DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. P SWATHI	Order No	: 1000099465
UHID	: UHJA24006717	Registered On	: 17/10/2024 09:04:35 AM
Age/Sex	: 36/Years Female	Collected On	: 17/10/2024 09:32:11 AM
Ward / Bed No	:	Reported On	: 17/10/2024 01:03:00 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240009213
Station	: Corp	Mobile No	: 8147515521
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	**100**	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	111	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.2	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	103	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.20	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	13.73	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.05	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)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	189	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	93	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	43.5	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	**126.90**	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	18.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.34		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	**2.92**		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	**145.50**	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.1	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)	**0.52**	mg/dL	0.6-1.1

LIVER FUNCTION TEST

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.49	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.10	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.39	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.13	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.87	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.44		2:1
SERUM SGOT (Method:IFCC without P5P)	17	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	11	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	**132**	U/L	46-122
GGT (Method:IFCC)	10	U/L	< 38

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

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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)	13.03	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	39.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5300	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.58	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	24.83	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.32	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.87	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.40	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.09	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	**76.8**	fL	78-100
MCH (Method: Calculated)	**25.6**	pg	27-31
MCHC (Method: Calculated)	33.3	g/dL	31-37
RDW - CV (Method: Calculated)	**14.8**	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.91	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)	**7.28**	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	**20.7**	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	3480	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method:Calculated Automated)	180	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1320	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	310	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	**22**	mm/hour	1-20

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

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

Interpretation Notes

Note: Both forward and reverse grouping performed

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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	1.020		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			

DEPARTMENT OF LABORATORY MEDICINE

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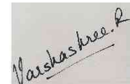
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	0-2	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		



Verified By
G Mahesh kumar

---End of Report---

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

NABH No.1

Out Patient Record

Patient Name	: Mrs.P SWATHI	UHID	: UHJA24006717
Age / Sex	: 36 Years / Female	OP NO/Reg Dt	: 17-10-2024 09:04 AM
Spouse / Father Name	: .	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

Ht. 159
Wt - ~~159~~ 58kg
BP - 115/70
PR - 86bpm
SpO2 - 98%

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH

No.1

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and
Gynecologist, Laparoscopy
and IVF Specialist
KMC Reg. No. 90304

Jayanagar, Bangalore

Name: Swathi
36 Y/F

Gynaecology

BP – 115/70
PR – 80 bpm.

Rx Lab check

ML – 8y
P1 G

- H/. Hypogonadotropic hypogonadism.
- Treated for it, P1 – ♀, 1yr.
- c IVF conception IVF conception (8y)
- No h/ DM, HTN, Thyroid
- (GDM, ~~ht~~ HTN)

cons – postpartum.
PMC – H/o Amenorrhea

- ~~Pt~~ H/. DHL & CPT.
- ~~PS~~ G/. folic acid – Mother – Blood [illegible]

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	P Swathi	Date	17/10/24
Age	36 years	Hospital ID	UHJA24006717
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 (9.2 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.1 x 4.6 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 distended, normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and atrophic, measures 4.1 x 2.9 x 1.8 cms. Endometrium measures 4.8 mm.
Echogenic foci are seen in the endometrium - likely calcifications.
Right ovary appears atrophic, measures 0.5 cc.
Left ovary appears atrophic, measures 0.9 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:

- **Atrophic uterus and ovaries - K/c/o hypogonadism.**
- **Echogenic foci in the endometrium - likely calcifications.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME :	Mrs. P SWATHI	DATE :	17/10/24
AGE :	36 YEARS GENDER : FEMALE	PATIENT ID :	24006717
REF BY :	CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(cm)	(cm)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 3.5 (3.5-5.5)	MV EV: 0.8	AV: 0.6	MR : NORMAL
LA : 2.8 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 1.0		AR : NORMAL
RA : 1.9 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 0.8		PR : NORMAL
RV : 1.8 (<3.5)	IVSS : 0.8 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE : 1.7 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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 AND COLLAPSING

IMPRESSION:

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

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

NABH No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	P Swathi	Date	17/10/24
Age	36 years	Hospital ID	UHJA24006717
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

