NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	**: Mr.SANTHOSH S**	**UHID**	**: UHJA23018273**
Age / Sex	: 40 Years / Male	OP NO/Reg Dt	: 13-02-2024 08:28 AM
Spouse / Father Name	: SUBBARAJU R	Department	:
Address	: # T2,138/5,Balaji Residency Arkere Banglore, BANGALORE CITY H O,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Anuradha

Complaints / Findings / Observations :

- Dyslipidemia
- Grade I fatty liver

Wt - 91.7
HT - 191
BP - 115/75
SpO2 - 98%
PR - 78 b/m

Investigations:

Treatment / Care of Plan / Provisional Diagnosis : Adv

- Low fat diet
- physical activity
- protein rich food

Follow Up Advice :

(1) Tab ROSEDAY 10 0-0-1 x 3 months (A/F)

Lipid profile after 3 months

Medically fit

Signature of the Doctor

UNITED HOSPITAL (A Unit of United Brotherss Healthcare Services Private Limited)

United Hospital
No.110 (30), Madhavan Park Circle, 10th Main Rd,
3rd Block Jayanagar, Bangalore - 560 011
T: 080 4566 6666
E: appointments@unitedhospital.in
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NABH

NABL

No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Santhosh S	Date	13/02/24
Age	40 years	Hospital ID	UHJA23018273
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

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DEPARTMENT OF RADIODIAGNOSIS

Name	Santhosh S	Date	13/02/24
Age	40 years	Hospital ID	UHJA23018273
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (16 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 focal lesion.

Right Kidney is normal in size (10.6 x 4.4 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.5 x 5.2 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 minimally distended.

Prostate is normal in echopattern and size, measures ~ 18 cc. *There is a small cyst measuring 6 mm in the prostatic parenchyma.*

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 significant sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH

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Jayanagar, Bangalore

Patient name :	Mr. SANTHOSH S	Date :	13/02/24
Age :	40 years GENDER: MALE	Patient ID :	18273
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.9 (2.5-3.7)	LVIDD : 4.3 (3.5-5.5)	MV EV : 78.6	AV : 61.6	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 107		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 88.3		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 : 1.0 (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

NABH NABL No.1

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		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

V/A < 6/9, 6/6 } N6 (blurred) nil systemic

Investigations:

A/S: OU normal

Treatment / Care of Plan / Provisional Diagnosis : Fundus (undilated) OU CDR 0.3:1 (SH CP)

Rx: OU Ref Error.

Follow Up Advice : Progressive glass

BE: ~~0.75~~ -1.00 DC. X 90° 6/6.

Add +1.00 DS for near V.

Signature of the Doctor

Dr Shweta

Name: Mr. Santhosh
Sex: M   Birth date: 40 years
cm   kg   /   mmHg
Medication:
Symptoms:
History:

Vent. rate	79	bpm
PR int	164	ms
QRS dur	84	ms
QT/QTc(E) int	364/ 399	ms
P/QRS/T axis	48/ 26/ 31	°
RV5/SV1 amp	1.79/ 0.90	mV
RV5+SV1 amp	2.70	mV

