NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

# Out Patient Record

| | | | |
|---|---|---|---|
| **Patient Name** | : **Mr.HANUMANTHARAYAPPA R** | **UHID** | : **UHJA23018480** |
| Age / Sex | : 53 Years / Male | OP NO/Reg Dt | : 16-02-2024 08:17 AM |
| Spouse / Father Name | : RANGAPPA | Department | : |
| Address | : Yellapura, BANGALORE CITY H O, Bengaluru Urban, Karnataka, INDIA, 560002 | Refered By | : S/B Dr RP. |
| | | Consultant | : Dr.Preventive Health Check Up |
| | | KMC No. | : |

**Complaints / Findings / Observations :**

Ht - 177cm
Wt - 81.8kg
BP - 127/68
PR - 68b/m
SPO2 - 98%

Consult

**Investigations:** Dr. NIRANJAN

Gen surgery.

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

**Follow Up Advice :**

**Signature of the Doctor**

## DEPARTMENT OF LABORATORY MEDICINE

| | | | |
|---|---|---|---|
| Patient Name | : Mr. HANUMANTHARAYAPPA R | Order No | : 1000073232 |
| UHID | : UHJA23018480 | Registered On | : 16/02/2024 08:17:48 AM |
| Age/Sex | : 53/Years Male | Collected On | : 16/02/2024 08:25:05 AM |
| Ward / Bed No | : | Reported On | : 16/02/2024 02:30:24 PM |
| Reference | : Dr. Preventive Health Check Up | Bill No | : OPBJA230022861 |
| Station | : At Hospital | Mobile No | : 9349147566 |
| Payer Name | : Mediwheel | Report Status | : Final Report |

| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| **BIOCHEMISTRY** | | | |
| **FASTING GLUCOSE**<br>(Method: Hexokinase) | 107 | mg/dL | ADA Guidelines<br>< 100 mg/dl - Normal<br>100 to 125 mg/dl - Prediabetes<br>≥ 126 mg/dl - Diabetes |
| **POST PRANDIAL GLUCOSE**<br>(Method: Hexokinase) | 116 | mg/dL | 70-140 |
| **GLYCOSYLATED HAEMOGLOBIN (HBA1C)** | | | Sample: Whole blood (EDTA) |
| HBAIC<br>(Method: HPLC) | 4.9 | % | ADA Guidelines<br>< 5.7% - Normal<br>5.7 to 6.4% - Prediabetes<br>≥ 6.5% - Diabetes |
| Estimated Average Glucose (eAG)<br>(Method: Calculated) | 93.92 | mg/dL | |
| **THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)** | | | Sample: Serum |
| TOTAL T3<br>(Method:CLIA) | 1.22 | ng/mL | 0.87-1.78 |
| TOTAL T4<br>(Method:CLIA) | 7.22 | ≂g/dL | 5.1-14.1 |
| THYROID STIMULATING HORMONE (TSH)<br>(Method:CLIA: Ultra-sensitive) | 4.11 | ı IU/mL | 0.34-5.60 |
| **LIPID PROFILE** | | | Sample: Serum |
| TOTAL CHOLESTEROL<br>(Method:CHOD-POD) | 133 | mg/dL | ATP III Guidelines<br>< 200 - Desirable<br>200-239 - Borderline high<br>≥ 240 - High |
| TRIGLYCERIDES<br>(Method:Enzymatic GPO-POD) | 61 | mg/dL | < 150 - Normal<br>150-199 - Borderline High<br>200-499 - High<br>≥ 500 - Very High |
| HDL CHOLESTEROL<br>(Method:ENZYMATIC METHOD) | 31.5 | mg/dL | < 40 - Low<br>≥ 60 - High |

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|---|---|---|---|
| LDL CHOLESTEROL<br>(Method:ENZYMATIC METHOD) | 89.3 | mg/dL | <100 - Optimal<br>100-129 - Near or above optimal<br>130-159 - Borderline high<br>160-189 - High<br>≥190 - Very high |
| VLDL CHOLESTEROL<br>(Method: Calculated) | 12.19 | mg/dL | < 30 |
| TOTAL CHOLESTEROL : HDL RATIO<br>(Method: Calculated) | 4.2 | | Low Risk: 3.3 - 4.4<br>Average Risk: 4.5 - 7.1<br>Moderate Risk: 7.2 - 11.0 |
| LDL/HDL CHOLESTEROL RATIO<br>(Method: Calculated) | 2.8 | | < 2.5 Optimal |
| NON HDL CHOLESTEROL<br>(Method: Calculated) | 101.5 | mg/dL | < 130 |
| **URIC ACID**<br>(Method:Uricase - POD(Enzymatic)) | 5.9 | mg/dL | 3.5-7.2 |

