NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mrs.SUBRAMANIAN SUGUNA DEVI**	**UHID**	**: UHJA23018562**
Age / Sex	: 46 Years / Female	OP NO/Reg Dt	: 17-02-2024 08:28 AM
Spouse / Father Name	: DHANDABANI	Department	:
Address	: hosur, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Routine eye exam

Investigations:

VA < 6/6P (BE)
PHP

N<R N6 (BE)
PHP

Treatment / Care of Plan / Provisional Diagnosis :

AS < (N)

Fundus < (N)

Follow Up Advice :

Rx: Reg. presbyopic glasses

Adv: Yearly review

Signature of the Doctor
17/2/24

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Mrs Subramanian Suguna Devi

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and
Gynecologist, Laparoscopy
and IVF Specialist
KMC Reg. No. 90384

17/2/24

49y

For health check up

BP - 142/100 PR-74

No h/o DM, HTN,

K/c/o Hypothyroid

No h/o any surgery

h/o ant. fah cancer

Aunt - Breast Ca

ML - 23y

P2L2

All LSCS

Tubectomy

LTO

CMP - Regular

PMC - 1 month

Breast - NAD

P/A - Soft

P/S - Mild Cervicitis

P/V - Mild Cervicitis

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Address	: hosur, , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Hypothyroid - 13 yrs

Tab. Thyronorm 75 mcg.

Ht - 153 cm
Wt - 69.3 kg
PR - 74 bpm
SPO2 - 98%
BP - 142/100

Investigations:

TSH - 12.8

Treatment / Care of Plan / Provisional Diagnosis :

℞

Repeat TSH / FT3 / FT4

1 Tab. Thyronorm 100 mcg.
Empty Stomach.
1 — 0 — 0.

Follow Up Advice : After 6 wks.

Signature of the Doctor

17-Feb-2024 AM9:14:28

ID:18562

Name:Mrs.Suguna Devi

46 years

lex:F Birth date:

cm kg / mmHg

ledication:

lymptoms:

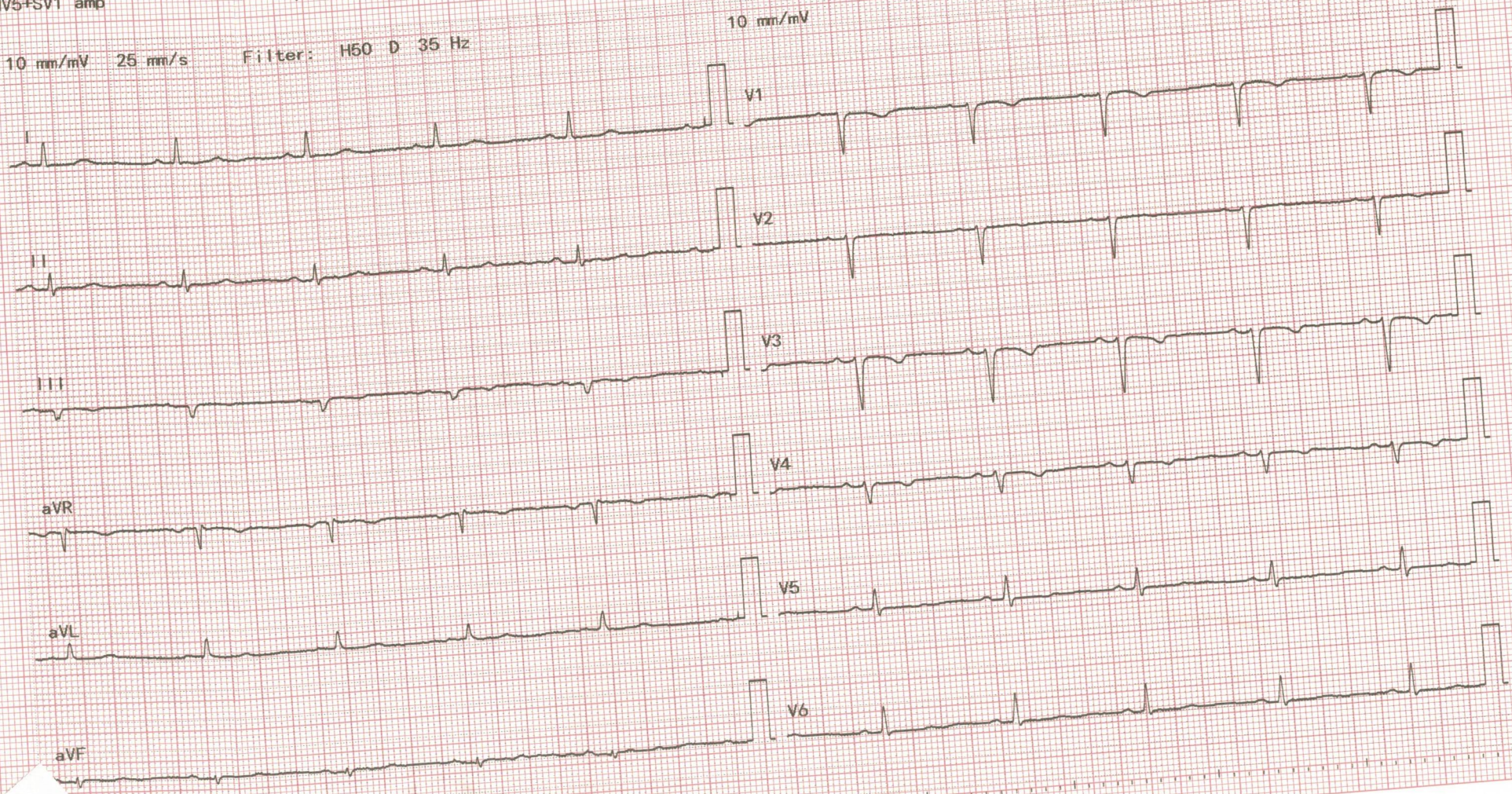
listory:

