UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. UDAY GANAPATI HEGDE	Order No	: 1000074716
UHID	: UHJA23019194	Registered On	: 27/02/2024 08:32:32 AM
Age/Sex	: 58/Years Male	Collected On	: 27/02/2024 08:41:36 AM
Ward / Bed No	:	Reported On	: 27/02/2024 03:31:32 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023744
Station	: At Hospital	Mobile No	: 8310302569
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	112	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	208	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	111.14	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.00	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	7.27	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.19	ı IU/mL	0.38-5.33
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)	155	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	36.0	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	134.0	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	31.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.5		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.7		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	165.0	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.7	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.78	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	12.7		12¯20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.80	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.16	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.65	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.8	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.55	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.25	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.39		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	39	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	53	U/L	50-116
GGT (Method:IFCC)	42	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	3.52	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	21.2	mg/dL	17-43

Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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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)	13.86	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	41.5	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	10590	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	83.11	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	11.19	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	0.87	%	0-6
MONOCYTES (Method:Optical/Impedance)	4.55	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.28	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.80	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	86.4	fL	78-100
MCH (Method: Calculated)	28.9	pg	27-31
MCHC (Method: Calculated)	33.4	g/dL	31-37
RDW - CV (Method: Calculated)	13.1	%	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)	6.12	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	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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CLINICAL PATHOLOGY

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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)	Trace		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	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

NABH NABL No.1

UNITE HOSPITA
Care Par Excelle
Jayanagar, Banga

Patient name :	**Mr. UDAY GANAPATI HEGDE**	**Date :**	**27/02/24**
Age :	**58 years GENDER: MALE**	**Patient ID :**	**19194**
Ref by :	**DR. CMO**	**OP/ IP :**	**HEALTH CHECKUP**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.9 (2.5-3.7)	LVIDD : 4.1 (3.5-5.5)	MV EV : 71.8	AV : 87.8	MR : MILD MR
LA : 3.0 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 117		AR : MILD AR
RA : 2.2 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 99.0		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ----	AV : ----	TR : MILD TR
TAPSE: 1.8 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : GRADE 1 LVDD		
	LVPWS : 1.0 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: MILD CONCENTRIC LVH
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis	: NO RWMA
Mitral Valve	: NORMAL, MILD MR
Aortic Valve	: SCLEROTIC CHANGES, NON-STENOTIC – 5mmHg, MILD AR
Tricuspid Valve	: NORMAL, MILD TR, PASP-30mmHg
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

MILD CONCENTRIC LV HYPERTROPHY
SCLEROTIC AORTIC VALVE
NORMAL LV SYSTOLIC FUNCTION EF : 60%
GRADE 1 LV DIASTOLIC DYSFUNCTION
MILD MR/AR/TR, PASP-30mmHg
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

27-Feb-2024 AM9:33:25

ID:19194
Name:Mr.Uday Ganapati H
Birth date:

