

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. KEERTHIR BHAJ ANTRI	Order No	: 1000075713
UHID	: UHJ A23019764	Registered On	: 06/03/2024 10:03:32 AM
Age/Sex	: 34/Years Female	Collected On	: 06/03/2024 10:08:42 AM
Ward / Bed No	:	Reported On	: 06/03/2024 01:06:11 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230024420
Station	: At Hospital	Mobile No	: 7892097547
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	90	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	92	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	4.8	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	91.05	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.16	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	9.57	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	2.48	μIU/mL	0.34 - 5.60 μIU/mL (Non Pregnant) 0.3 - 4.5 μIU/mL (I trimester) 0.5 - 5.2 μIU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	166	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	79	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	44.8	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	105.4	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	15.8	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.70		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.35		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	2.3	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.9	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)	0.69	mg/dL	0.6-1.1
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.44	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.08	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.36	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.8	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	3.83	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.96	g/dL	2.3-3.5

Sample: Serum

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AG RATIO (Method: Calculated)	1.28		2:1
SERUM SGOT (Method:IFCC without P5P)	17	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	12	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	63	U/L	46-122
GGT (Method:IFCC)	10	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)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.00	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	42.7	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7550	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	60.20	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	27.45	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.55	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.65	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.15	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.65	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	91.9	fL	78-100
MCH (Method: Calculated)	30.1	pg	27-31
MCHC (Method: Calculated)	32.8	g/dL	31-37
RDW - CV (Method: Calculated)	13.1	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.22	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.38	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	20	mm/hour	1-20
BLOOD GROUPING & RH TYPING			
Sample: Whole blood (EDTA)			
ABO Group (Method:Agglutination Gel Method)	A		
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	6.5		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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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	6-8	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		

Verified By
PREETHIR

---End of Report---

Naveen M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mrs. KEERTHI R BHAJANTRI	Order No : 1000075716
UHID : UHJA23019764 \	Registered On : 06/03/2024 10:03:31 AM
Age/Sex : 34/Years Female	Collected On : 06/03/2024 03:37:47 PM
Ward / Bed No :	Reported On : 06/03/2024 04:31:13 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJA230024420
Station : At Hospital	Mobile No : 7892097547
Payer Name : Mediwheel	Report Status : Final Report

Samples

CERVICAL SMEAR - 06/03/2024 03:37 PM

Test Name : PAP SMEAR

NUMBER OF SLIDES RECEIVED: 02

TYPE OF THE SMEAR: Conventional

SOURCE OF THE SMEAR: Ecto and endocervix

CLINICAL DETAILS: Mild white discharge PV, P1L1

L M P: 25/02/2024

SPECIMEN ADEQUACY:

Satisfactory for evaluation.

Transformation zone/ Endocervical cell component is absent.

MICROSCOPY:

Smears show predominantly superficial and intermediate squamous cells.