lent. rate	65	bpm
R int	162	ms
RS dur	74	ms
T/QTc(E) int	362/ 374	ms
/QRS/T axis	24/ -1/ 47	°
V5/SV1 amp	0.39/ 0.78	mV
V5+SV1 amp	1.17	mV

1100 Sinus rhythm
3114 Cannot rule out anterior myocardial infarction, age undetermined [R amp. (V4) < 0.2 mV]
8101 Low QRS voltage in limb leads [QRS deflection < 0.5 mV in limb leads]
9150 ** abnormal ECG **

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: H60 D 35 Hz



Exam:UNITED HOSPITAL

Patient name :	**Mrs. SUBRAMANIAN SUGUNA DEVI**	**Date :**	**17/02/24**
Age :	**46 years GENDER: FEMALE**	**Patient ID :**	**18562**
Ref by :	**DR. CMO**	**OP/ IP :**	**HEALTH CHECKUP**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.0 (2.5-3.7)	LVIDD : 3.9 (3.5-5.5)	MV EV : 86.3	AV : 72.1	MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 103		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 82.9		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 0.9 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.0 (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 PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

DEPARTMENT OF RADIODIAGNOSIS

Name	Subramanian Suguna Devi	**Date**	17/02/24
Age	46 years	**Hospital ID**	UHJA23018562
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

No focal solid / cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- **No significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Subramanian Suguna Devi	**Date**	17/02/24
Age	46 years	**Hospital ID**	UHJA23018562
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and ***shows mildly 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 evidence of mass or focal lesions.

Right Kidney is normal in size (9.3 x 4.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (10.2 x 4.3 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 atrophic, measures 7.0 x 2.3 x 4.6 cms. Endometrium measures 3.9 mm.
Both ovaries appear atrophic.

Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

- **Mild fatty infiltration of liver (Grade I).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Subramanian Suguna Devi	**Date**	17/02/24
Age	46 years	**Hospital ID**	UHJA23018562
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

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Care Par Excellence

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DEPARTMENT OF LABORATORY MEDICINE

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UHID	: UHJA23018562	Registered On	: 17/02/2024 08:28:49 AM
Age/Sex	: 46/Years Female	Collected On	: 17/02/2024 08:32:35 AM
Ward / Bed No	:	Reported On	: 17/02/2024 12:33:43 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022954
Station	: At Hospital	Mobile No	: 9488785168
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	96	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	87	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.6	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	114.01	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)	8.26	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	12.88	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	175	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	43	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	45.9	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	120.5	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	8.59	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.8		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.6		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	129.1	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	2.4	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.49	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.37	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.8	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.10	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.70	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.10		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	29	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	82	U/L	46-122
GGT (Method:IFCC)	82	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	20.1	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
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
BUN/CRE-RATIO (Method: Calculated)	15.5		12-20 : 1

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)	11.79	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	36.4	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4910	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	47.44	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	43.04	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.67	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.68	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.17	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.40	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.7	fL	78-100
MCH (Method: Calculated)	26.8	pg	27-31
MCHC (Method: Calculated)	32.4	g/dL	31-37
RDW - CV (Method: Calculated)	15.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.32	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)	7.63	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.0	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)	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	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.010		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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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/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
Parameshwar B

---End of Report---

Naveen.M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418