1.015		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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DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/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
PREETHI R

---End of Report---

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

DEPARTMENT OF LABORATORY MEDICINE

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BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Interval
FASTING GLUCOSE (Method: Hexokinase)	92	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	94	mg/dL	70-140
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.89	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.25	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.29	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	184	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	46	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	60.4	mg/dL	< 40 - Low ≥ 60 - High
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	114.4	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	9.19	mg/dL	< 30

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DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.05		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.89		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	123.6	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.2	mg/dL	3.5-7.2
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	14	mg/dL	7.93-20.07
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.18	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.24	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.94	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.51	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.49	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.81		2:1
SERUM SGOT (Method:IFCC without P5P)	28	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	26	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	80	U/L	50-116

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Test Name	Result	Unit	Bio. Ref. Interval
GGT (Method:IFCC)	15	U/L	< 55
CREATININE (Method:Modified Jaffe, Kinetic)	0.88	mg/dL	0.9-1.3

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

UNITED HOSPITAL
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DEPARTMENT OF LABORATORY MEDICINE

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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)	15.38	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.3	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4780	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	55.88	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	34.69	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.90	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.91	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.62	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.30	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	85.4	fL	78-100
MCH (Method: Calculated)	29.0	pg	27-31
MCHC (Method: Calculated)	34.0	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.81	Lakhs/Cum	1.5-4.5

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DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.91	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.2	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-15

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
ABO Group (Method:Agglutination Gel Method)	B		
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

DEPARTMENT OF LABORATORY MEDICINE

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		5.0-8.0
SPECIFIC GRAVITY	1.015		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			

UNITED HOSPITAL
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Age/Sex	: 30/Years Male	Collected On	: 26/01/2024 09:59:29 AM
Ward / Bed No	:	Reported On	: 26/01/2024 01:39:25 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230020602
Station	: At Hospital	Mobile No	: 8050336513
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/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
PREETHI R

---End of Report---

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418