### BUN/CREATININE RATIO

Sample: Serum

| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| BLOOD UREA NITROGEN(BUN)<br>(Method:Urease GLDH - Kinetic) | 13 | mg/dL | 7.93-20.07 |
| CREATININE<br>(Method:Modified Jaffe, Kinetic) | 1.10 | mg/dL | 0.9-1.3 |
| BUN/CRE-RATIO<br>(Method: Calculated) | 11.8 | | 12⁻20 : 1 |

### LIVER FUNCTION TEST

Sample: Serum

| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| TOTAL BILIRUBIN<br>(Method:Dichlorophenyl Diazotization) | 0.72 | mg/dL | 0.3-1.2 |
| DIRECT BILIRUBIN<br>(Method:Dichlorophenyl Diazotization) | 0.17 | mg/dL | 0.0-0.2 |
| INDIRECT BILIRUBIN<br>(Method: Calculated) | 0.55 | mg/dL | 0.2-1.0 |
| TOTAL PROTEIN<br>(Method:BIURET) | 7.3 | g/dL | 6.6-8.3 |

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| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| ALBUMIN<br>(Method:BCG) | 4.25 | g/dL | 3.5-5.2 |
| GLOBULIN<br>(Method: Calculated) | 3.04 | g/dL | 2.3-3.5 |
| AG RATIO<br>(Method: Calculated) | 1.39 | | 2:1 |
| SERUM SGOT<br>(Method:IFCC without P5P) | 24 | U/L | < 50 |
| SERUM SGPT<br>(Method:IFCC without P5P) | 23 | U/L | < 50 |
| ALKALINE PHOSPHATASE, SERUM<br>(Method:PNPP AMP Buffer) | 84 | U/L | 50-116 |
| GGT<br>(Method:IFCC) | 10 | U/L | < 55 |
| **PROSTATE SPECIFIC ANTIGEN (PSA)**<br>(Method:CLIA) | 0.58 | 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.

| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| **UREA**<br>(Method:Urease GLDH - Kinetic) | 28.6 | mg/dL | 17-43 |

**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<br>(Method:Photometric Measurement: Oxyhemoglobin method) | 13.63 | g/dL | 13.5-17.5 |
| PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)<br>(Method: Calculated) | 40.7 | % | 42-52 |
| TOTAL WBC COUNT (TLC)<br>(Method:Coulter Principle) | 3790 | Cells/Cum | 4000-11000 |
| DIFFERENTIAL COUNT | | | |
| NEUTROPHILS<br>(Method:Optical/Impedance) | 60.43 | % | 40-75 |
| LYMPHOCYTES<br>(Method:Optical/Impedance) | 22.99 | % | 20-45 |
| EOSINOPHILS<br>(Method:Optical/Impedance) | 6.34 | % | 0-6 |
| MONOCYTES<br>(Method:Optical/Impedance) | 9.94 | % | 2-10 |
| BASOPHILS<br>(Method:Optical/Impedance) | 0.30 | % | 0-2 |
| RED BLOOD CORPUSCLES(RBC)<br>(Method:Coulter Principle) | 4.45 | million/cum | 4.5-5.9 |
| MCV<br>(Method:Derived from RBC Histogram) | 91.5 | fL | 78-100 |
| MCH<br>(Method: Calculated) | 30.6 | pg | 27-31 |
| MCHC<br>(Method: Calculated) | 33.5 | g/dL | 31-37 |
| RDW - CV<br>(Method: Calculated) | 13.4 | % | 11.5-14.5 |
| PLATELET COUNT<br>(Method:Electrical Impedance) | 1.85 | Lakhs/Cum | 1.5-4.5 |

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|---|---|---|---|
| MEAN PLATELET VOLUME(MPV)<br>(Method:Derived from PLT Histogram) | 8.09 | fl | 9-13 |
| PLATELET DISTRIBUTION WIDTH (PDW)<br>(Method: Calculated) | 16.7 | fl | 9-19 |
| **ERYTHROCYTE SEDIMENTATION RATE(ESR)**<br>(Method:Modified Westergren Method) | 15 | mm/hour | 1-20 |

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| ABO Group<br>(Method:Agglutination Gel Method ) | B | | |
| Rh Factor<br>(Method:Agglutination Gel Method ) | Positive | | |

<u>Interpretation Notes</u>

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

| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| PHYSICAL EXAMINATION | | | |
| VOLUME | 15 | 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 | | | |

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| Test Name | Result | Unit | Bio. Ref. Interval |
|---|---|---|---|
| EPITHELIAL CELLS | 2-4 | /HPF | 0-5 |
| PUS CELLS | 0-2 | /HPF | 0-5 |
| RBCs | 4-6 | /HPF | 0-2 |
| CASTS | Nil | /LPF | |
| CRYSTALS | Nil | | |
| OTHERS | Nil | | |
| **URINE SUGAR, FASTING**<br>(Method:GOD-POD) | Absent | | |

