UNITED HOSPITAL
Care Par Excellence

ilac-MRA

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SMITA GUPTA	Order No	: 1000072019
UHID	: UHJA23017955	Registered On	: 08/02/2024 08:38:21 AM
Age/Sex	: 48/Years Female	Collected On	: 08/02/2024 08:45:22 AM
Ward / Bed No	:	Reported On	: 08/02/2024 12:34:10 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022209
Station	: At Hospital	Mobile No	: 9769470610
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	112	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	137	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.8	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	119.75	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.27	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.37	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.51	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	180	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	83	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	49.8	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	113.6	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.6		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.2		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	130.2	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.3	mg/dL	2.6-6.0

LIVER FUNCTION TEST

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.55	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.44	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.34	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.95	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.46		2:1
SERUM SGOT (Method:IFCC without P5P)	33	U/L	< 35

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGPT (Method:IFCC without P5P)	25	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	58	U/L	46-122
GGT (Method:IFCC)	13	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	22.9	mg/dL	17-43

BUN/CREATININE RATIO

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	11	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.62	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	17.7		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)	11.27	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	35.5	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4510	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	64.80	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	26.54	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	0.95	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.50	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.21	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.60	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	77.1	fL	78-100
MCH (Method: Calculated)	24.5	pg	27-31
MCHC (Method: Calculated)	31.7	g/dL	31-37
RDW - CV (Method: Calculated)	16.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.33	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)	10.10	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	25.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	12	mm/hour	1-20

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

Test Name	Result
ABO Group (Method:Agglutination Gel Method)	O
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

DEPARTMENT OF LABORATORY MEDICINE

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Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.030		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)	Trace		Negative

MICROSCOPIC EXAMINATION

DEPARTMENT OF LABORATORY MEDICINE

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Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022209
Station	: At Hospital	Mobile No	: 9769470610
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	0-2	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
PRAVEEN T

---End of Report---

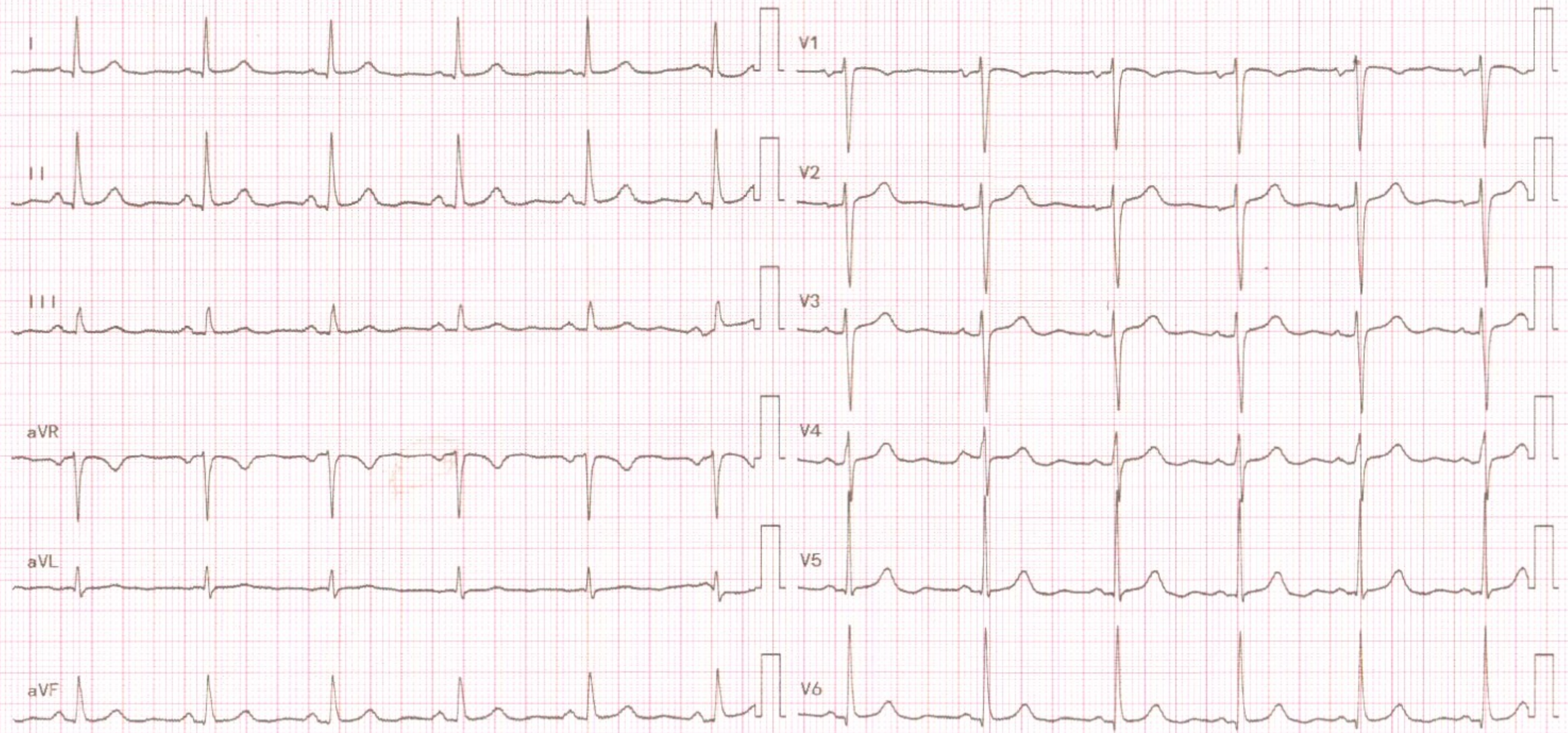
Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

ID: 8-Feb-2024 AM9:00:36

Name: Mrs.. Smita Gupta

lex:F	Birth date:	48 years	1100 Sinus rhythm
cm kg	/ mmHg		9110 ** normal ECG **
ledication:			
lymptoms:			
listory:			
lent. rate	72	bpm	
IR int	148	ms	
IRS dur	78	ms	
IT/QTc(E) int	366/ 390	ms	
I/QRS/T axis	72/ 46/ 51	°	
IV5/SV1 amp	1.84/ 1.42	mV	Unconfirmed Report
IV5+SV1 amp	3.26	mV	Reviewed by:

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



2350K 03-08 07-01 Dept.: Exam: UNITED HOSPITAL

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. SMITA GUPTA	Date :	08/02/24
Age :	48 years GENDER: FEMALE	Patient ID :	17955
Ref by :	DR.CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.0 (2.5-3.7)	LVIDD : 5.0 (3.5-5.5)	MV EV : 72.3	AV : 61.7	MR : NORMAL
LA : 3.4 (1.9-4.0)	LVIDS : 3.2 (2.4-4.2)	AV : 94.2		AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 78.5		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 0.8 (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

IMPRESSION :

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

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

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NABH

NABL

No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

8/4/24

Mrs Smitha Gupta 40y

Dr. Yoga Lakshmi SK
MBBS, MS O[illegible]
Consultant O[illegible] and
Gynecolog[illegible]py
and IVF [illegible]
KMC Reg. No. [illegible]384

for health checkup

PR 78 BP-160/80

SpO2 99

MC - 23y

Rx

All NVD

No h/o DM, HTN

c/o hypothyroid

No: Tubectomised

LMP - 29/12/23

No h/o any surgery

PMC -> Irregular

H/o ~~[illegible]~~ Ca in mother.

Uterus Ca

Breast -

P/A - Soft

P/S - Vagina

cervix [illegible]

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Surgery = take precaution-sign

Jayanagar, Bangalore

NABH NABL No.1

Out Patient Record

Patient Name	: Mrs.SMITA GUPTA	UHID	: UHJA23017955
Age / Sex	: 48 Years / Female	OP NO/Reg Dt	: 08-02-2024 08:38 AM
Spouse / Father Name	: .	Department	: Health Check
Address	: # Flat No 004,Ground Floor Krishna Gardenia Apartment BCM Layout	Refered By	: Mediwheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha

Complaints / Findings / Observations :

On Tab Thyronorm 50 mcg

Investigations: Vn (glass) 6/6, 6/6 } N. AS OU Normal.

Treatment / Care of Plan / Provisional Diagnosis : Fundus OU CD 0.4:1 (undilated) FR (+)

If: OU Ref Error

Follow Up Advice :

Continue same glass

Signature of the Doctor

8/2/24 Dr Shweta

Out Patient Record

Patient Name	: **Mrs.SMITA GUPTA**	**UHID**	: **UHJA23017955**
Age / Sex	: 48 Years / Female	OP NO/Reg Dt	: 08-02-2024 08:38 AM
Spouse / Father Name	: .	Department	: Health Check
Address	: # Flat No 004,Ground Floor Krishna Gardenia Apartment BCM Layout	Refered By	: Medіwheel
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Anulekha.

Complaints / Findings / Observations :

- Hypothyroidism
- ~~T. thyronorm~~ T. thyroxl 50 mcg / 100

SpO2 = 99%
PR = 78 b/m
Bp = 160/80 mm Hg
Ht = 155 cm
Wt - 62 kg

Investigations:

Grade I fatty liver

BP < 130/80

Adv ~~[illegible]~~ salt restricted food.

Treatment / Care of Plan / Provisional Diagnosis :

- Low fat diet, walking - ½ hour.

1. Tab NEXPRO - RD 40 1-0-0 (BF) x 10d
2. Tab GEMCAL - XT 0-1-0 x 2 months (A/F)

Follow Up Advice :

3. Tab SEDER OM 0-0-1 x 1 month (A/F)

(RA - Factor) - Blood test

Sonomammography after 6 months

Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Smita Gupta	**Date**	08/02/24
Age	48 years	**Hospital ID**	UHJA23017955
Sex	Female	**Ref.**	Health check

SONOMAMMOGRAPHY OF BILATERAL BREASTS

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.

Heterogeneous background echotexture is seen in both breasts.

There is tiny hypoechoic lesion measuring 3.4 mm in right breast at 9 o'clock position, approximately 5-6 cms from the nipple. There is no internal calcifications / posterior acoustic shadowing.

No focal cystic lesions seen.

Ducts appear normal.

No significant lymphnodes noted in bilateral axilla. ***Thickened right axillary fat pad.***

IMPRESSION:

- **Tiny hypoechoic lesion in right breast at 9 o'clock position as mentioned above. BIRADS 3 – probably benign.** *Suggested followup scan in 3-6 months.*
- **Thickened right axillary fat pad.**
- **No other significant abnormality detected in this study.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Smita Gupta	Date	08/02/24
Age	48 years	Hospital ID	UHJA23017955
Sex	Female	Ref.	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 evidence of mass or focal lesions.

Right Kidney is normal in size (9.3 x 3.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (9.8 x 4.1 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 atrophic, measures 6.4 x 2.3 x 4.2 cms. Endometrium measures 5 mm.
Both ovaries are atrophic.

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. Elluru Santosh Kumar
Consultant Radiologist

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DEPARTMENT OF RADIODIAGNOSIS

Name	Smita Gupta	**Date**	08/02/24
Age	48 years	**Hospital ID**	UHJA23017955
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

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