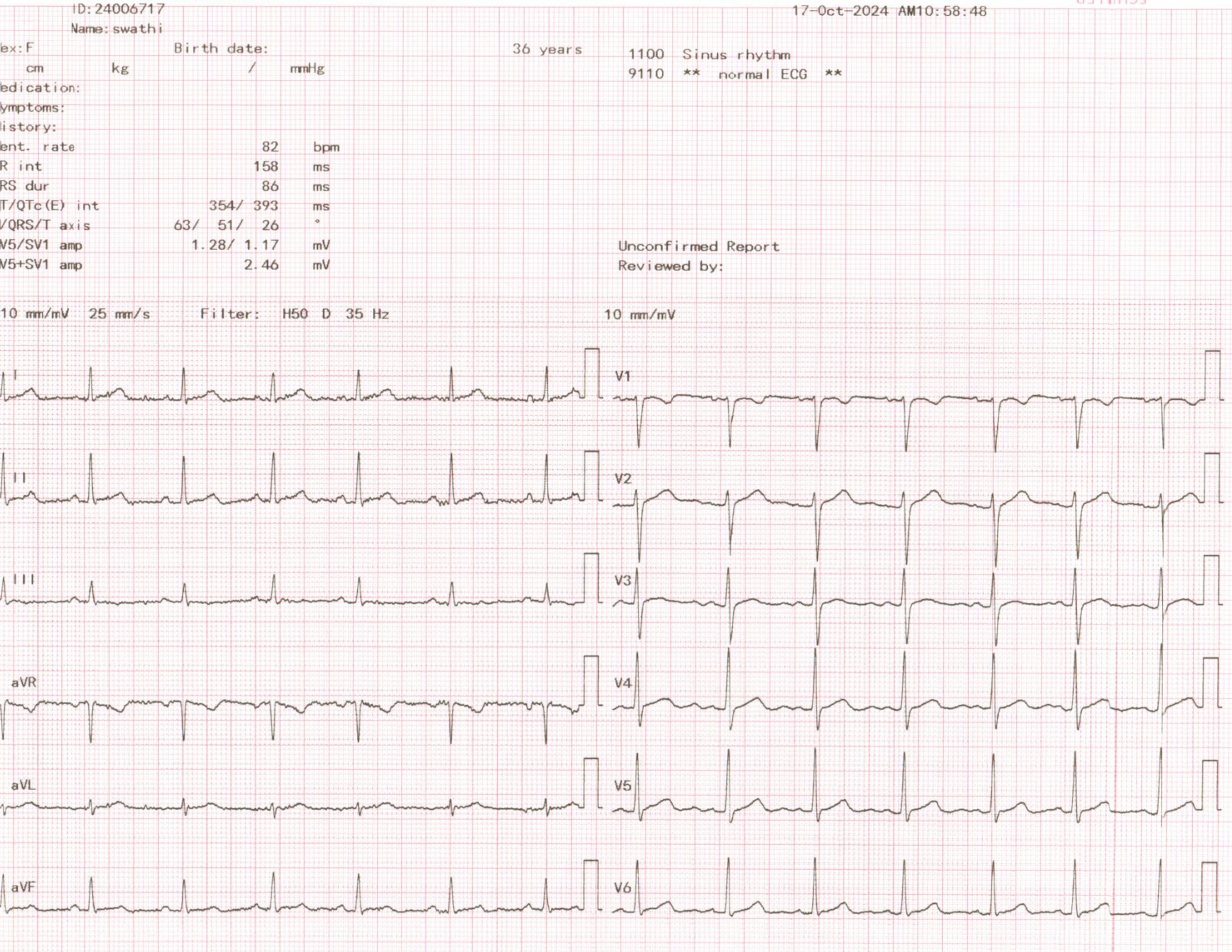
Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist



SCHILLER
Part No.2.157017M
ID: 24006717
Name: swathi
17-Oct-2024 AM10:58:48
ex: F
Birth date:
36 years
cm
kg
/
mmHg
1100 Sinus rhythm
9110 ** normal ECG **
edication:
ymptoms:
istory:
ent. rate 82 bpm
R int 158 ms
RS dur 86 ms
T/QTc(E) int 354/ 393 ms
/QRS/T axis 63/ 51/ 26 °
V5/SV1 amp 1.28/ 1.17 mV
V5+SV1 amp 2.46 mV
Unconfirmed Report
Reviewed by:
10 mm/mV 25 mm/s Filter: H50 D 35 Hz
10 mm/mV
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
2350K 03-08 07-01 Dept.:
Exam: UNITED HOSPITAL