58 years

1100 Sinus rhythm
9110 ** normal ECG **

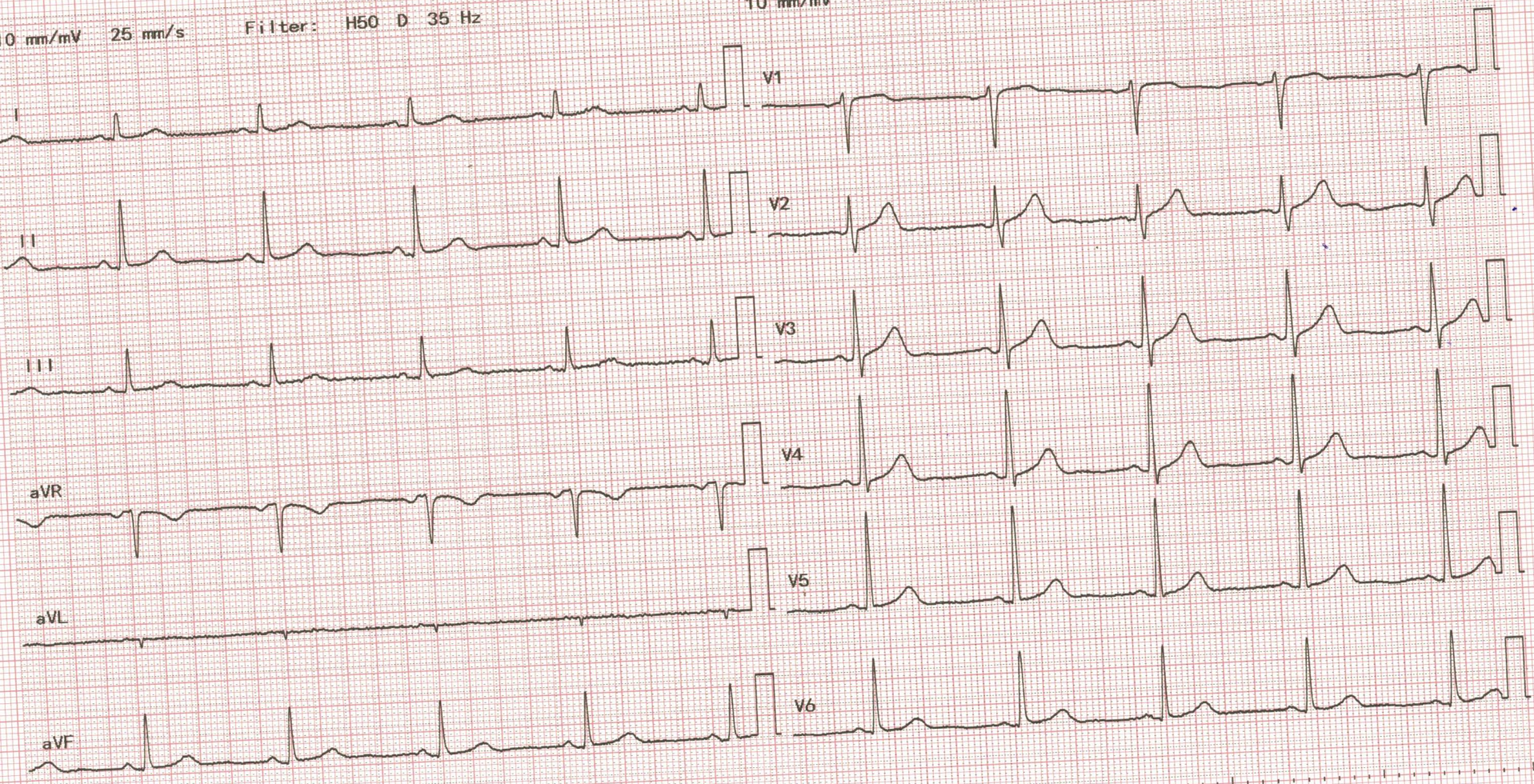
:M
cm kg / mmHg
ication:
ptoms:
tory:

nt. rate	62	bpm
int	136	ms
S dur	86	ms
/QTc(E) int	404/ 408	ms
QRS/T axis	61/ 69/ 62	°
5/SV1 amp	1.66/ 0.87	mV
5+SV1 amp	2.53	mV

Unconfirmed Report
Reviewed by:

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

10 mm/mV



Exam:UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
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Jayanagar, Bangalo

Out Patient Record

Patient Name	**: Mr.UDAY GANAPATI HEGDE**	**UHID**	**: UHJA23019194**
Age / Sex	: 58 Years / Male	OP NO/Reg Dt	: 27-02-2024 08:32 AM
Spouse / Father Name	: GANAPATHI GANESH HEGDE	Department	:
Address	: a1 402 cavery block natural games village koramangala , , Bengaluru Urban, Karnataka,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha [Ophth.

Complaints / Findings / Observations :

Routine eye check.

HTN - Tys.

Vn (glass) — 6/6P, 6/6P } OU.

Investigations:

Adj OU Nml

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (undilated) OU CD ratio 0.4:1 FR +.

Follow Up Advice : Rf: OU Ref Error.

Signature of the Doctor

NABH NABL No.1

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Jayanagar, Bangalore

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Address	: a1 402 cavery block natural games village koramangala , , Bengaluru Urban, Karnataka,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Ashwita Padma

Complaints / Findings / Observations :

HTN – T. Metzok. ✓
OS
1 — 0 — 1.

T. Rosuvas 10mg
0 — 0 — 1.

Wt- 57.1
HT- 166.
Bp- 111/69
SpO2- 98%
PR- 66b/m

Investigations:

LDL - 132.

Treatment / Care of Plan / Provisional Diagnosis :

℞

Tab. Rosuvas ASD.
75/10
0 — 0 — 1.

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL
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Jayanagar, Bangalore
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.unitedhosp

NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Uday Ganapati Hegde	**Date**	27/02/24
Age	58 years	**Hospital ID**	UHJA23019194
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (17.7 cms) and shows moderately 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 focal lesion.

Right Kidney is normal in size (10.9 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (10.4 x 4.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus 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, mass or mural lesion.
Prevoid volume - 200 ml Postvoid volume - 13 ml

Prostate ***is enlarged in size, measures ~ 31 cc.***

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

IMPRESSION:

- **Grade I prostatomegaly with no increased postvoid residual urine.**
- **Mild hepatomegaly with moderate fatty infiltration (Grade II).**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Uday Ganapati Hegde	**Date**	27/02/24
Age	58 years	**Hospital ID**	UHJA23019194
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. Elluru Santosh Kumar
Consultant Radiologist