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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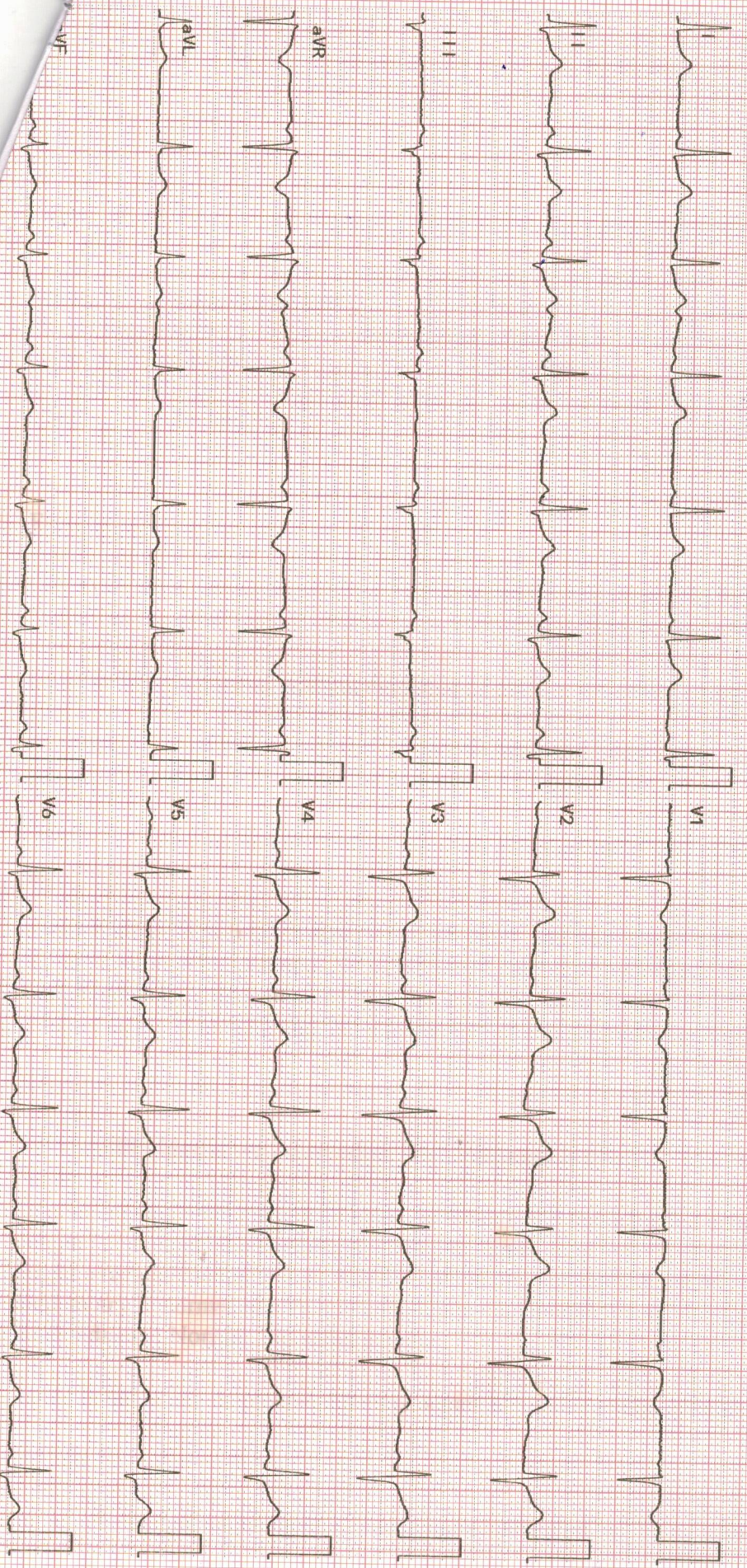
Sex: F
cm
kg
Birth date: /
mmHg

34 years
1100 Sinus rhythm
9110 ** normal ECG **

symptoms:
history:
heart rate 77 bpm
RR int 132 ms
RS dur 82 ms
P/QTc(E) int 372/403 ms
I/O RS/T axis 64/17/30 °
V5/SV1 amp 0.78/0.80 mV
V5-SV1 amp 1.58 mV

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

10 mm/mV



Unconfirmed Report
Reviewed by:

2



NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. KEERTHI R BHAJANTRI	Date :	06/03/24
Age :	34 years GENDER: FEMALE	Patient ID :	19764
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

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

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 3.7 (3.5-5.5)	MV EV : 96.0	AV : 74.2	MR : NORMAL
LA : 2.7 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 126		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 86.8		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.8 (>1.6)	LVPWD : 0.9 (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
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



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No.1



UNITED
HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs.KEERTHI R BHAJANTRI	UHID	: UHJA23019764
Age / Sex	: 34 Years / Female	OP NO/Reg Dt	: 06-03-2024 10:03 AM
Spouse / Father Name	: KRISHNA	Department	:
Address	: NO 452 4TH MAIN 6TH CROSS JP NAGAR 3RD BLOCK , , Bengaluru Urban, Karnataka,	Referred By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: <i>Dr. Vignesh</i>

Complaints / Findings / Observations :

*Came for Routine ENT
Checkup.*

Investigations:

*Ear, }
Nose, }
oral cavity }
Throat } within normal
limits.*

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

[Signature]
DR. VIGNESH J
MBBS, DLO(MANIPAL), DNB(DELHI), FHNS(KIDWAI)
ENT, HEAD AND NECK CANCER SURGEON
REG. NO: 92095

Signature of the Doctor



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No.1



UNITED HOSPITAL

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Jayanagar, Bangalore

mm record.

