Chief complains: ens opd.

History of present illness: ass't ?SNHL 2° to trauma .hearing loss sine childhood where after he susfaried fall down injury to the head . no discharge per ear.(o)clear EAC . infact TM. Plan audiometry .consult senior.

History of present illness: p_type and DM.lenge 13-1-17 Ru 1day.regular 7-1-13 Ru 1day .S no polyanafs .no polydypsis.no fever.no ut loss.

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History present illness, person LKH 03 weeks back time started high grade intermittent fever chills higher. Migrators joint pain one year duration.he started expanse migrators joint pain started ankle inter phelynyeal joint cyigbtes involves wrist, knee, elbow, past one year associated several joint pain. He also joint swelling high grade intermit fever chills, rigors .he also heanatuhs frequency urgency. He falls vaccinated according EPI schedule.physical examiner says health, CPD, concinslaler .no edema, joint swelling, tenderness limitation fever. intermittent joint pain. taking ibuprofen 400 mg. family history similar users.so sick looking, joint smelling.The fever prominent night time propose night smoothing. Associated abdominal pain, decreased appetite significant un formalized weight loss. History present illness, person LKH 03 weeks back time started high grade intermittent fever chills higher. Migrators joint pain one year duration.he started expanse migrators joint pain started ankle inter phelynyeal joint cyigbtes involves wrist, knee, elbow, past one year associated several joint pain. He also joint swelling high grade intermit fever chills, rigors .he also heanatuhs frequency urgency. He falls vaccinated according EPI schedule.physical examiner says health, CPD, concinslaler .no edema, joint swelling, tenderness limitation fever. intermittent joint pain. family history similar users.so sick looking, joint smelling.The fever prominent night time propose night smoothing. Associated abdominal pain, decreased appetite significant un formalized weight loss.

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C/C : POLY URICE polydipsia of 6months and abdominal patient of 3 days .

HIP: This 7years old male child was lost healthy 6months back when he started to experience poly dyspepsia and policer it might day ratio of 4:2 associated with these appetitive was increased and he lost significant amount of weight. There is no family hx of diabetes mellitus intermittent but hot of father is unknown. 15 days back his sys where worsened and D:N.

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History of present illness modeless exacerbation of daily intermittent as thing. On salbutamol puff PRAL.

She was daze cough of one day duration, but no fast breathing granting of fever she has also on wised wheezing episode. but got impaired. good air entry birth, sigh well heard. Fail control.

Pln- salbutamol puff advices to identify exacebose factual

History of present illness a known asthmatic at for the past one month(a month before. She was offed for moderate exacerbation of mild intermittent a asthma on salbutamol puff pain. In the past one month GA stable

Chest no sign of distress and no wheeze crept. Assistant his improving and finally appoint after one month. Patient history presented with exacerbation of shortness of breath growing LGIF of one day duration .since three days back she was haring common cold like symptoms known mild

intermittent asthma pt for the past three years was on off but discontinued follows since one year back because she was told to be enough and she is well. She has three admissions this year only and has symptoms one up to two weeks ,was using salbutamol puff.

Patient laboratory data PRN but has finished if three months back immediately after her last admission .Course in the hospital chest flaring of noses .

Final diagnosis moderate exacerbation of mild intermittent asthma. Advice on discharge given amoxicillin syrup for six days. Prednisone one milligram per kilogram for four days. Salbutamol puff QID basis for three days and then PRN. Appointed after two weeks on chronic follows.

Chief complaint shortness of breath of one day duration. History of present illness this is one day back at which time. She started to have shortness of breath grunting and LGIF since three days back. She was having common cold like symptoms like cough sneezing.

She is know mild intermittent asthmatic pt since three years back she follow up , but she stopped follow since one year back because she was told enough by physicians .

No family hx of asthma. She ,has repeated attack and admission 3x this year.

Assit moderate exacerbation of mild intermittent asthma.

Chief complaint shortness of breathing one days durations.

History of present illness this is sign old female child known mild intermittent asthma on follow up presented with SOB, associated grunted , fast breathing and low grade intermittent fever one days duration. The follow up discontinue one days back but had granted admission three years.

No family lx of asthma. No hx of contact from chronic cougher or known lap pts.

She is a well growing for her peers. Chief complaint cough of one day duration.

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She is a known esthetic patient for the past three years with repeated hospital admissions on hospital was treated for preumesia and asthma and treated with spends salbutamol puff impelled ,

History of present illness this patient was last relatively healthy two day at which time she stated to have day cough which is intermittent ,associated with high grade intermittent fever and fest beefy

History of present illness this patient was LRH 3 days cack at which time she started to experience difficulty of swallowing of three days duration with associated with grade intermittent fever cough and heavy nose. she lives that house with three people and she eats bread with rice, patient start injira with made of tonsils, she eats 3c days with normal size plates.

