

ID: 19578
Name: Mr. Harish Babu M
Birth date: /

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

kg mmHg

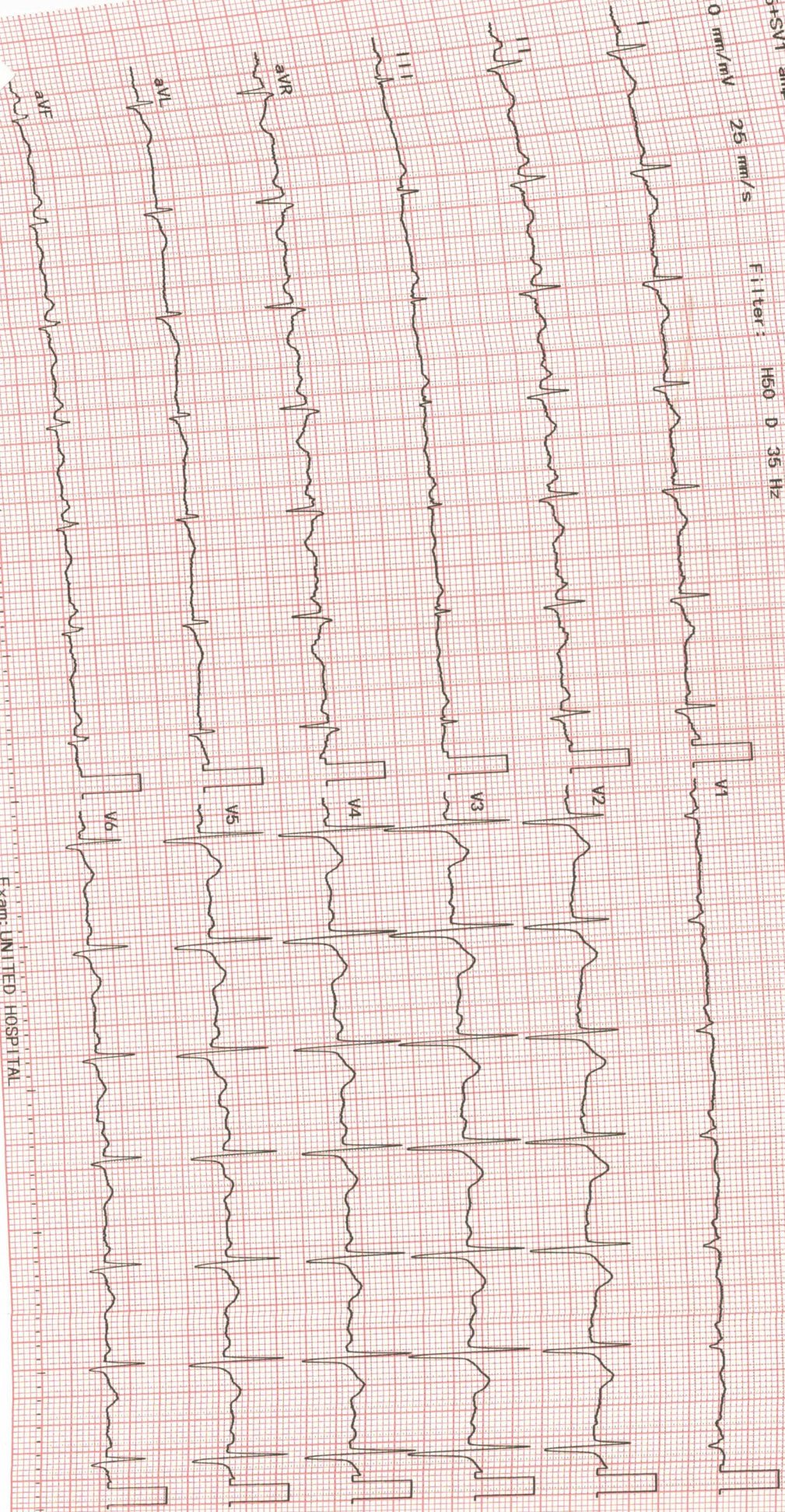
ications:
ptoms:
story:
nt. rate
R int
RS dur
T/QTe (E) int
/QRS/T axis
V5/SV1 amp
V5+SV1 amp

83	bpm
150	ms
102	ms
364/403	ms
67/36/28	ms
1.15/0.23	mV
1.38	mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s

10 mm/mV



Unconfirmed Report
Reviewed by:

Exam: UNITED HOSPITAL

03-08 07-01

Dept.:



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.HARISH BABU M	UHID	: UHJA23016578
Age / Sex	: 37 Years / Male	OP NO/Reg Dt	: OP230000019687 / 27-01-2024 09:09 AM
Father Name	:	Department	: Health Check
Spouse Name	: VIDHYASHRI A	Referred By	: Mediwheel
Address	: # 5105,23rd ward 3rd Cross Rajeevanagar Vijayapura Banlgore , BANGALORE CITY H O, Bengaluru Urban, Karnataka, INDIA,	Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr.vignesh

Complaints / Findings / Observations :

ENT prescription

Routine ENT check up.


