ID:24005596
Name:mr kumar anil

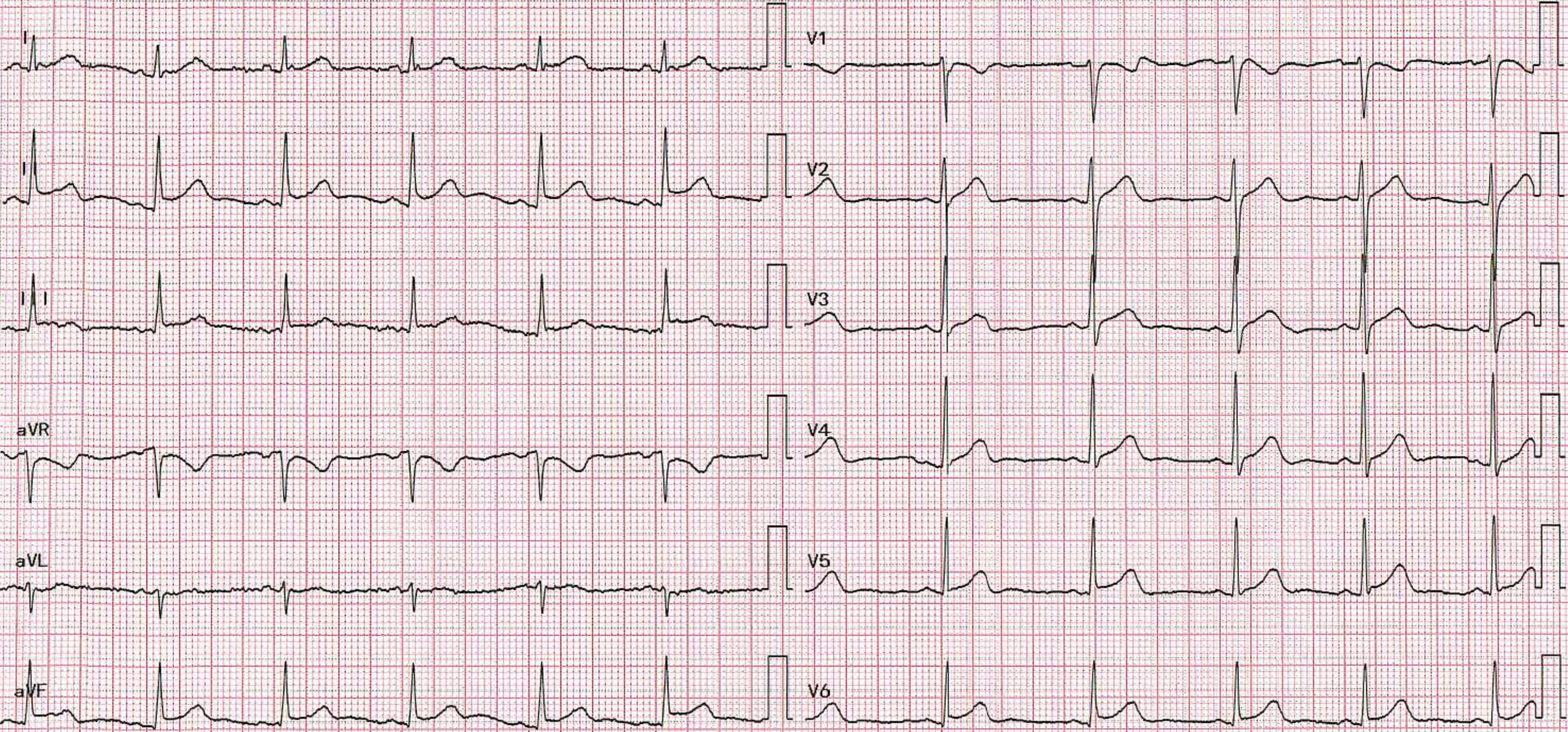
16-Sep-2024 AM10:51:19

ex:M	Birth date:	34 years
cm kg	/ mmHg	
ledication:		
ymptoms:		
listory:		
lent. rate	70	bpm
R int	142	ms
RS dur	88	ms
T/QTc(E) int	368/ 389	ms
/QRS/T axis	38/ 64/ 55	°
V5/SV1 amp	1.29/ 0.98	mV
V5+SV1 amp	2.27	mV

1100 Sinus rhythm
1102 Sinus arrhythmia [RR int. change over 20%]
40303 Early repolarization [ST elevation (II, III, aVF, V4, V5, V6)]
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

Part No.2.157017M CE 0123
SCHILLER

DEPARTMENT OF RADIODIAGNOSIS

Name	Anil Kumar	Date	16/09/24
Age	34 years	Hospital ID	UHJA24005596
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 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 (10.8 x 4.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (10.5 x 5.0 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 distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 11.3 cc.

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

IMPRESSION:

- **Mild fatty infiltration of liver (Grade I).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Anil Kumar	**Date**	16/09/24
Age	34 years	**Hospital ID**	UHJA24005596
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

NABH No.1

Out Patient Record

Patient Name	: Mr.KUMAR ANIL	UHID	: UHJA24005596
Age / Sex	: 34 Years / Male	OP NO/Reg Dt	: 16-09-2024 08:55 AM
Spouse / Father Name	: RUPA KUMARI	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Ht: 179 Cm
Wt: 72.3 kg
BP: 110/70 mmHg
SpO_2: 99%
PR: 75 b/m

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH

No.1

UNITED
HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME :	Mr.KUMAR ANIL	DATE :	16/09/24
AGE :	34 YEARS GENDER : MALE	PATIENT ID :	5596
REF BY :	CMO	OP/ IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M - MODE AND DOPPLER MEASUREMENTS

(cm)	(cm)	(cm/sec)		
AO :3.0 (2.5-3.7)	LVIDD : 3.9 (3.5-5.5)	MV EV: 1.0	AV: 0.4	MR : NORMAL
LA :3.2 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 0.89		AR : NORMAL
RA : 3.6 (<4.4)	IVSD : 10.9 (0.6-1.1)	PV :		PR : NORMAL
RV : 2.3 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE : 1.9 (>1.6)	LVPWD : 0.8 (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 PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL S PATIL
CONSULTANT CARDIOLOGIST

UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. KUMAR ANIL	Order No	: 1000096273
UHID	: UHJA24005596	Registered On	: 16/09/2024 08:55:24 AM
Age/Sex	: 34/Years Male	Collected On	: 16/09/2024 09:04:22 AM
Ward / Bed No	:	Reported On	: 16/09/2024 01:11:15 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240007726
Station	: At Hospital	Mobile No	: 8896756311
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	102	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	116	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.4	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	108	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.72	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.76	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.77	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	153	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	171	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	33.4	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	85.40	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	34.20	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.58		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.56		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	119.60	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.9	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.76	mg/dL	0.9-1.3

LIVER FUNCTION TEST

Sample: Serum

Test Name	Result	Unit	Bio. Ref. Interval
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.92	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.15	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.77	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.21	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	1.99	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	2.12		2:1

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Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	35	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	73	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	137	U/L	50-116
GGT (Method:IFCC)	65	U/L	< 55

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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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)	12.27	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	38.1	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5050	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	45.59	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	42.45	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.23	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.36	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.37	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.11	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	92.8	fL	78-100
MCH (Method: Calculated)	29.9	pg	27-31
MCHC (Method: Calculated)	32.2	g/dL	31-37
RDW - CV (Method: Calculated)	13.7	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.54	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)	10.77	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.5	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	06	mm/hour	1-15

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
ABO Group (Method:Agglutination Method)	B		
Rh Factor (Method:Agglutination Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.5		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)	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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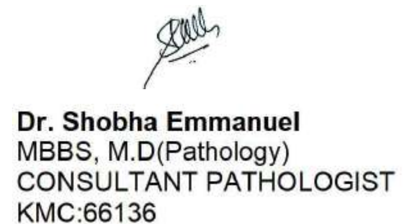
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	0-2	/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
Rashmita



---End of Report---

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