Vaccinated acc to ale and can speak fluently with 3 word sentences, can run, climb upstairs, a stairs, down stairs

HEENT- inflamed tonsils with involvement of posterior tongue.

History of present illness is 4 years old female child presented cough and fast breathing of one days duration. In association to this she has hx of sneezing, nose and low grade fever. She has hx of non-luminous, non-projection vomiting. She lies hx of repeated hospital admission for the same emplace. She has no hx of abnormal body. She has no hx of diarrhea. She has hx of contact to chronically coughing person. She has no hx of checking episode.

No family hx of asthma or no self hx of allergy vaccinated according to EPI schedule . she had been in chronic follow up in this hospital and followed for 3 month then told to be no longer needed the follow up 2009. She Is screamed for RUI told to be NR . she uses EBF for the first 6 month of lifein know on family diet. Lives in afamily site of with single room house with no window only one door and separate kitchen.

No sign of fluid collection and no edema or deformity. She has been admitted to our hospital repeatedly with diapauses of hyperactive airway disease and pneumonias. She does not have checking episode.no family history of asthma. She has been on chronic follow up for HAAD for about three months and was told she no cougher needed follow up in

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No family hx of asthma or no self hx of allergy vaccinated according to EPI schedule . she had been in chronic follow up in this hospital and followed for 3 month then told to be no longer needed the follow up 2009. She Is screamed for RUI told to be NR . she uses EBF for the first 6 month of lifein know on family diet. Lives in afamily site of with single room house with no window only one door and separate kitchen.

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She is on chronic follow up for HAAD find the age of 2 years who has a monthly follow up at this hospital on salbutamol puff permed. She did not have increased recumbent of attack recently. She is the first child the family who has vaccinated according to EPI schedule. She is currently family diet.

History of present illness this patient was one day. She began to experience non-product, non-whopping, non-baker. Cough with associated high grade intermittent fever. But no vomiting.

She has no fast breathing or grunting. She has no hx of for adenine pain. She is known HAAD patient on salbutamol puff PRN base patient for the past 2 years. She is no family diet. She can run by herself. She can communicate with any one.

History of present illness a known a HDDA patient for the past one year on salbutamol puff and on choric follow up and adherent to her mediator.

Currently presented with non-whooping , non –barking cough associate with low grade fever, fast breathing, but no chest pain. she has no crying during Mie hum urgency them.

A known HAAD patient on salbutamol puff PRN currently presentd with cough, fast breathing , low grade fever and abnormal breath sound. Continue on salbutamol puff for 4 hours, hydrocrtizone , crystalline pencillin until 72 hours from admission then PoABx.

History of present illness this baby is a known mild intermittent asthma patient on salbutamol puff PRN. Currently presented with cough fast breathing, low grade fever and abnormal breath sound. She has flu like illness since 3 days back. she has no family hx of asthma. She has no hx of eczema. She has episode of vomiting after frequent coughs. She is fully vaccinated according to EPI schedule. She has 2 episodes of attacks over the past month. She is on family diet currently. She plays with her peers without limitation . the mother had gave her salbutamol puff every 20 minutes since 4 am to night. She is screened for RNI and VR..

Abdominal full, that moves with respiration. No organometallic, no of fluid collection. Plan is CBC, salbutamol puff, hydrocortisone, crystalline penicillin.

Moderate exacerbation of intermittent asthma by common cold +current pneumonia. Treatment low order and salbutamol 6 puffs for 20 minutes with hydrocortisone 52 mg . History of present illness this 3 years old female was best relatively healthy. 2 days back she started to have sneezing and rhinorrhea and later followed by a day non-barking, non-whooping cough with associated fast breathing, but no history of fever. She also has hx of similar symptoms.

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A known HAAD  patient on salbutamol puff PRN currently presentd with cough, fast breathing , low grade fever and abnormal breath sound. Continue on salbutamol puff for 4 hours, hydrocrtizone , crystalline pencillin until 72 hours from admission then PoABx.

History of present illness this baby is a known mild intermittent asthma patient on salbutamol puff PRN. Currently presented with cough fast breathing, low grade fever and abnormal breath sound. She  has flu like illness since 3 days back. she has no family hx of asthma. She has no hx of eczema. She has episode of vomiting after frequent coughs. She is fully vaccinated according to EPI schedule. She has 2 episodes of attacks over the past month. She is on family diet currently. She plays with her peers without limitation . the mother had gave her salbutamol puff every 20 minutes since 4 am to night. She is screened for RNI  and VR..