Investigations:

Bil Ears,
 Nose,
 Oral cavity,
 Oropharynx
 TFF

} will

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :


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

Signature of the Doctor



NABH



NABL



No.1



UNITED HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mr.HARISH BABU M

UHID : UHJA23016578

Age / Sex : 37 Years / Male

OP NO/Reg Dt : OP230000019687 / 27-01-2024 09:09 AM

Father Name :

Department :

Spouse Name : VIDHYASHRI A

Referred By :

Address : # 5105,23rd ward 3rd Cross Rajeevanagar
Vijayapura Banglore , BANGALORE CITY H
O, Bengaluru Urban, Karnataka, INDIA,

Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

Routine Eye test

Investigations:

VA < 6/6

AS < 0

Treatment / Care of Plan / Provisional Diagnosis :

Under C 0

Eye normal both eyes

Follow Up Advice :

Yearly review

[Signature]
Signature of the Doctor

DEPARTMENT OF RADIODIAGNOSIS

Name	Harish Babu M	Date	27/01/24
Age	37 years	Hospital ID	UHJA23016578
Sex	Male	Ref.	Healthcheck

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 focal lesion.

Right Kidney is normal in size (9.3 x 1.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (9.8 x 1.4 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 partially distended.

Prostate is normal in echopattern and size.

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

IMPRESSION:

- **Grade I fatty liver.**
- **No other definite sonological abnormality detected.**



Dr. Giridhar V S
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Harish Babu M	Date	27/01/24
Age	37 years	Hospital ID	UHJA23016578
Sex	Male	Ref.	Healthcheck

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. Giridhar V S
Consultant Radiologist

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. HARISH BABU M	Order No : 1000068760
UHID : UHJ A23016578	Registered On : 27/01/2024 09:09:33 AM
Age/Sex : 37/Years Male	Collected On : 27/01/2024 09:10:23 AM
Ward / Bed No :	Reported On : 27/01/2024 01:09:06 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230020641
Station : At Hospital	Mobile No : 9916593730
Payer Name :	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)	90	mg/dL	70-140
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.14	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.25	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	0.89	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	155	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	94	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	44.5	mg/dL	< 40 - Low ≥ 60 - High
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	91.7	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	18.80	mg/dL	< 30

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HARISH BABU M	Order No	: 1000068760
UHID	: UHJ A23016578	Registered On	: 27/01/2024 09:09:33 AM
Age/Sex	: 37/Years Male	Collected On	: 27/01/2024 09:10:23 AM
Ward / Bed No	:	Reported On	: 27/01/2024 01:09:06 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230020641
Station	: At Hospital	Mobile No	: 9916593730
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.4		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.0		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	110.5	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.7	mg/dL	3.5-7.2
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	10	mg/dL	7.93-20.07
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.81	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.18	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.64	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.20	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.79	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.50		2:1
SERUM SGOT (Method:IFCC without P5P)	25	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	29	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	113	U/L	50-116

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HARISH BABU M	Order No	: 1000068760
UHID	: UHJ A23016578	Registered On	: 27/01/2024 09:09:33 AM
Age/Sex	: 37/Years Male	Collected On	: 27/01/2024 09:10:23 AM
Ward / Bed No	:	Reported On	: 27/01/2024 01:09:06 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230020641
Station	: At Hospital	Mobile No	: 9916593730
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
GGT (Method:IFCC)	24	U/L	< 55
CREATININE (Method:Modified Jaffe, Kinetic)	0.86	mg/dL	0.9-1.3



Dr. Shanthakumar Muruda
Sr CONSULTANT BIOCHEMIST
KMC No : 54192

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HARISH BABU M	Order No	: 1000068760
UHID	: UHJ A23016578	Registered On	: 27/01/2024 09:09:33 AM
Age/Sex	: 37/Years Male	Collected On	: 27/01/2024 09:10:23 AM
Ward / Bed No	:	Reported On	: 27/01/2024 01:09:06 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230020641
Station	: At Hospital	Mobile No	: 9916593730
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
-----------	--------	------	--------------------

HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	16.38	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	49.0	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7930	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	51.02	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	32.56	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	8.61	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.31	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.50	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.51	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	89.0	fL	78-100
MCH (Method: Calculated)	29.7	pg	27-31
MCHC (Method: Calculated)	33.4	g/dL	31-37
RDW - CV (Method: Calculated)	13.4	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.47	Lakhs/Cum	1.5-4.5

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. HARISH BABU M	Order No : 1000068760
UHID : UHJ A23016578	Registered On : 27/01/2024 09:09:33 AM
Age/Sex : 37/Years Male	Collected On : 27/01/2024 09:10:23 AM
Ward / Bed No :	Reported On : 27/01/2024 01:09:06 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230020641
Station : At Hospital	Mobile No : 9916593730
Payer Name :	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.61	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.8	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	08	mm/hour	1-15
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

Naveen N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. HARISH BABU M	Order No	: 1000068760
UHID	: UHJ A23016578	Registered On	: 27/01/2024 09:09:33 AM
Age/Sex	: 37/Years Male	Collected On	: 27/01/2024 09:10:23 AM
Ward / Bed No	:	Reported On	: 27/01/2024 01:09:06 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230020641
Station	: At Hospital	Mobile No	: 9916593730
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
-----------	--------	------	--------------------

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	30	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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

Patient Name	: Mr. HARISH BABU M	Order No	: 1000068760
UHID	: UHJ A23016578	Registered On	: 27/01/2024 09:09:33 AM
Age/Sex	: 37/Years Male	Collected On	: 27/01/2024 09:10:23 AM
Ward / Bed No	:	Reported On	: 27/01/2024 01:09:06 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230020641
Station	: At Hospital	Mobile No	: 9916593730
Payer Name	:	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		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
PRAVEEN T

---End of Report---

Naveen M

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418