

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mrs. GEETHA.A	Order No : 1000092989
UHID : UHJ A24004415	Registered On : 10/08/2024 08:17:44 AM
Age/Sex : 41/Years Female	Collected On : 10/08/2024 08:31:01 AM
Ward / Bed No :	Reported On : 10/08/2024 01:43:40 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A240006161
Station : At Hospital	Mobile No : 9480434856
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	132	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	159	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	6.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	128	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.18	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	10.85	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	1.32	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)	217	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	174	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	52.6	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	129.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	34.79	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.1		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.4		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	164.4	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.7	mg/dL	2.6-6.0
LIVER FUNCTION TEST			
Sample: Serum			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.63	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.52	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.31	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.79	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.5		2:1
SERUM SGOT (Method:IFCC without P5P)	45	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	51	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	50	U/L	46-122
GGT (Method:IFCC)	17	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	18.9	mg/dL	17-43
BUN/CREATININE RATIO			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.63	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	14.0		12~20 : 1

Sample: Serum



Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	12.48	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	37.8	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7660	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	63.47	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	25.05	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.20	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.92	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.36	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.56	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.8	fL	78-100
MCH (Method: Calculated)	27.4	pg	27-31
MCHC (Method: Calculated)	33.0	g/dL	31-37
RDW - CV (Method: Calculated)	13.3	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.92	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) <small>(Method:Derived from PLT Histogram)</small>	7.54	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) <small>(Method: Calculated)</small>	19.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) <small>(Method:Modified Westergren Method)</small>	15	mm/hour	1-20
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group <small>(Method:Agglutination Method)</small>	A		
Rh Factor <small>(Method:Agglutination Method)</small>	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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


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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		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Dr Shobha Emmanuel

---End of Report---



Dr. Shobha Emmanuel
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NABH



NABL



No.1

(2)



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mrs.GEETHA.A

UHID : UHJA24004415

Age / Sex : 41 Years / Female

OP NO/Reg Dt : 10-08-2024 08:17 AM

Spouse / Father Name : .

Department : Ophthalm

Address : siddaya road, kr bank of baroda, ,
Bengaluru Urban, Karnataka, INDIA,

Referred By : Mediwheel

Consultant : Dr.Preventive Health Check Up

KMC No. : Dr. Sheneta

Complaints / Findings / Observations :

Investigations:

u } 6/12
6/18 } M.

DM - recently detected.

FSS - 102

Hg ov norm.

PPBS - 232

Treatment / Care of Plan / Provisional Diagnosis :

Fundus OU CD. 0.3:1
(addictal) FR (+)

Follow Up Advice :

Rf Ena.

RE: -1.00 X 140 6/6

LE: -0.75 DC X 40 6/6

Adv. Dilat fundus Examinat

Signature of the Doctor

Dr. Sheneta



NABH



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

Mrs. Geetha . A.

41 yrs / F.

Hyperpigmentation

Consult with Dermatologist

+ KOJIVIT Ultra
 1-0-0 x 1 month
 + Sunscreen
 (Neutrogena)


 10/8/24.



3



Out Patient Record

NABH

No.1

Patient Name : Mrs. GEETHA.A

UHID : UMJA24004415

Age / Sex : 41 Years / Female

OP NO/Reg Dt : 10-08-2024 08:17 AM

Spouse / Father Name : .

Department :

Address : siddaya road, kr bank of baroda, Bengaluru Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

No. No any current complains

BP - 138 / 90 mmHg

SpO₂ - 96 %

P - 80 bpm

Ht - 152 cm

wt - 65.1 kg

Investigations:

K/O - hypothyroidism on T. thyronorm 100mg.

- Allergic rhinitis not on Rx.

FBS / PPBS
132 / 159
HBA_{1c} : 6.1

Treatment / Care of Plan / Provisional Diagnosis :

Systemic Exam: Normal findings noted.

Follow Up Advice :

- Diet advised
- Review in OPD after 1 month.

Tab. METFORMIN 500mg.
1 - 0 - 1 (B/F)
x 1 month.

[Signature]
Signature of the Doctor
10/8/24.

Name: geetha a
 Birth date: /
 kg
 mmHg
 bpm
 ms
 ms
 ms
 ms
 mV
 mV

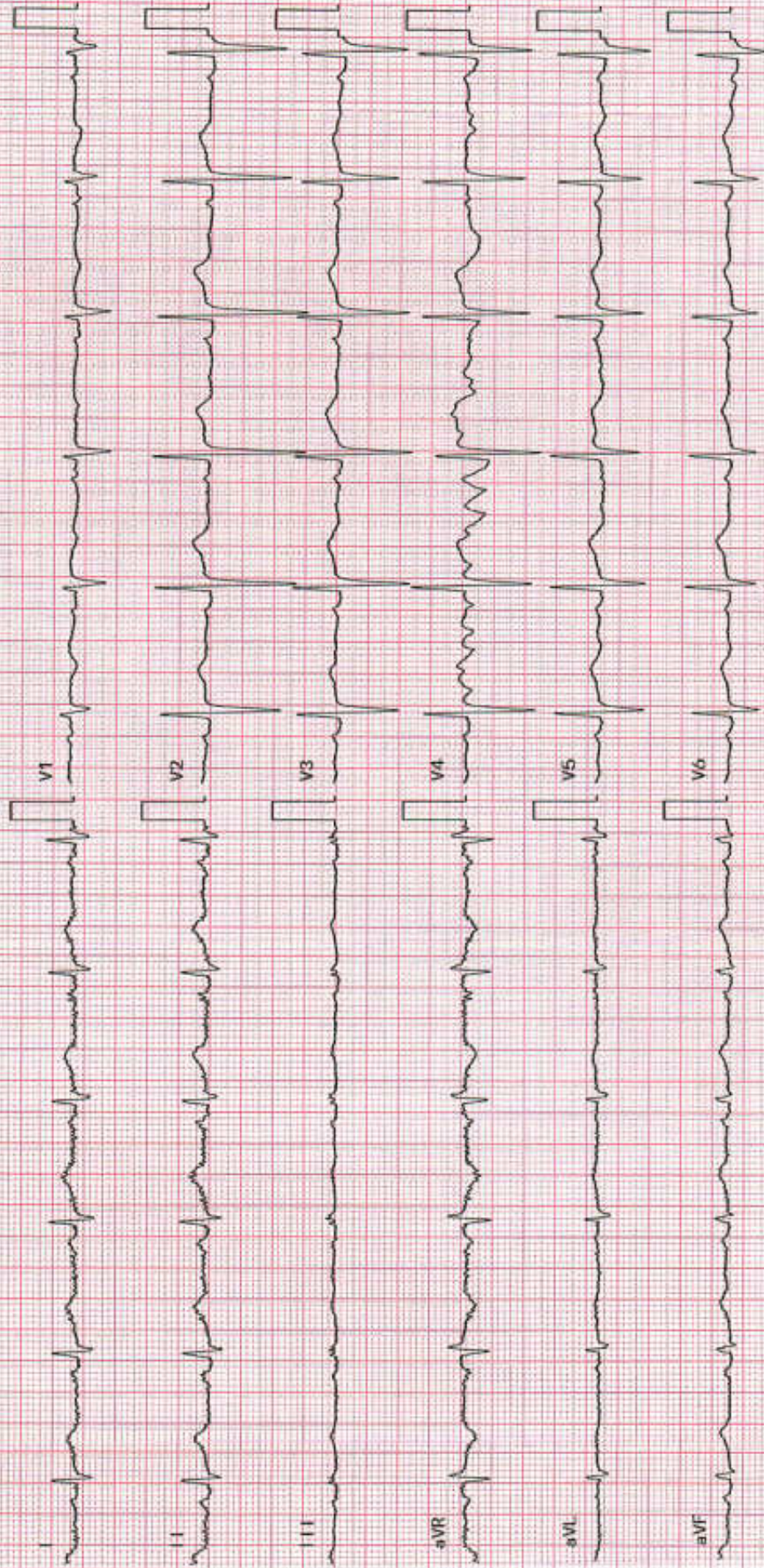
41 years
 1100
 9110
 Sinus rhythm
 normal ECG

Unconfirmed Report
 Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s





NABH



No.1

DEPARTMENT OF RADIO DIAGNOSIS

Care Par Excellence
Jayanagar, Bangalore

Name	Geetha A	Date	10/08/24
Age	41 years	Hospital ID	UHJA24004415
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVISFINDINGS:

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 (11.4 cms), shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (10.9 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (10.7 x 3.6 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 normal in size, measures 7.2 x 5.3 x 8.1 cms. Myometrial and endometrial echoes are normal. Endometrium measures 9 mm.

Right ovary is normal in size and echopattern, measures 2.7 x 2.2 cms.

Left ovary is normal in size and echopattern, measures 2.6 x 2.4 cms.

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. Manu Srinivas H, MD, RD
Consultant Radiologist



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No.1

PATIENT NAME :	Mrs. GEETHA A	DATE :	10/08/24
AGE :	41 YEARS GENDER : FEMALE	PATIENT ID :	24004415
REF BY :	CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY**M - MODE AND DOPPLER MEASUREMENTS**

(cm)	(cm)	(cm/sec)	
AO : 2.4 (2.5-3.7)	LVIDD : 4.6 (3.5-5.5)	MV EV : 0.7 AV : 0.4	MR : MILD MR
LA : 3.4 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 1.2	AR : MILD AR
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.9	PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ---- AV : ----	TR : MILD TR
TAPSE: 1.7 (>1.6)	LVPWD : 0.7 (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
 MILD MR, AR, TR, PASP- 35mmHg
 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	Geetha A	Date	10/08/24
Age	41 years	Hospital ID	UHJA24004415
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. Manu Srinivas H, MD, RD
Consultant Radiologist



DEPARTMENT OF RADIODIAGNOSIS

Name	Geetha A	Date	10/08/24
Age	41 years	Hospital ID	UHJA24004415
Sex	Female	Ref.	Health check

BILATERAL SONOMAMMOGRAPHY

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. Manu Srinivas H, MD, RD
Consultant Radiologist



3



Out Patient Record

NABH

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Department :

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Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. :

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SpO₂ - 96 %
P - 80 bpm
Hd - 152 cm
wt - 65.1 kg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL (A Unit of United Brothers Healthcare Services Private Limited)

United Hospital

No.110 (20), Madhavan Park Circle, 10th Main Rd

T: 080 4544 6666

E: appointments@unitedhospital.in