Abdominal full, that moves with respiration. No organometallic, no of fluid collection. Plan is CBC,  salbutamol puff, hydrocortisone,  crystalline penicillin.

Moderate exacerbation of intermittent asthma by common cold +current pneumonia. Treatment low order and salbutamol 6 puffs for 20 minutes with hydrocortisone 52 mg . History of present illness this 3 years old female was best relatively  healthy.  2 days back she started to have sneezing and rhinorrhea and later followed by a day non-barking, non-whooping cough with associated fast breathing,  but no history of fever. She also has hx of similar symptoms.

Currently  presented with non-whooping , non –barking cough associate with low grade fever, fast breathing, but no chest pain. she has no crying during Mie hum  urgency them.

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Sex male

CIC He has Fever .He has Fast berating.He has Cough Two day duration Assessment pneumonia RX Amoxicillin / 25 Mg /5m/ /ten spine

PO TID for five days

Sex male

CIC He has Fever .He has Fast berating.He has Cough Two day duration Assessment pneumonia RX Amoxicillin / 25 Mg /5m/ /ten spine

PO TID for five days History of present illness modeless exacerbation of daily intermittent as thing. On salbutamol puff PRAL.

She was daze cough of one day duration,t. Assistant his improving and finally appoint after one month. Patient history presented with exacerbation of shortness of breath growing LGIF of one day duration .since three days back she was haring common cold like symptoms known mild intermittent asthma pt for the past three years was on off but discontinued follows since one year back because she was told to be enough and she is well. She has three admissions this year only and has symptoms one up to two weeks ,was using salbutamol puff.

Patient laboratory data PRN but has finished if three months back immediately after her last admission .Course in the hospital chest flaring of noses .

Final diagnosis moderate exacerbation of mild intermittent asthma. Advice on discharge given amoxicillin syrup for six days. Prednisone one milligram per kilogram for four days. Salbutamol puff QID basis for three days and then PRN. Appointed after two weeks on chronic follows.

Chief complaint shortness of breath of one day duration.

Sex male CIC He has Headache He has Backache He has Chills He has fever He has for three day duration Assessment acute febrail I 11 less RIO Malaria Plan RDT Positive for RDT RX Coartem 4 tab PO Bio for 03 days diclozenac in ejection 75 Mg/3m / I m stat PCM 2 Tab PO PRU Patients history:Sex male CIC He has Headache He has Backache He has Chills He has fever He has for three day duration Assessment acute febrail I 11 less RIO Malaria Plan RDT Positive for RDT RX Coartem 4 tab PO Bio for 04 days diclozenac in ejection 75 Mg/3m / I m stat PCM 2 Tab PO PRU

The child not available father refill the medication Assist GTC epilepsy Plan –refill Advices on adherence Appointed for 2 months Follow up on phone bacbitone 75mg po/day GA –stable HEENT – pink conjunctive NIS LGS- NO scap Chest clear and resonant with good air entry WS- s1 and s2 well heard, no M or gallop Plan –phemobarbifore 50m/day pharytoil 750 gm po/day History of present illness: He is presented with abnormal body movement of 2wm meat .during of bthe few and purling of eye 75 by abnormal body movement of both upper estimate 77 by petivacted He has no headache or we know.He has no LX of herd traumas.HEENT –PC ,NIS LG- NO LAB CHAT- clear and menet CVS - s,1ad n s2 heard no M ABD –No organelles MSH – no edema ASS= GTC Epllspsy Plan= phensantine 42mg po/days

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History of present illness modeless exacerbation of daily intermittent as thing. On salbutamol puff PRAL.

She was daze cough of one day duration, but no fast breathing granting of fever she has also on wised wheezing episode. but got impaired. good air entry birth, sigh well heard. Fail control.

Pln- salbutamol puff advices to identify exacebose factual last admission .Course in the hospital chest flaring of noses .

Final diagnosis moderate exacerbation of mild intermittent asthma. Advice on discharge given amoxicillin syrup for six days. Prednisone one milligram per kilogram for four days. Salbutamol puff QID basis for three days and then PRN. Appointed after two weeks on chronic follows.

Chief complaint shortness of breath of one day duration. History of present illness this is one day back at which time. She started to have shortness of breath grunting and LGIF since three days back. She was having common cold like symptoms like cough sneezing.

She is know mild intermittent

History of present illness :

then is 3year and zonular which for ox of mam sourly currently he is on plump not 2seched, Sam moderately stunted rickets on no medicals, No plump not, Crimpy and pain and musty and musty stool, No face limiting. No couth fast breathing looks mal nourished not in debases vls .Sam t moderately stinted t rickets on no medicals no plump not cramp and pain and mucus steal. No face something. No Casey fast breathing looks malnourished not in distress. Under right +mam+moderately stunk with nick effs pl vit a defi

History of present illness

she was long relative health two days back at with time system to experience peylumbical focus enemy abdominal path an related with mucus diagnosis of two residences with also had two residence of none progress.

With is funny vacillated

In is for six mgs currently in usually enter made of tiffin Stanley planed berry

History of present illness

Picante with none happy none banally course of days but no fasted health focused of days but no fast health for

She was given a anemically happy

She was LRH 6 days back of which time he stated to experience a cramp associated with less of appetite foul-smelling blood mixed dashes of 2episode which is fond smelling non bilious vomiting of 1 episode but no fever for which re visited HC where stool exam and done foot inspected medication for 3days of cotrimoxazole for 5days but not improvident.He has no hx ofcontent with tb patient or chroidcouse

-NOFX of pain during or change in urine color

History present illness this diarrhea for three days Sex male He has Abdominal distention Take for one day duration He has Abdominal crap

Assessment Intestinal parasite Mebendazole 200 MG PO BIO For three days History present illness this diarrhea for three days Sex male

He has Abdominal distention. History present illness, person LKH 03 weeks back time started high grade intermittent fever chills higher. Migrators joint pain one year duration.he started expanse migrators joint pain started ankle inter phelynyeal joint cyigbtes involves wrist, knee, elbow, past one year associated several joint pain. He also joint swelling high grade intermit fever chills, rigors .he also heanatuhs frequency urgency.physical examiner says health, CPD, concinslaler .no edema, joint swelling, tenderness limitation fever. intermittent joint pain. family history similar users.so sick looking, joint smelling.The fever prominent night time propose night smoothing. Associated abdominal pain, decreased appetite significant un formalized weight loss. History present illness, person LKH 03 weeks back time started high grade intermittent fever chills higher.he started expanse migrators joint pain started ankle inter phelynyeal joint cyigbtes involves wrist, knee, elbow, past one year associated several joint pain. He also joint swelling high grade intermit fever chills, rigors .he also heanatuhs frequency urgency.no edema, joint swelling, tenderness limitation fever. intermittent joint pain. family history similar users.so sick looking, joint smelling.The fever prominent night time propose night smoothing. Associated abdominal pain, decreased appetite significant un formalized weight loss.Take for one day duration He has Abdominal crap Assessment Intestinal parasite Mebendazole 200 MG PO BIO For three days Chief of complaint cane fore chorionic follow up History of present illness p_ type I dmdm leas 4/2 and regulate insulin 3/1 nothing rbs=197 mgldc (irundetolyadteakpast) adeptly polcasia,polydysispolyehagia no fever at cause nohxop, lass of consciousness o_G/A healthy looking not in posfecatogy distress HEENT pmkcanjutng non ictslsdzecgs no cap chort clear and peasant cur s1, and s2 well hart Patient history presented with polyuria and paradise of more dotation non projective vomiting 02 episodic easy fasiguabiliti weight loss despite polyphonic Patient scaly scalp lesion acutely sick looking in distress lookin distress look male most back pr 120 rr 32 to 37 under eight self retracting Patent lab dese sketosd3 glucose13 RBS 381mg/cl CBC Course in the hospital N/S bolus gamiest give regulate in such kcl because one of oka the slanting dose of insole grasses foul Final diagnosis under weight dewily types iom with module olka

Advice on discharge (treatment appointment referrals) on standing dose of insulin educated about DM(mother) pointed offer 08 week Chief complaint pleura poly dipole of month back History of present illness this is a preschool child who was last weather healthy OL month back at which time begin to experience polyuria and polytypic of which he venous 8x/day and 3_4x/at night the drink frequently 6x the day and 3x/at night associated with this he has also poly and easily fatigue but the associated 3x/day to the admit ion but no dine or abdomen pain he has no hx two cough he is not for his dines he has no tend lorries out pet or altered mentation use in fanning size of 03 in iron corrugated lousy use tape water he has no hx 2 shaping in the week child hood Progress note 2nd DOA for the dx of under weight + recovery diagnosis type I DM with monocolate DKA polydypia and polyyuria of 01 month duration fatrygalolity of 01 week non perspective vomiting of ejected matter fetch looking distress deep labored breathing urine feetone done put on 160 ml of NS for currently conscious taking profeeding and modicatin HEEROT pink conjunction chest no fast breathing no scic retraction clear with good air entry abdomen full moves with respiration no tenderness no organomegry no sign of fluid collection

Age 6 Sex male

CIC He has Fever .He has Fast berating He has Cough Two day duration.