Verified By
Rashmita

---End of Report---

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

E:
E: 2024/02/16 15:13
3658
AROPS CRK-1
00.10A

EF] VD: 0.00
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| | SPH | CYL | AX |
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| > | +0.75 | -0.25 | 160 |
| VG: | +0.75 | -0.25 | 160 |
| E: | +0.63 | | |

| | SPH | CYL | AX |
|---|---|---|---|
| L> | +1.50 | -0.75 | 169 |
| VG: | +1.50 | -0.75 | 169 |
| E: | +1.13 | | |

D: 64mm

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| ears / Male | | OP NO/Reg Dt | : 16-02-2024 08:17 AM |
| GAPPA | | Department | : Opthal |
| | | Refered By | : |
| oura, BANGALORE CITY H O, luru Urban, Karnataka, INDIA, 560002 | | Consultant | : Dr.Preventive Health Check Up |
| | | KMC No. | : |

ervations :

Nil sythic.

**Investigations:**

Vn < 6/6, 6/6 } n6.

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

Ns ov Normal.

**Follow Up Advice :**

- Z/f. ov. chilly nil

Signature of the Doctor
Dr Shwetha

ID: 18480

16-Feb-2024 AM9:45:02

Name: hanumanthrayappa

lex: M    Birth date:    53 years

cm    kg    /    mmHg

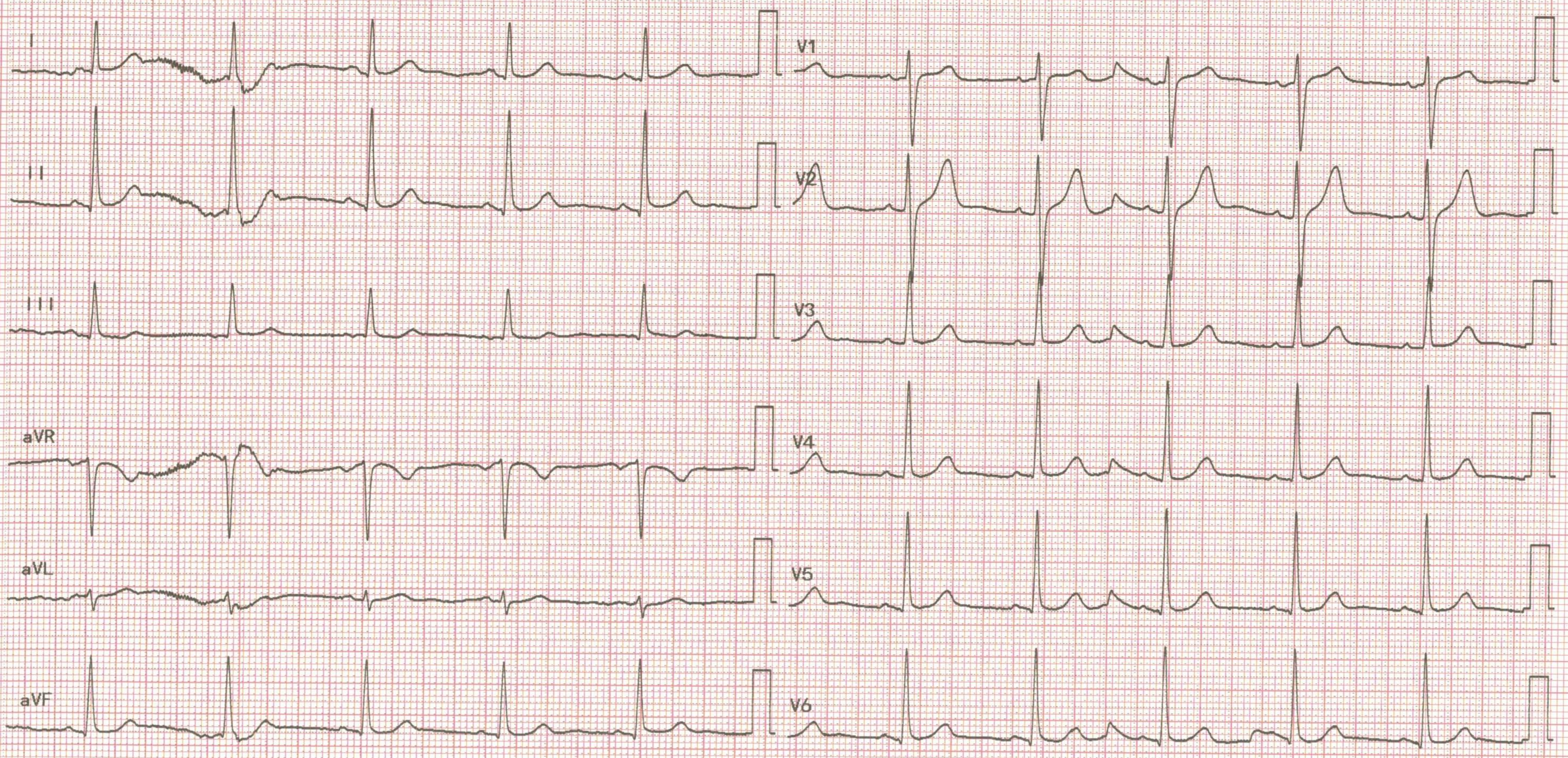
ledication:
lymptoms:
listory:

