UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. J LAKSHMIPATHY	Order No	: 1000074305
UHID	: UHJA23019000	Registered On	: 24/02/2024 08:19:28 AM
Age/Sex	: 35/Years Male	Collected On	: 24/02/2024 08:33:18 AM
Ward / Bed No	:	Reported On	: 24/02/2024 01:56:54 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023493
Station	: At Hospital	Mobile No	: 9790671698
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	314	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	426	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	12.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	309.18	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.99	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	17.18	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	0.63	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	235	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	183	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.3	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	151.1	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	36.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.9		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.1		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	187.7	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.3	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.68	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.74	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.13	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.61	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.77	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.43	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.96		2:1

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	26	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	42	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	111	U/L	50-116
GGT (Method:IFCC)	30	U/L	< 55

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)	16.06	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	47.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	8430	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.96	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	21.22	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.67	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.73	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.42	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.35	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	89.2	fL	78-100
MCH (Method: Calculated)	30.0	pg	27-31
MCHC (Method: Calculated)	33.7	g/dL	31-37
RDW - CV (Method: Calculated)	13.3	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.76	Lakhs/Cum	1.5-4.5

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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.36	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.5	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

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	6.5		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)	Present (1.5%)		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	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Present (1.5%)		
URINE SUGAR (POST PRANDIAL)	Present (2.0%)		

Verified By
NAGARATNA

---End of Report---

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

ID:23019000 24-Feb-2024 AM9:08:15

Name:mr. j lakshmipathy

ex:M Birth date: 35 years

cm kg / mmHg

edication:

ymptoms:

istory:

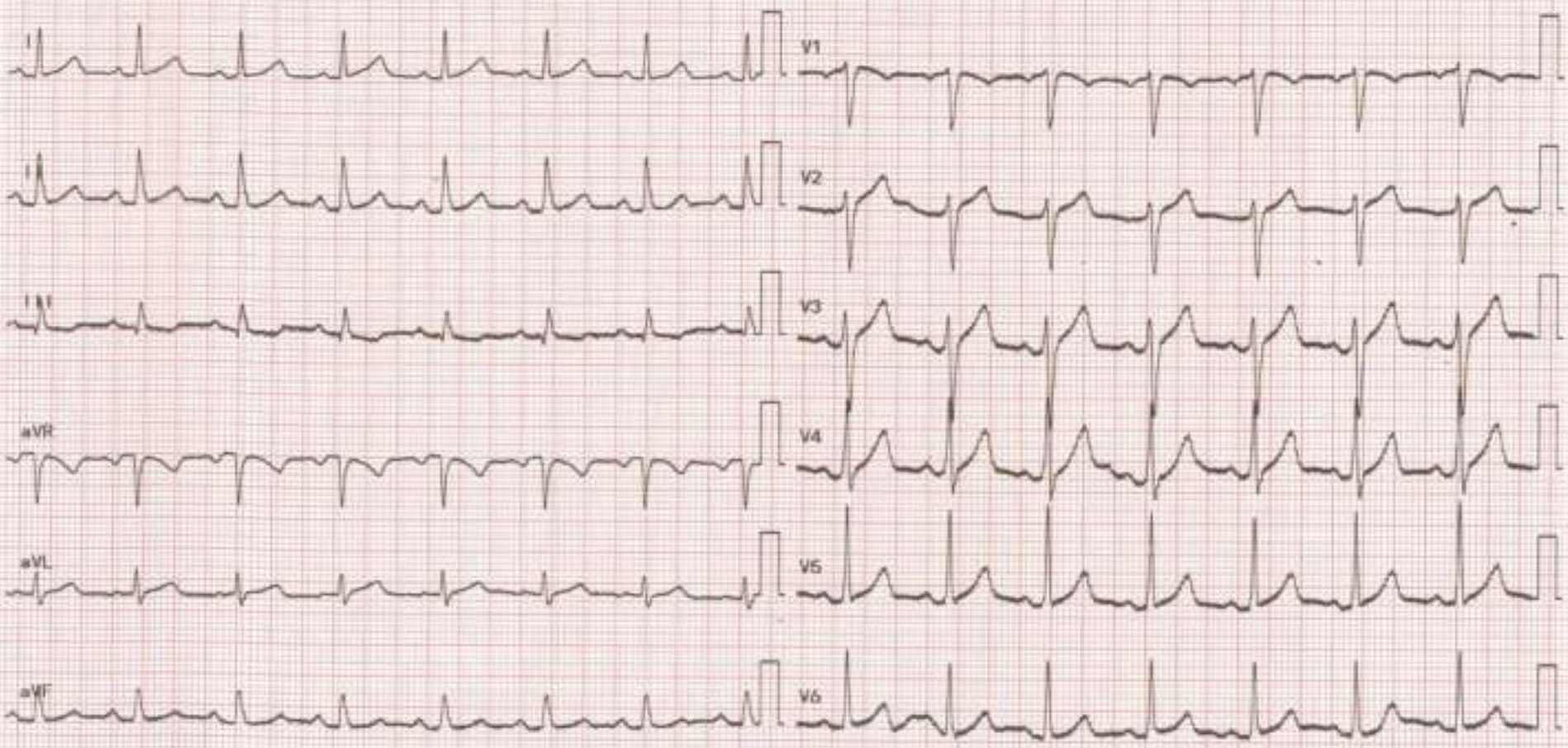
ent. rate	92	bpm
R int	148	ms
RS dur	110	ms
T/QTc(E) int	366/ 415	ms
P/QRS/T axis	54/ 34/ 27	°
V5/SV1 amp	1.71/ 0.99	mV
V5+SV1 amp	2.70	mV

1100 Sinus rhythm
40302 ST elevation, probably early repolarization [ST elevation (I, V2, V3, V4, V5)]
0102 ARTIFACT PRESENT
9130 ** borderline ECG **

Unconfirmed Report
Reviewed by:

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

10 mm/mV



Z350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mr. J LAKSHMIPATHY**	**Date :**	**24/02/24**
Age :	**35 years GENDER: MALE**	**Patient ID :**	**19000**
Ref by :	**DR.CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.8 (2.5-3.7)	LVIDD : 3.5 (3.5-5.5)	MV EV : 77.6	AV : 58.2	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 97.7		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 83.4		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 0.8 (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
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

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

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.J LAKSHMIPATHY**	**UHID**	**: UHJA23019000**
Age / Sex	: 35 Years / Male	OP NO/Reg Dt	: 24-02-2024 08:19 AM
Spouse / Father Name	: V JAYAPAL	Department	: Health checic
Address	: # Vijaypura Bank off Baroda opposite to Besam Office, BANGALORE CITY H O,	Refered By	: corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. vignesh

Complaints / Findings / Observations : ENT Prescription

Came for Routine ENT check up.

Investigations:

↓

Ears, Nose, throat, oral Cavity } within Normal limits.

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Dr. VIGNESH J
MBBS, DLO(MAMC), DNB(ENT), FHM(KDHW)
ENT, HEAD AND NECK ONCO SURGEON
REG. NO: 92083

Signature of the Doctor

NABH NABL No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.J LAKSHMIPATHY	UHID	: UHJA23019000
Age / Sex	: 35 Years / Male	OP NO/Reg Dt	: 24-02-2024 08:19 AM
Spouse / Father Name	: V JAYAPAL	Department	: Health Check
Address	: # Vijaypura Bank off Baroda opposite to Besom Office, BANGALORE CITY H O,	Refered By	: Corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha

Complaints / Findings / Observations : Ophthomology prescription

DM + 4 years

VA < 6/nr

Investigations:

A/C Q

Treatment / Care of Plan / Provisional Diagnosis : fundus c Q

Imp: Normal sem [illegible]

Follow Up Advice :

Dilated fundus / refraction

Signature of the Doctor
24/2/24

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.unitedhospital.com

NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	J Lakshmipathy	**Date**	24/02/24
Age	35 years	**Hospital ID**	UHJA23019000
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (15.4 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 (11.7 x 4.1 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.6 x 5.1 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.

Prostate is normal in echopattern and size, measures ~ 17.2 cc.

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

IMPRESSION:

- **Mild hepatomegaly with moderate fatty infiltration (Grade II).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	J Lakshmipathy	**Date**	24/02/24
Age	35 years	**Hospital ID**	UHJA23019000
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