

## DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. KANDIKUNTA DILIP KUMAR	Order No : 1000074396
UHID : UHJ A23019024	Registered On : 24/02/2024 09:51:15 AM
Age/Sex : 34/Years Male	Collected On : 24/02/2024 10:14:59 AM
Ward / Bed No :	Reported On : 24/02/2024 01:59:11 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230023522
Station : At Hospital	Mobile No : 9066714196
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	91	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	112	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	5.2	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
<b>Estimated Average Glucose (eAG)</b> (Method: Calculated)	102.54	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method: CLIA)	1.07	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method: CLIA)	7.24	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method: CLIA: Ultra-sensitive)	1.27	μIU/mL	0.34-5.60
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method: CHOD-POD)	226	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method: Enzymatic GPO-POD)	101	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method: ENZYMATIC METHOD)	34.5	mg/dL	< 40 - Low ≥ 60 - High

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<b>LDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	171.3	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
<b>VLDL CHOLESTEROL</b> (Method: Calculated)	20.19	mg/dL	< 30
<b>TOTAL CHOLESTEROL : HDL RATIO</b> (Method: Calculated)	6.5		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
<b>LDL/HDL CHOLESTEROL RATIO</b> (Method: Calculated)	4.9		< 2.5 Optimal
<b>NON HDL CHOLESTEROL</b> (Method: Calculated)	191.5	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	6.6	mg/dL	3.5-7.2
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	0.83	mg/dL	0.9-1.3
<b>LIVER FUNCTION TEST</b>			Sample: Serum
<b>TOTAL BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.82	mg/dL	0.3-1.2
<b>DIRECT BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.13	mg/dL	0.0-0.2
<b>INDIRECT BILIRUBIN</b> (Method: Calculated)	0.69	mg/dL	0.2-1.0
<b>TOTAL PROTEIN</b> (Method:BIURET)	6.9	g/dL	6.6-8.3
<b>ALBUMIN</b> (Method:BCG)	4.49	g/dL	3.5-5.2
<b>GLOBULIN</b> (Method: Calculated)	2.41	g/dL	2.3-3.5
<b>AG RATIO</b> (Method: Calculated)	1.86		2:1

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SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	20	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	57	U/L	50-116
GGT (Method:IFCC)	20	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)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.93	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	48.1	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4790	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
NEUTROPHILS (Method:Optical/Impedance)	44.20	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	46.60	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.03	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.10	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.07	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.47	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	87.9	fL	78-100
MCH (Method: Calculated)	29.1	pg	27-31
MCHC (Method: Calculated)	33.1	g/dL	31-37
RDW - CV (Method: Calculated)	14.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.45	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.02	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.2	fl	9-19
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	11	mm/hour	1-15
<b>BLOOD GROUPING &amp; RH TYPING</b>			
Sample: Whole blood (EDTA)			
ABO Group (Method:Agglutination Gel Method )	AB		
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

## PHYSICAL EXAMINATION

VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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		
<b>URINE SUGAR, FASTING</b> (Method:GOD-POD)	Absent		
<b>URINE SUGAR (POST PRANDIAL)</b>	Absent		

Verified By  
NAGARATNA

---End of Report---

*Naveen M*

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





NABH



NABL



No.1

Care Par Excellence  
Jayanagar, Bangalore

Patient name :	Mr. KANDIKUMTA DILIP KUMAR	Date :	24/02/24
Age :	34 years GENDER: MALE	Patient ID :	19024
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

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

(c.m)	(c.m)	(cm/sec)		
AO : 2.2 (2.5-3.7)	LVIDD : 4.4 (3.5-5.5)	MV EV : 99.4	AV : 60.6	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 95.0		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 107		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ----	AV : ----	TR : TRIVIAL TR
TAPSE: 1.7 (>1.6)	LVPWD : 1.0 (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, TRIVIAL TR, PASP-15mmHg
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

