UNITED HOSPITAL
Care Par Excellence

MC-5013

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SANKAR POTHANNAGARI SIVA	Order No	: 1000074300
UHID	: UHJA23018998	Registered On	: 24/02/2024 08:16:39 AM
Age/Sex	: 36/Years Male	Collected On	: 24/02/2024 08:25:11 AM
Ward / Bed No	:	Reported On	: 24/02/2024 02:01:55 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230023491
Station	: At Hospital	Mobile No	: 7019694889
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	235	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	328	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	11.7	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	289.08	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.09	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.18	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.63	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	182	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	180	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.9	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	98.1	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	36.00	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.7		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)	134.1	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.7	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.76	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.31	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.28	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.04	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.8	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.33	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.46	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.75		2:1

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	37	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	63	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	70	U/L	50-116
GGT (Method:IFCC)	85	U/L	< 55

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)	15.55	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	46.5	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	8029	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	46.14	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	39.69	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	7.72	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.13	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.32	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.46	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	85.2	fL	78-100
MCH (Method: Calculated)	28.5	pg	27-31
MCHC (Method: Calculated)	33.4	g/dL	31-37
RDW - CV (Method: Calculated)	13.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.45	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)	7.75	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.6	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	B		
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

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	15	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.020		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Present (1.5%)		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	4-6	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Present (1.5%)		
URINE SUGAR (POST PRANDIAL)	Present (1.0%)		

Verified By
NAGARATNA

---End of Report---

Naveen.N

Dr. Naveen Kumar
CONSULTANT PATHOLOGIST
KMC NO : 71418

ID: 23018998

Name: sankarpothannagari s

24-Feb-2024 AM9:13:40

ex: M Birth date: 36 years

cm kg / mmHg

edication:

ymptoms:

istory:

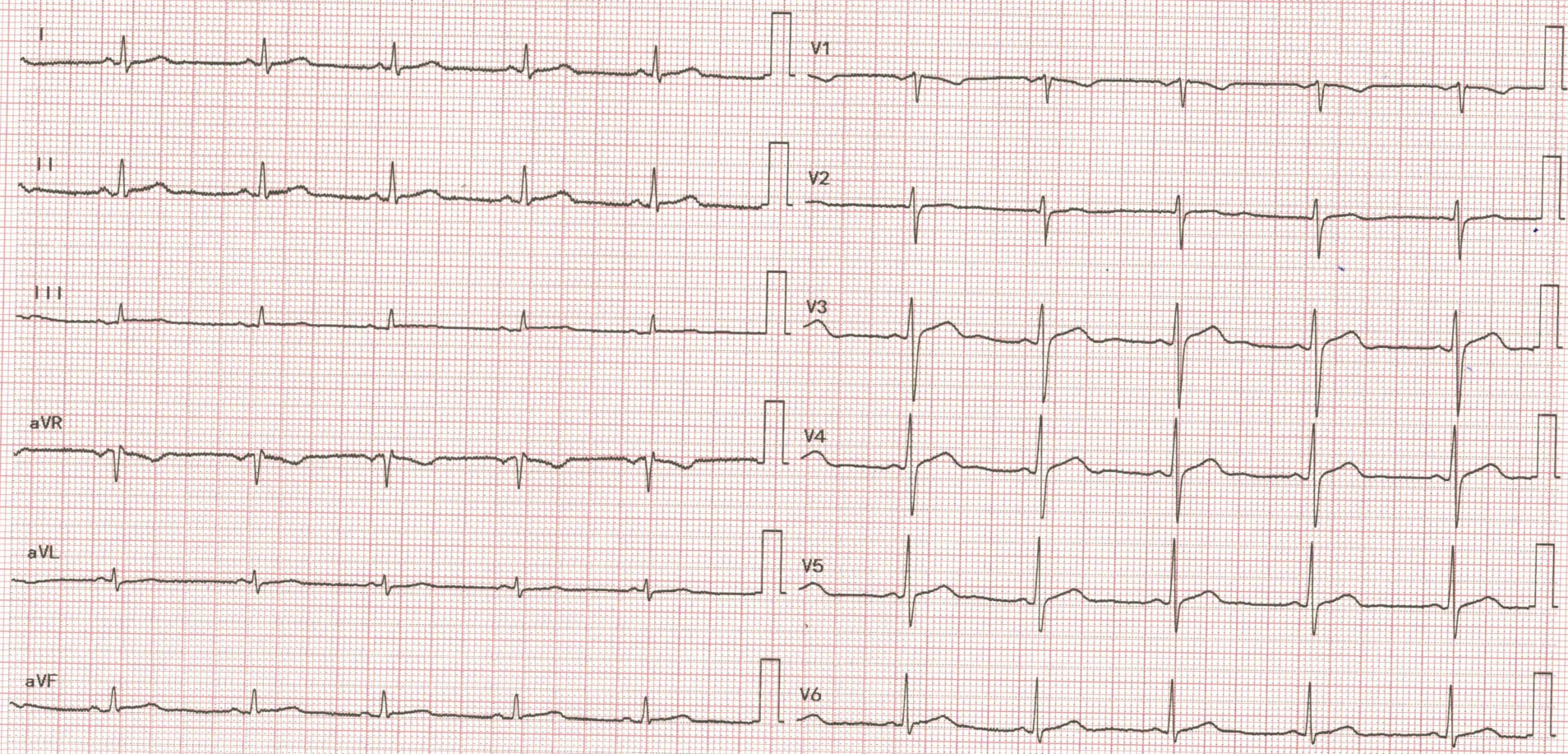
ent. rate	69	bpm
R int	118	ms
RS dur	86	ms
T/QTc(E) int	362/ 381	ms
/QRS/T axis	33/ 54/ 47	°
V5/SV1 amp	1.17/ 0.46	mV
V5+SV1 amp	1.63	mV