34g

Dr. Yoga Lakshmi SK
MBBS, MS OBG, FMAS
Consultant Obstetrician and
Gynecologist, Laparoscopy
and IVF Specialist
KMC Reg. No. 90384

6/3/24

for health club of

4. Hypertension since 14y.

no 4. DM, HT, triglycerides

no 4. on eye

no 4. Cervical Cancer -
metastatic.

ml - 2y
0.4
1.0 - 2y
CH
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me after

PA - Mr Iron bar

PA - 9 shd delc

Advis T. H. (100) - 1st

Brul.
[Signature]

9/7/24
ASV-D



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NABL



No.1

Out Patient Record

Patient Name : Mrs.KEERTHI R BHAJANTRI **UHID** : UHJA23019764
Age / Sex : 34 Years / Female **OP NO/Reg Dt** : 06-03-2024 10:03 AM
Spouse / Father Name : KRISHNA **Department** : Dr. Shetty
Address : NO 452 4TH MAIN 6TH CROSS JP NAGAR 3RD BLOCK , , Bengaluru Urban, Karnataka, **Referred By** :
Consultant : Dr.Preventive Health Check Up
KMC No. : Dr. Shetty

Complaints / Findings / Observations :

Routine eye check

Investigations:

$$\left. \begin{array}{l} \text{Un} \\ \text{(faint)} \end{array} \right\} \begin{array}{l} \text{6/6P} \\ \text{6/9} \end{array} \text{ } \left. \begin{array}{l} \\ \\ \end{array} \right\} \text{No.}$$

 Wt: normal

Treatment / Care of Plan / Provisional Diagnosis :

R: 0.3:1
 751 (P)

Follow Up Advice :

If: OU Ref Encl.

RE: - 0.50 DC X 170 6/6P
 LE: - 0.50 DC X 30 6/9.

Signature of the Doctor





Out Patient Record

Patient Name : Mrs.KEERTHI R BHAJANTRI **UHID** : UHJA23019764
Age / Sex : 34 Years / Female **OP NO/Reg Dt** : 06-03-2024 10:03 AM
Spouse / Father Name : KRISHNA **Department** :
Address : NO 452 4TH MAIN 6TH CROSS JP NAGAR 3RD BLOCK , , Bengaluru Urban, Karnataka, **Referred By** :
Consultant : Dr.Preventive Health Check Up
KMC No. : *Dr. Raghavendra pr...*

Complaints / Findings / Observations :

Investigations:

- T. FOLTS OD x 3 each

- T. E 2000 PMS

*WJ- 51.91
MI- 149
BP- 114/70
PR- 90b
SpO2- 90*

Treatment / Care of Plan / Provisional Diagnosis :

*OTD x 3
Man
~~Wed~~ Thu
Friday*

Follow Up Advice :

OK

[Signature]
Signature of the Doctor



NABH



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No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Keerthi Bhajantri	Date	06/03/24
Age	34 years	Hospital ID	UHJA23019764
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size measuring 14.0 cms and 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 measuring 8.2 cms, shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (9.9 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (10 x 4.4 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 7.0 x 4.9 x 3.8 cms. Myometrial and endometrial echoes are normal. Endometrium measures 7 mm.

Right ovary is normal in size and echopattern, measures 2.8 x 2.5 cms.

Left ovary is normal in size and echopattern, measures 2.1 x 2.1 cms.

Both adnexa: Normal. No mass is seen.

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

IMPRESSION:

- No definite sonological abnormality detected.

Manu H
Dr. Manu Srinivas H, MD, RD
Consultant Radiologist



NABL



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Keerthi Bhajantri	Date	06/03/24
Age	34 years	Hospital ID	UHJA23019764
Sex	Female	Ref.	Health check

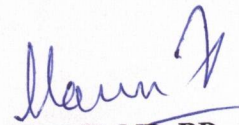
RADIOGRAPH OF THE CHEST (PA - VIEW)

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. Manu Srinivas H, MD, RD
Consultant Radiologist