

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. PALLA UDAYA SRI	Order No	: 1000074399
UHID	: UHJ A23019025	Registered On	: 24/02/2024 09:56:05 AM
Age/Sex	: 31/Years Female	Collected On	: 24/02/2024 10:23:04 AM
Ward / Bed No	:	Reported On	: 24/02/2024 03:08:20 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230023523
Station	: At Hospital	Mobile No	: 9573256300
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	86	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	105	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105.40	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:C LIA)	0.99	ng/mL	0.87-1.78
TOTAL T4 (Method:C LIA)	8.67	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:C LIA: Ultra-sensitive)	4.23	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:C HOD-POD)	161	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	233	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	31.2	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	83.2	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	46.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.1		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.6		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	129.8	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.4	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.58	mg/dL	0.6-1.1
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.57	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.09	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.48	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.31	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.69	g/dL	2.3-3.5

Sample: Serum

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AG RATIO (Method: Calculated)	1.60		2:1
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	15	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	70	U/L	46-122
GGT (Method:IFCC)	12	U/L	< 38



Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	10.53	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	33.8	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7140	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	64.83	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	26.70	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.04	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.02	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.41	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.57	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	73.9	fL	78-100
MCH (Method: Calculated)	23.0	pg	27-31
MCHC (Method: Calculated)	31.2	g/dL	31-37
RDW - CV (Method: Calculated)	15.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.87	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.31	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	23.4	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	09	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)	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

PHYSICAL EXAMINATION

VOLUME	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		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

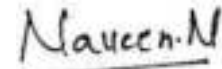
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EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---



Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

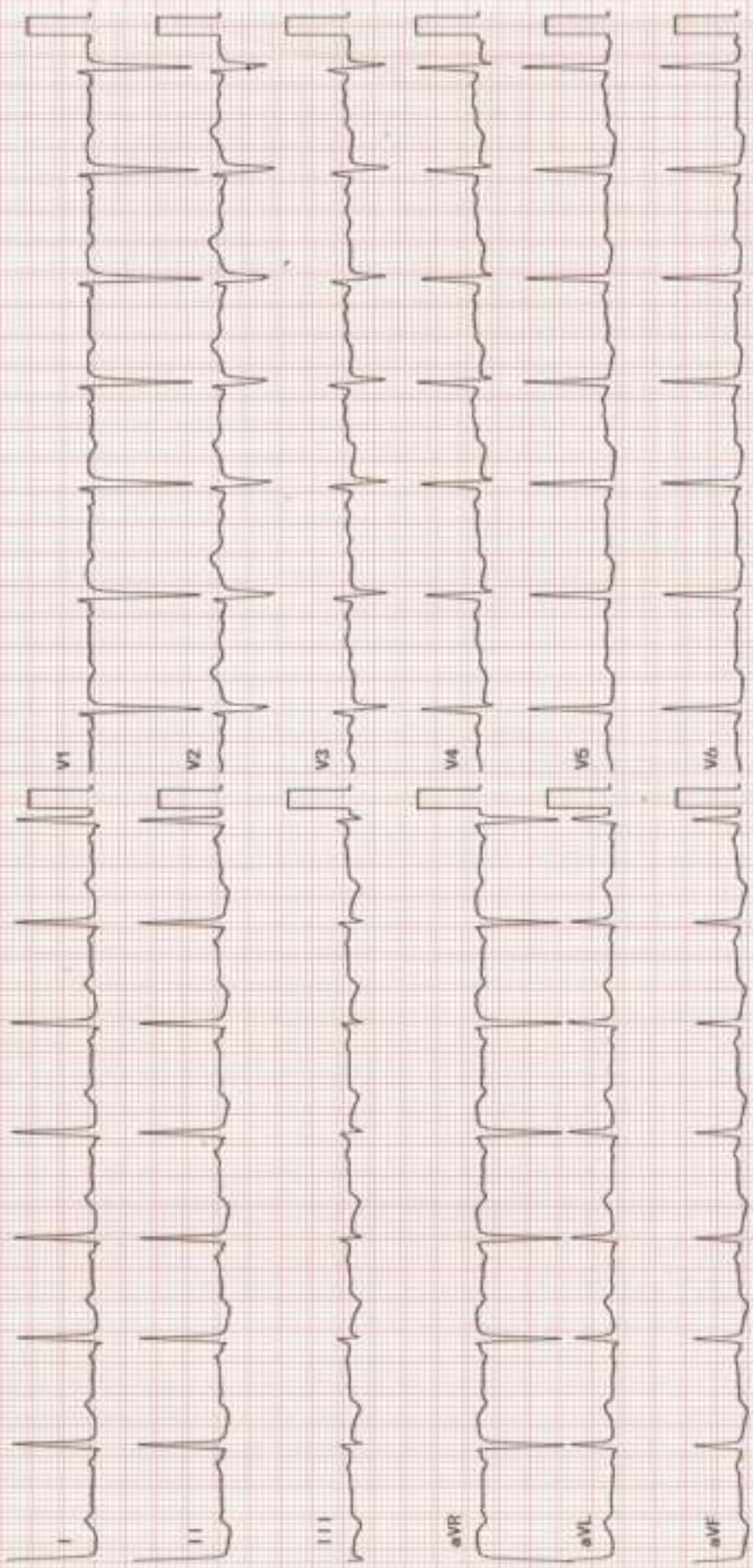
Name: Mr. s. Palla Udaya. Sr.
 Birth date: / /
 Sex: F
 cm kg
 Indication:
 Symptoms:
 History:
 Int. rate 87 bpm
 R int 126 ms
 PR dur 94 ms
 T/QTc(E) int 356/ 401 ms
 VQRS/T axis 44/ 34/ -66
 V5/SV1 amp 1.38/ 1.79 mV
 V5+SV1 amp 3.17 mV

31 years

1100 Sinus rhythm
 4012 Moderate ST depression [0.052 mV ST depression (II, V5)]
 4564 Two-lead abnormality, possible lateral ischemia [negative T (V4, V5, V6)]
 4664 Two-lead abnormality, possible inferior ischemia [negative T (II, aVF)]
 9150 ** abnormal ECG **

Unconfirmed Report
 Reviewed by:

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





NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs.PALLA UDAYA SRI	UHID	: UHJA23019025
Age / Sex	: 31 Years / Female	OP NO/Reg Dt	: 24-02-2024 09:56 AM
Spouse / Father Name	: KANDIKUNTA DILIP KUMAR	Department	: Health check
Address	: NO 86, GR FLR NISARGA 4TH PHASE KANNURAHALLI HOSKOTE, , Bengaluru	Referred By	: corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr.Vignesh

Complaints / Findings / Observations : ENT prescription

Investigations:

Ears,
Nose,
throat,
oralscavity } Normal.

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :


DR. VIGNESH J
 (BBS, DLO(MANIPAL), DNB(ENT), FRCR(MD,FRS))
 ENT, HEAD AND NECK CANCER SURGEON
 REG. NO: 92095

Signature of the Doctor



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 Age / Sex : 31 Years / Female OP NO/Reg Dt : 24-02-2024 09:56 AM
 Spouse / Father Name : KANDIKUNTA DILIP KUMAR Department :
 Address : NO 86, GR FLR NISARGA 4TH PHASE Referred By :
 KANNURAHALLI HOSKOTE, , Bengaluru Consultant : Dr.Preventive Health Check Up
 KMC No. :

Complaints / Findings / Observations :

for better chery.

wt - 72.
 HT - 158.
 Bp - 131/85
 SpO2 - 98
 PR - 92b/m

Investigations:

OP - 131/85
 PR - 92 ->

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

Treatment / Care of Plan / Provisional Diagnosis :

all hyp

no w/ any

Follow Up Advice :

no w/ any

no w/ any

p/s - by yoga lake
 Add
 Start case

MC - 2yo
 1/4
 P1 - can
 no w/ any.
 On Guide
 12/1/24
 ca, 12/1/24
 Signature of the Doctor
 Back: 1/4



NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore**Out Patient Record**

Patient Name : Mrs.PALLA UDAYA SRI UHID : UHJA23019025
 Age / Sex : 31 Years / Female OP NO/Reg Dt : 24-02-2024 09:56 AM
 Spouse / Father Name : KANDIKUNTA DILIP KUMAR Department :
 Address : NO 86, GR FLR NISARGA 4TH PHASE Referred By :
 KANNURAHALLI HOSKOTE, Bengaluru Consultant : Dr.Preventive Health Check Up
 KMC No. : Dr. Mohan

Complaints / Findings / Observations :S/S Dr. Mohan

Pt came for regular health check.

No known co-morbidities / no allergies.

Investigations:

No Hb premium sugars.

No fresh complaints.

Treatment / Care of Plan / Provisional Diagnosis :

Reports : CBC, RF, LFT - WNL

Lipid profile - TG - slightly raised.

ECh - normal sinus rhythm.

Follow Up Advice :Adv :- 1. Regular exercises / Balanced diet.

Signature of the Doctor

EXERCISE STRESS TEST REPORT

Patient Name: MRS. PALLA UDAYA SRI,
Patient ID: 19025
Height: 158 cm
Weight: 72 kg

DOB: 25.07.1992
Age: 31yrs
Gender: Female
Race: Indian

Study Date: 24.02.2024
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: DR. RAHUL PATIL
Attending Physician: DR. RAHUL PATIL
Technician: YAMINI/THABITHA

Medications:
--

Medical History:
NO H/O DM & HTN

Reason for Exercise Test:
Screening for CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:12	0.00	0.00	90	130/80	
	STANDING	00:21	0.00	0.00	83	130/80	
	HYPERV.	00:02	0.00	0.00	82	130/80	
	WARM-UP	00:20	0.00	0.00	86	130/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	146	130/80	
	STAGE 2	03:00	2.50	12.00	164	140/90	
	STAGE 3	02:07	3.40	14.00	179	150/100	
RECOVERY		05:47	0.00	0.00	105	150/100	

The patient exercised according to the BRUCE for 8:06 mins, achieving a work level of Max. METS: 10.10. The resting heart rate of 88 bpm rose to a maximal heart rate of 179 bpm. This value represents 94% of the maximal, age-predicted heart rate. The resting blood pressure of 130/80 mmHg, rose to a maximum blood pressure of 150/100 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP + appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions

GOOD EFFORT TOLERANCE
NORMAL HR AND BP RESPONSE
NO ANGINA OR ARRHYTHMIAS NOTED
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician

Technician

DEPARTMENT OF RADIODIAGNOSIS

Name	Palla Udaya Sri	Date	24/02/24
Age	31 years	Hospital ID	UHJA23019025
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and 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 (10.2 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (11.4 x 4.2 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 normal in size, measures 7.5 x 3.5 x 4.2 cms. Myometrial and endometrial echoes are normal. Endometrium measures 3.9 mm.

Right ovary is normal in size and echopattern, measures 5.1 cc.

Left ovary is normal in size and echopattern, measures 4.1 cc.

Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

- No definite sonological abnormality detected.



Dr. Elluru Santosh Kumar
Consultant Radiologist



NABH



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No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Palla Udaya Sri	Date	24/02/24
Age	31 years	Hospital ID	UHJA23019025
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