



NABH



No.1

Patient name :	Mr. N ARUN	Date :	09/11/24
Age :	46 Years Sex: MALE	UHID :	24007804
Ref by :	CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)	
AO : 3.1 (2.5-3.7)	LVIDD : 4.7 (3.5-5.5)	MV EV : 0.6 AV : 0.4	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.8 (2.4-4.2)	AV : 0.7	AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 0.9	PR : NORMAL
RV : 1.7 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ----- AV : -----	TR : TRIVIAL TR, PASP-27mmHg
TAPSE: 1.9 (>1.6)	LVPWD : 1.1 (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

IMPRESSION :

NORMAL CHAMBER DIMENSIONS
 NORMAL LV SYSTOLIC FUNCTION EF : 60%
 NORMAL LV DIASTOLIC FUNCTION
 NO PULMONARY ARTERY HYPERTENSION
 NO REGIONAL WALL MOTION ABNORMALITIES
 NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION


DR. RAHUL PATIL
 CONSULTANT CARDIOLOGIST

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. N ARUN	Order No : 1000102784
UHID : UHJA24007804	Registered On : 09/11/2024 09:51:45 AM
Age/Sex : 46/Years Male	Collected On : 09/11/2024 09:54:51 AM
Ward / Bed No :	Reported On : 09/11/2024 03:18:39 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJA240010533
Station : Corp	Mobile No : 9972541018
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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BIOCHEMISTRY

FASTING GLUCOSE (Method: Hexokinase)	90	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
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POST PRANDIAL GLUCOSE (Method: Hexokinase)	132	mg/dL	70-140
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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
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Estimated Average Glucose (eAG) (Method: Calculated)	105.55	mg/dL	
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THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH) Sample: Serum

TOTAL T3 (Method: CLIA)	1.21	ng/mL	0.87-1.78
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TOTAL T4 (Method: CLIA)	10.95	µg/dL	5.1-14.1
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THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	3.27	µIU/mL	0.34-5.60
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LIPID PROFILE Sample: Serum

TOTAL CHOLESTEROL (Method: CHOD-POD)	196	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
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TRIGLYCERIDES (Method: Enzymatic GPO-POD)	317	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
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HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	34.9	mg/dL	< 40 - Low ≥ 60 - High
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LDL CHOLESTEROL (Method: Calculated)	97.70	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	63.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.62		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.80		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	161.10	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.7	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.85	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	9.4		12–20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.61	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.13	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.48	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.8	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.42	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.38	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.86		2:1
SERUM SGOT (Method:IFCC without P5P)	28	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	32	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	69	U/L	50-116
GGT (Method:IFCC)	25	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.82	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	16.9	mg/dL	17-43
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Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.61	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	43.7	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5000	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	63.27	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	25.47	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.94	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.85	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.47	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.45	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	80.1	fL	78-100
MCH (Method: Calculated)	26.8	pg	27-31
MCHC (Method: Calculated)	33.4	g/dL	31-37
RDW - CV (Method: Calculated)	15.3	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.19	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.39	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	19.0	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	3160	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	200	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1270	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	340	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	14	mm/hour	1-15

BLOOD GROUPING & RH TYPING

ABO Group (Method:Agglutination Method)	O
Rh Factor (Method:Agglutination Method)	Positive

Interpretation Notes

Note: Both forward and reverse grouping performed

Sample: Whole blood (EDTA)

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CLINICAL PATHOLOGY

**URINE EXAMINATION, ROUTINE
PHYSICAL EXAMINATION**

Sample: Urine

VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.015		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	0-2	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	0-2	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

URINE SUGAR, FASTING Absent
(Method:GOD-POD)

Verified By
Rashmita

---End of Report---



Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567



Out Patient Record

Care Par Excellence
Jayanagar, Bangalore

NABH No.1	Patient Name	: Mr.N ARUN	UHID	: UHJA24007804
	Age / Sex	: 46 Years / Male	OP NO/Reg Dt	: 09-11-2024 09:51 AM
	Spouse / Father Name	: .	Department	:
	Address	: ., Bengaluru Urban, Karnataka, INDIA,	Referred By	:
			Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
			KMC No.	: 02M1087

Complaints / Findings / Observations :

HT - 176 cm
WT - 75.4 kg
BP - 130/90
PR - 96/100
SPO2 - 96%

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 (30), Madhavan Park Circle, 10th Main Rd,
3rd Block Jayanagar, Bangalore - 560 011

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E: appointments@unitedhospital.in



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	N Arun	Date	09/11/24
Age	46 years	Hospital ID	UHJA24007804
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is enlarged in size (15.3 cms) and shows mild 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 contracted. No obvious calculi are seen in the visualized portion of the lumen. Suggested review scan if any gallbladder pathology is suspected.

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 (9.8 x 3.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (9.6 x 4.6 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 distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 17 cc.