| | | |
|---|---|---|
| lent. rate | 69 | bpm |
| R int | 132 | ms |
| RS dur | 92 | ms |
| T/QTc(E) int | 376/ 395 | ms |
| /QRS/T axis | 26/ 58/ 44 | ° |
| V5/SV1 amp | 1.73/ 1.11 | mV |
| V5+SV1 amp | 2.84 | mV |

1100 Sinus rhythm
9110 ** normal ECG **

Unconfirmed Report
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

SCHILLER
Part No.2.157017M  CE 0123
M.BD

## DEPARTMENT OF RADIODIAGNOSIS

| Name | Hanumantharayappa R | Date | 16/02/24 |
|---|---|---|---|
| Age | 53 years | Hospital ID | UHJA23018480 |
| Sex | Male | 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 contracted. No obvious calculi are seen in the visualized portion of theh 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 (10.7 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
**Left Kidney** is normal in size (11.6 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis. *Prominent extra renal pelvis is seen, measures 1.4 cms in AP dimension.*

**Retroperitoneum** - Obscured by bowel gas.

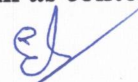
**Urinary Bladder** is distended, normal in contour and wall thickness. No evidence of calculi, mass or mural lesion.

**Prostate** is normal in echopattern and size, measures ~ 18.9 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.
***Umbilical defect measuring 2.8 x 1.3 cms is seen with herniation of omentum. The hernial contents are partially reducible with probe pressure. Bilateral small reducible indirect ingunial hernias are seen with omentum as contents.***

**IMPRESSION:** *Suboptimal evaluation due to poor acoustic window from thick body habitus.*

- **Mild fatty infiltration of liver (Grade I).**
- **Small umbilical and bilateral indirect ingunial hernias with omentum as contents as mentioned above.**



**Dr. Elluru Santosh Kumar**
**Consultant Radiologist**

UNITED HOSPITAL
*Care Par Excellence*
Jayanagar, Bangalore

## DEPARTMENT OF RADIODIAGNOSIS

| **Name** | Hanumantharayappa R | **Date** | 16/02/24 |
|---|---|---|---|
| **Age** | 53 years | **Hospital ID** | UHJA23018480 |
| **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**

| Patient name : | Mr. HANUMANTHARAYAPPA R | Date : | 16/02/24 |
|---|---|---|---|
| Age : | 53 years GENDER: MALE | Patient ID : | 18480 |
| Ref by : | DR. CMO | OP/ IP : | HEALTH CHECKUP |

# 2D- ECHOCARDIOGRAPHY

## M – MODE AND DOPPLER MEASUREMENTS

| (c.m) | (c.m) | (cm/sec) | | |
|---|---|---|---|---|
| AO : 2.8 (2.5-3.7) | LVIDD : 4.5 (3.5-5.5) | MV EV : 86.2 | AV : 71.3 | MR : NORMAL |
| LA : 3.3 (1.9-4.0) | LVIDS : 2.8 (2.4-4.2) | AV : 122 | | AR : NORMAL |
| RA : 2.2 (<4.4) | IVSD : 0.8 (0.6-1.1) | PV : 121 | | PR : NORMAL |
| RV : 2.0 (<3.5) | IVSS : 1.1 (0.9-1.2) | TV EV : ---- | AV : ---- | TR : TRIVIAL TR |
| TAPSE: 1.8 (>1.6) | LVPWD : 1.2 (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 | : SCLEROTIC CHANGES, NON-STENOTIC, JET GRDT-6mmHg |
| Tricuspid Valve | : NORMAL, TRIVIAL TR, PASP-25mmHg |
| Pulmonary Valve | : NORMAL |
| IAS | : INTACT |
| IVS | : INTACT |
| Pericardium | : NORMAL |
| Other Findings | : IVC NORMAL AND COLLAPSING |

**IMPRESSION:**

SCLEROTIC AORTIC VALVE
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
TRIVIAL AR/TR, PASP-25mmHg
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST