UNITED HOSPITAL
Care Par Excellence
A Unit of United Brotherss Healthcare Services Private Limited
No. 110 (30), Madhavan Park Circle, 10th Main Road, 3rd Block, Jayanagar, Bangalore – 560011. T: 080 4566 6666/ 080 6933 3333 E: info@unitedhospital.in

DEPARTMENT OF RADIODIAGNOSIS

Name	Sandinti Yamuna	**Date**	10/02/24
Age	30 years	**Hospital ID**	UHJA23018092
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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Disclaimer for Radiology Scans and Procedures :

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2) Radiology results are affected by patient body habitus, food consumption, bowel contents, hydration status, foreign bodies and artifacts.

3) Small renal/ureteric stones, some of the pathologies of bowel, peritoneum and retroperitoneum may not be detected on ultrasound study.

4) Antenatal ultrasound: Maternal body variables, gestational age, fetal position at the time of the scan affects the scanning. Patient should come for review scan if and when recommended. Chromosomal anomalies cannot be diagnosed on ultrasound only. If ultrasound markers indicate high risk for chromosomal anomalies, further evaluation including karyotyping may be needed.

5) Duplicate reports can be provided only upto 30 days from the date of scan/procedure.

6) X-ray is a screening modality and not a diagnostic test. It should be correlated clinically and complemented by other requisite imaging modalities and lab tests. X-ray cannot detect soft tissue injuries (like tendon/ ligament injuries) and small renal/ ureteric stones.

7) All disputes relating to the reports are subject to jurisdiction of courts at Bengaluru city only.

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DEPARTMENT OF RADIODIAGNOSIS

Name	Sandinti Yamuna	**Date**	10/02/24
Age	30 years	**Hospital ID**	UHJA23018092
Sex	Female	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is enlarged in size (15.6 cms) and shows moderately 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 (11.2 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.
Left Kidney is normal in size (11.2 x 4.5 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 7.8 x 2.3 x 5.2 cms. Myometrial and endometrial echoes are normal. Endometrium measures 3.0 mm.
Right ovary is normal in size and echopattern, measures 1.3 cc.
Left ovary is normal in size and echopattern, measures 1.8 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:

Mild hepatomegaly with moderate fatty infiltration (Grade II).
No other definite sonological abnormality detected.

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Consultant Radiologist

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Patient name :	**Mrs. SANDINTI YAMUNA**	**Date :**	**10/02/24**
Age :	**30 years GENDER: FEMALE**	**Patient ID :**	**18092**
Ref by :	**DR.CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.7 (2.5-3.7)	LVIDD : 3.9 (3.5-5.5)	MV EV : 76.3	AV : 84.7	MR : NORMAL
LA : 3.4 (1.9-4.0)	LVIDS : 3.2 (2.4-4.2)	AV : 100		AR : NORMAL
RA :2.4 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 97.5		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.9 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (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 :

TACHYCARDIA OBSERVED DURING THE STUDY (HR-132bpm)
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

UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SANDINTI YAMUNA	Order No	: 1000072370
UHID	: UHJA23018092 \	Registered On	: 10/02/2024 09:16:31 AM
Age/Sex	: 30/Years Female	Collected On	: 10/02/2024 03:41:16 PM
Ward / Bed No	:	Reported On	: 12/02/2024 12:52:53 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022380
Station	: At Hospital	Mobile No	: 8088851814
Payer Name	: Mediwheel	Report Status	: Final Report

Samples

CERVICAL SMEAR - 10/02/2024 03:41 PM

Test Name :PAP SMEAR

NUMBER OF SLIDES RECEIVED: 02
TYPE OF THE SMEAR: Conventional
SOURCE OF THE SMEAR: Ecto and endocervix
CLINICAL DETAILS: P1L1A1
L M P: 6days back

SPECIMEN ADEQUACY:
Satisfactory for evaluation.
Transformation zone/ Endocervical cell component is absent.

MICROSCOPY:
Smears show predominantly superficial and intermediate squamous cells.Occasional endometrial cell cluster is present.
Background shows moderate neutrophilic infiltrate.
No trichomonads, candida, other parasites or non-specific microorganisms are present.

IMPRESSION: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY (NILM)

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SANDINTI YAMUNA	Order No	: 1000072367
UHID	: UHJA23018092	Registered On	: 10/02/2024 09:16:32 AM
Age/Sex	: 30/Years Female	Collected On	: 10/02/2024 09:34:24 AM
Ward / Bed No	:	Reported On	: 10/02/2024 02:11:48 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022380
Station	: At Hospital	Mobile No	: 8088851814
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	124	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	162	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	6.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	134.11	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.50	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	12.98	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.05	ı IU/mL	0.34 - 5.60 ı IU/mL (Non Pregnant) 0.3 - 4.5 ı IU/mL (I trimester) 0.5 - 5.2 ı IU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	185	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	178	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	38.2	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	111.2	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	35.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.8		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.9		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	146.8	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.1	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	11	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.59	mg/dL	0.6-1.1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.61	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.50	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	8.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.66	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.33	g/dL	2.3-3.5

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Test Name	Result	Unit	Bio. Ref. Interval
AG RATIO (Method: Calculated)	1.39		2:1
SERUM SGOT (Method:IFCC without P5P)	43	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	38	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	91	U/L	44-107
GGT (Method:IFCC)	29	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)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	13.70	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	42.2	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9210	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	69.49	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	24.76	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	0.62	%	0-6
MONOCYTES (Method:Optical/Impedance)	4.93	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.20	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.09	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	82.9	fL	78-100
MCH (Method: Calculated)	26.9	pg	27-31
MCHC (Method: Calculated)	32.5	g/dL	31-37
RDW - CV (Method: Calculated)	13.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	4.20	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)	7.58	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.7	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	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)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed

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Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

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CLINICAL PATHOLOGY

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
PREETHI R

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418