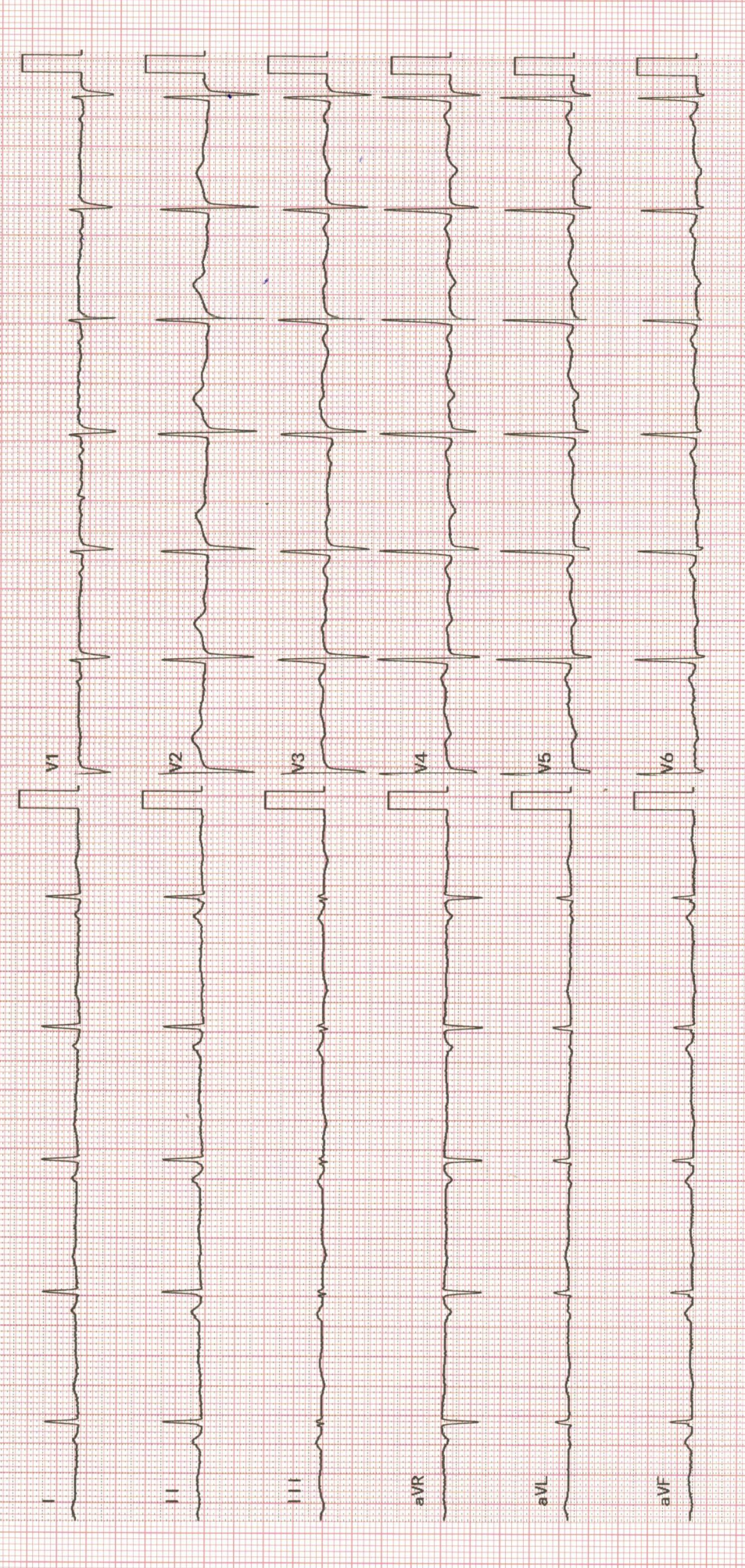


ID: 19024  
Name: Mr. Dilip Kumar K  
Birth date: /  
Sex: M  
Weight: kg  
Height: mmHg  
Age: 34 years

1100 Sinus rhythm  
4068 Nonspecific T wave abnormality, [flat T or negative T (I, II, V3, V4, V5, V6)]  
9130 \*\* borderline ECG \*\*

Unconfirmed Report  
Reviewed by:

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









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No.1



**UNITED HOSPITAL**

Care Par Excellence  
Jayanagar, Bangalore

**Out Patient Record**

Patient Name : Mr.KANDIKUNTA DILIP KUMAR

UHID : UHJA23019024

Age / Sex : 34 Years / Male

OP NO/Reg Dt : 24-02-2024 09:51 AM

Spouse / Father Name : K VISHWANATH

Department : *ophthology*

Address : NO 86, GR FLR NISARGA 4TH PHASE  
KANNURAHALLI HOSKOTE, , Bengaluru

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. : *Dr. Shukla*

**Complaints / Findings / Observations :**

*Un < 6/6 } 4.*

*nil systemic*

**Investigations:**

*MS (2)*

**Treatment / Care of Plan / Provisional Diagnosis :**

*Fundus (normal) OU CRT 0.3:1*

**Follow Up Advice :**

*OU only*

*[Signature]*  
Signature of the Doctor

**DEPARTMENT OF RADIODIAGNOSIS**

<b>Name</b>	Kandikunta Dilip Kumar	<b>Date</b>	24/02/24
<b>Age</b>	34 years	<b>Hospital ID</b>	UHJA23019024
<b>Sex</b>	Male	<b>Ref.</b>	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 focal lesion.

**Right Kidney** is normal in size (9.4 x 4.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

**Left Kidney** is normal in size (9.7 x 4.1 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 minimally distended.

**Prostate** is normal in echopattern and size, measures ~ 12.7 cc.

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





NABH



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No.1

**DEPARTMENT OF RADIODIAGNOSIS**

Name	Kandikunta Dilip Kumar	Date	24/02/24
Age	34 years	Hospital ID	UHJA23019024
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**