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

IMPRESSION:

- Mild hepatomegaly with mild fatty infiltration (Grade I).
- No other definite sonological abnormality detected.



Dr. Elluru Santosh Kumar
 Consultant Radiologist

UNITED HOSPITAL (A Unit of United Brothers HealthCare Pvt. Ltd.)



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	N Arun	Date	09/11/24
Age	46 years	Hospital ID	UHJA24007804
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

ID: Name: arun n Birth date: / month

Sex: M cm kg 46 years 1100 g 9110 ** normal ECG **

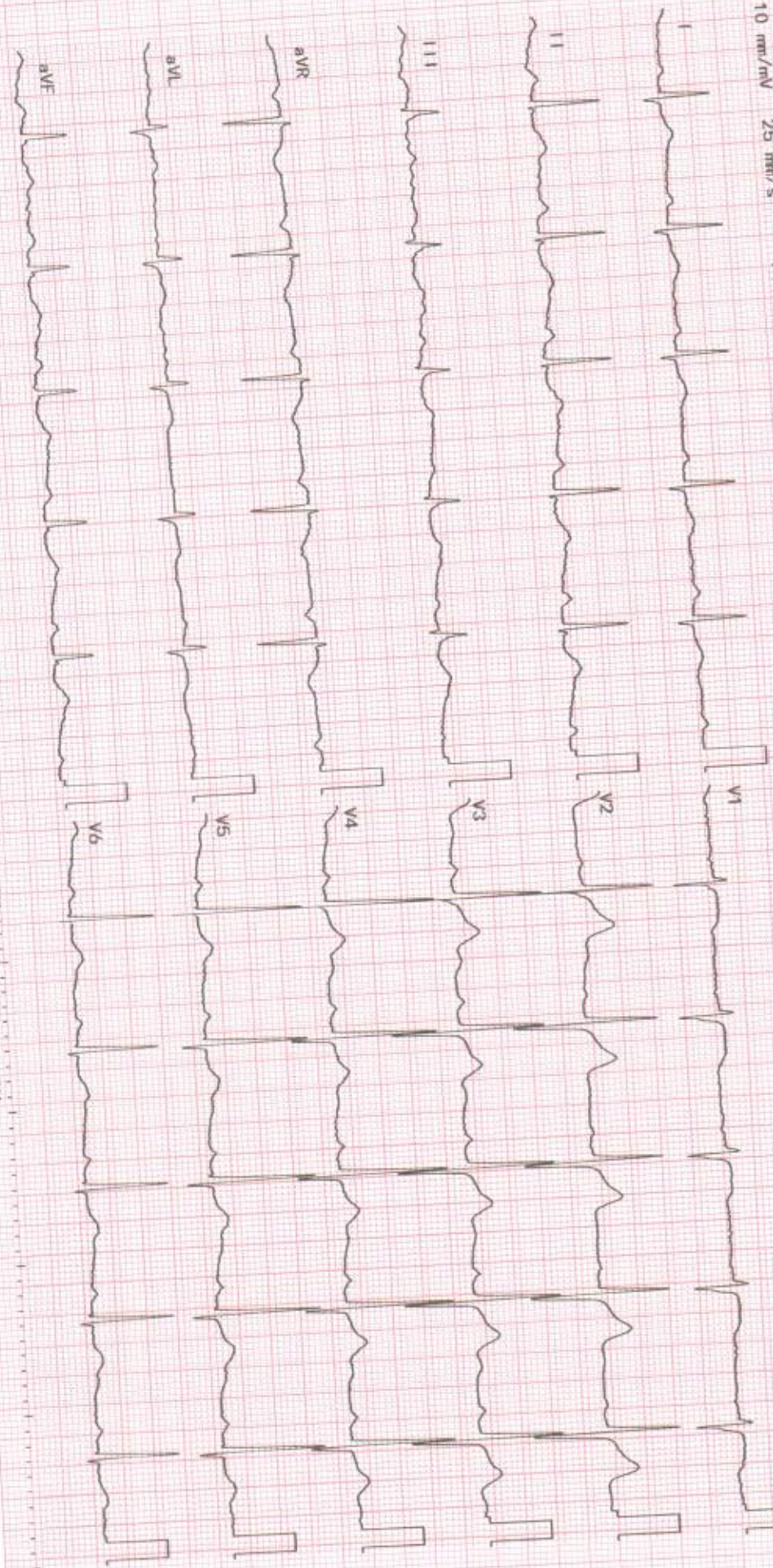
Medications: Symptoms: History: Heart rate 68 bpm

R int 196 ms RS dur 386/404 ms T/QTc(E) int 49/53/50 ms V/RS/T axis 1.83/0.73 mV V5+SV1 amp 2.56 mV

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

10 mm/mV

Unconfirmed Report Reviewed by:



2350K 03-08 07-01 Dept.:

Exam: UNITED HOSPITAL