UNITED HOSPITAL
Care Par Excellence
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	Madava Saroja	**Date**	25/01/24
Age	53 years	**Hospital ID**	UHJA23016539
Sex	Female	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Mild cardiomegaly is seen.

The bony thorax is grossly normal.

Dr. Giridhar V S
Consultant Radiologist

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MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. MADAKA SAROJA	Order No	: 1000068644
UHID	: UHJA23016539	Registered On	: 26/01/2024 09:12:19 AM
Age/Sex	: 53/Years Female	Collected On	: 26/01/2024 09:16:56 AM
Ward / Bed No	:	Reported On	: 26/01/2024 01:39:12 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230020597
Station	: At Hospital	Mobile No	: 8015299714
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	**106**	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	**183**	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	**6.2**	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	**131.24**	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.88	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.42	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.23	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	**214**	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	71	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	50.7	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	**149.1**	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	14.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.22		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	**2.94**		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	**163.3**	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.4	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.71	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.13	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.58	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.7	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.31	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.39	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.27		2:1
SERUM SGOT (Method:IFCC without P5P)	32	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	24	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	109	U/L	46-122
GGT (Method:IFCC)	24	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	21.9	mg/dL	17-43

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)	0.62	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	16.12		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)	13.97	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5160	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	61.57	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	29.84	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.29	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.80	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.50	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.93	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	87.4	fL	78-100
MCH (Method: Calculated)	28.3	pg	27-31
MCHC (Method: Calculated)	32.4	g/dL	31-37
RDW - CV (Method: Calculated)	14.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.79	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)	**7.03**	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.3	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	**32**	mm/hour	1-30

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	O		
Rh Factor (Method:Agglutination Gel Method)	Negative		

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	5.5		5.0-8.0
SPECIFIC GRAVITY	1.005		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	4-6	/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)	Absent		

Verified By
PREETHI R

---End of Report---

Naveen.M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

ID:1[illegible]9

26-Jan-2024 AM10:19:29

Name:MRS MADAKA SAROJA

ex:F Birth date: 53 years

cm kg / mmHg

edication:

ymptoms:

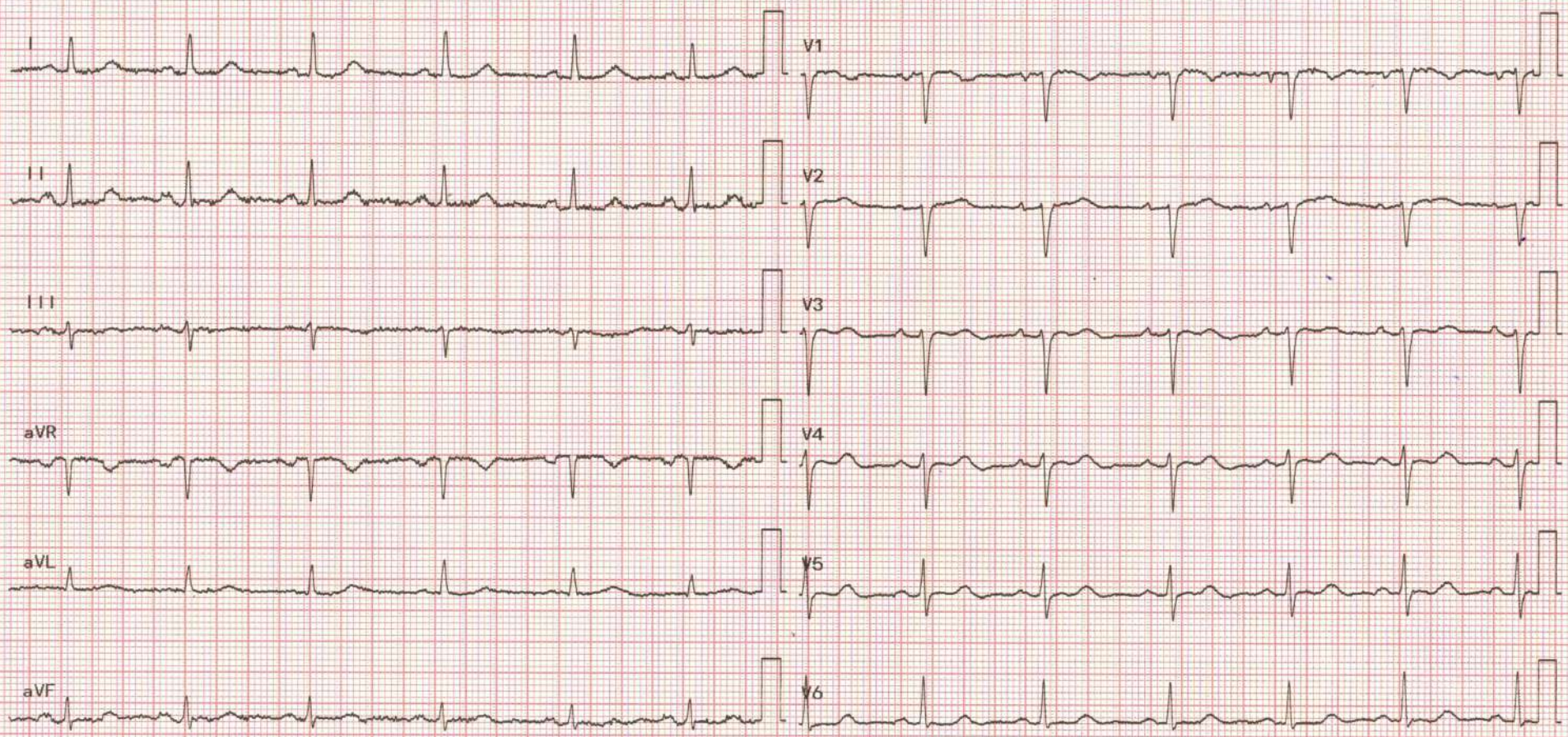
istory:

1100 Sinus rhythm
0102 ARTIFACT PRESENT
9110 ** normal ECG **

ent. rate	77	bpm
R int	166	ms
RS dur	80	ms
T/QTc(E) int	378/ 410	ms
/QRS/T axis	46/ 30/ 32	°
V5/SV1 amp	0.65/ 0.78	mV
V5+SV1 amp	1.43	mV

Unconfirmed Report
Reviewed by:

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



2350K 03-08 07-01 Dept.:

Exam:UNITED HOSPITAL

NABH NABL No.1

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DEPARTMENT OF RADIODIAGNOSIS

Patient name	Mrs. Madava Saroja	Patient ID	UHJA23016539
Age	53 years	Sex	Female
Referring doctor	Health check	Date	26/01/24

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and shows 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(10cms, PT -1.04cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size(10cms, PT-1.3cms), position, shape and echopattern. Corticomedullarydifferentiation 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.
Uterus is **atrophic.** Myometrial and endometrial echoes are normal. Endometrium measures 5 mm. Endometrial cavity is empty.
Both ovaries are atrophic.
There is no ascites or pleural effusion.
Appendix could not be localized, obscured by bowel gas. No mass / collection in RIF /LIF.

IMPRESSION:
Grade 1 fatty liver
No definite sonological abnormality detected.

Dr. GIRIDHAR V S
Consultant Radiologist