1100 Sinus rhythm
2210 Short PR interval [PR int. < 120 ms]
4038 Nonspecific ST elevation [ST elevation (II, V3, V4, V5)]
0102 ARTIFACT PRESENT
9150 ** abnormal 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

NABH NABL No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mr. SANKAR POTHANNAGARI SIVA**	**Date :**	**24/02/24**
Age :	**36 years GENDER: MALE**	**Patient ID :**	**18998**
Ref by :	**DR. CMO**	**OP/ IP :**	**HEALTH CHECKUP**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.5 (2.5-3.7)	LVIDD : 3.6 (3.5-5.5)	MV EV : 81.0	AV : 52.4	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 100		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 64.0		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 0.9 (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 : 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	: 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

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

NABH NABL No.1

Out Patient Record

Patient Name	**: Mr.SANKAR POTHANNAGARI SIVA**	**UHID**	**: UHJA23018998**
Age / Sex	: 36 Years / Male	OP NO/Reg Dt	: 24-02-2024 08:16 AM
Spouse / Father Name	: NARASIMMALU	Department	: Health check
Address	: # Vijaypura Opp Bescom Bank off Baroda, BANGALORE CITY H O, Bengaluru Urban,	Refered By	: corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Shwetha

Complaints / Findings / Observations : ophthomology prescription

Routine eye test

Investigations:

VA < 6/6 N/8 BE

AS < N

Treatment / Care of Plan / Provisional Diagnosis :

Fundus < N

Dx: Refractive error BE

Follow Up Advice :

Adv: Dilated fundus

+ Refractions

Signature of the Doctor
[illegible]

NABH NABL MC-5013 No.1

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Address	: # Vijaypura Opp Bescom Bank off Baroda, BANGALORE CITY H O, Bengaluru Urban,	Refered By	: corporate
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. vignesh

Complaints / Findings / Observations : ENT Prescription

Came for Routine ENT check up.

Investigations:

Ear
Nose
Throat
Oral Cavity

} within Normal limits

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

DR. VIGNESH
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
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Spouse / Father Name	: NARASIMMALU	Department	:
Address	: # Vijaypura Opp Bescom Bank off Baroda, BANGALORE CITY H O, Bengaluru Urban,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	: Dr. Srijina

Complaints / Findings / Observations :

Ht - 164
wt - 75.6
Bp - 108/79
Spo2 - 99%
PR - 75 b/m

* T2 DM

Investigations:

* Urology opinion

Treatment / Care of Plan / Provisional Diagnosis :

1) Tab Glimisave - M2
1-0-1 x 60 days.

Follow Up Advice :

2) Tab PPG 0.3mg
(BLD) 1-1-0 x 60 days

Review : FBS
PPBS
Next visit.

Signature of the Doctor

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NABH NABL No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Sankar Pothannagari Siva	**Date**	24/02/24
Age	36 years	**Hospital ID**	UHJA23018998
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver ***is enlarged in size (15.2 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 ***lumen shows a calculus measuring 8 mm.*** There is no evidence of 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 (9.9 x 4.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (10.0 x 4.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis. ***There is a simple cortical cyst measuring 8 x 8 mm in the interpole region.***

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 ~ 10 cc.

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

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

- **Cholelithiasis. No evidence of cholecystitis.**
- **Mild hepatomegaly with moderate fatty infiltration (Grade II).**
- **Left renal simple cortical cyst. Bosniak 1 – Benign.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

DEPARTMENT OF RADIODIAGNOSIS

Name	Sankar Pothannagari Siva	**Date**	24/02/24
Age	36 years	**Hospital ID**	UHJA23018998
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