1100 Sinus rhythm
9110 ** normal ECG **

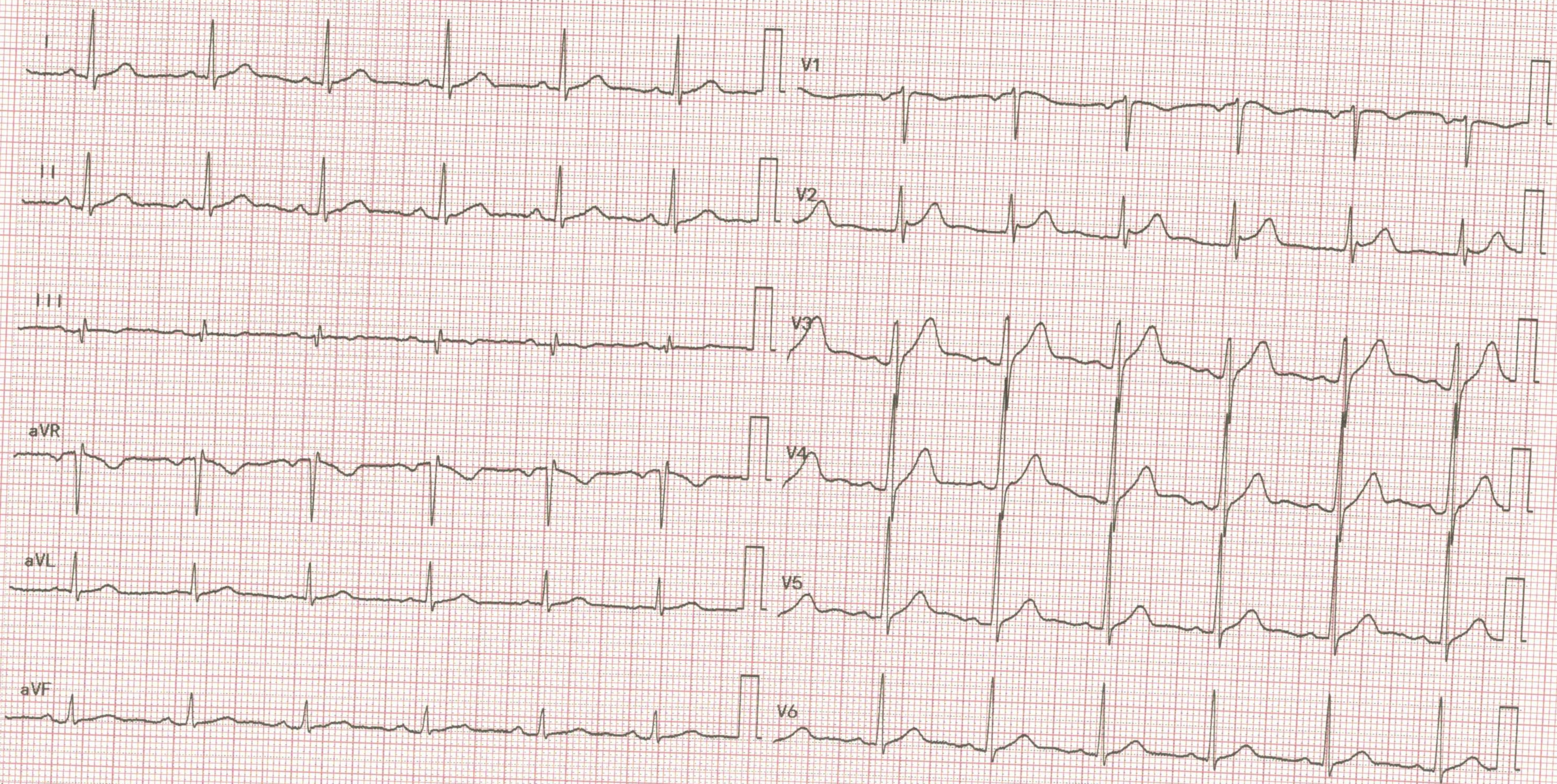
Unconfirmed Report
Reviewed by:

13-Feb-2024 AM9:27:17

SCHILLER

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

10 mm/mV



2350K 03-08 07-01 Dept.:

Exam: UNITED HOSPITAL

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SANTHOSH S	Order No	: 1000072780
UHID	: UHJA23018273	Registered On	: 13/02/2024 08:28:57 AM
Age/Sex	: 40/Years Male	Collected On	: 13/02/2024 08:37:48 AM
Ward / Bed No	:	Reported On	: 13/02/2024 01:04:17 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230022614
Station	: At Hospital	Mobile No	: 9886105101
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	119	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	146	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)	1.01	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.17	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.87	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	279	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	219	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	48.0	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	187.2	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	43.79	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.8		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.9		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	231	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.2	mg/dL	3.5-7.2

BUN/CREATININE RATIO

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	16	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.89	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	17.97		12ˉ20 : 1

LIVER FUNCTION TEST

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.66	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.55	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3

UNITED HOSPITAL

Care Par Excellence

ilac-MRA

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.17	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.03	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.37		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	23	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	50	U/L	50-116
GGT (Method:IFCC)	71	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.50	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 (Method:Urease GLDH - Kinetic)	35.3	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 (Method:Photometric Measurement: Oxyhemoglobin method)	14.67	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	44.9	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4930	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	64.45	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	23.35	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.85	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.87	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.48	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.65	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	79.5	fL	78-100
MCH (Method: Calculated)	26.0	pg	27-31
MCHC (Method: Calculated)	32.7	g/dL	31-37
RDW - CV (Method: Calculated)	14.9	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.46	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)	8.19	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.2	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
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

DEPARTMENT OF LABORATORY MEDICINE

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.5		5.0-8.0
SPECIFIC GRAVITY	1.025		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
Parameshwar B

---End of Report---

Naveen.N
Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418