Assessment pneumonia RX Amoxicillin / 25 Mg /5m/ /ten spine PO TID for five days

Chief complaint care for follows up History of present illness p-MVHD(MR,TR,AR,AS)ON Lasix 20mg po Bio.spirnoloctene 25mg per 1day.monthly benzamine penicillin 600,000 10 1m .currently no less swelled, no cough, sdb, no fever ,Pno. Chief complaint came far follow-up. History of present illness p-MVHD(MR,TR,AR,AS)ON lasix 20mg po Bio. spololactone 25mg po daily monthly 600000 IV B ,penicillin. Currently s-no menu completion.

History present illness:

p-MVDH on to six 2 day paracetamol 25mg per day/currently no fever, pno . p =multivalued heard diseases presented by rhea vary recon junctive. benzo note percaline.

This is a six-year-old female from Gonder k-18 admitted four days back with the ASS't chef 20 to vho 20 to crho ppd by muculves +uti.

She was LHR foure day back at which female she begins to express a migratory. Joint pain. Which in fully begging in the left knee joint which cut the program to involve the rt knee joint .

History present illness:

This patient was LHR a week back at which time she begins to experience migratory joint pain which initially begins the left knee joint and result progress to involve the patient knee joint and elbows flash anointed with them. she had no hx emotive drugs of witness. She had no previous

Chief complaint diarrhea of 01 week duration. History of present illness she no lit contemn hints a week back. At which stated to explain fleshed 2-3 100w tools per day to stool is not by need much constituting. Its assoiled with calamity per lamblike adoration pain. But no vomiting or teres.sm 100 no programs disarm. She has no panting drug Smalling. She has egg peat or disease. She is funny vaulted. She has entry by attached acting to EPE. She is on faint .she has a history of soling of analog dissed physical exam. Chief complaint diarrhea vomiting of 01 day duration History of present illness this sine old female child last relationally heating 01 day beat she statted.to experience 2-3 episode none bloody non mucus. Watery diarrhea associated with vomiting at 2-3 episode of ingested matter per day. She has also sullen eye ball but nori tabling adhered mentation. She has no hx change in urine volume.no hx of abnormal body movement .no hx of the same issues previously. She does not eat contaminated food. She is vaccinated according to epi sclecloff. History of present illness . She is comparable to her friends.no discharge hx with known TB pts

Sex male CIC He has Headache He has Backache He has Chills He has fever He has for three day duration Assessment acute febrail I 11 less RIO Malaria Plan RDT Positive for RDT RX Coartem 4 tab PO Bio for 03 days diclozenac in ejection 75 Mg/3m / I m stat PCM 2 Tab PO PRU

History of present illness:

Type I DM on –lent 15-17 regular 6-4 currently she has no hx of fever ,she has no hx of heachacke blurring revision smiling of loss of consciousness, she has no hx of pohyrun , she has no hx of abdominal pain of vomiting

History of present illness:

c/c –polyvidone and poly despair and she has no hx of cough or contact is chronic. She has no hx loss of conscious wel. She has no family hx of DM/HNT. She has no syncopal attack.

C/C Abnormal patient:

She was lost faltering healthy 2 days before and which time she started to experience abnormal associated cows leads intermittent fever. She has no dirt, vomiting or abnormal distinction. She is known diabetic patients on following for the past 3 months. She has fully vaccinated according to EPI. She has no cough or contact with tbc pet. she has no self on family hx of DM.

History of present illness:

This patient presented with polarized and polydipsia of 01 hacek diluter with associated no hx of fever on cools.

Course on discharge:

Admitted: hypoed vinous stock calculated Dka meaning pe protocol ad below 01 DKA diabetes edoater given and finally incited and dislodged given and appointment.

History present illness this diarrhea for three days Sex male He has Abdominal distention Take for one day duration He has Abdominal crap Assessment Intestinal parasite Mebendazole 200 MG PO BIO For three days

History of present illness he was LRH 6days bae panicky of which time RE stated to experience a crampy cigars pained associated with loss of appetite foul smelling blood mixed dishes 2episodes which is fonl smelling non bullous vomiting of 1episode but no fever of for which re visited l hr. where stool exam and done took unspecified modulation for 3days of cotrimoxayale sync for days but not improved

He has no hx of contact with tb pt. or chorine cause

No hx of pain dulling urination or change in urine color or amant

Fnlly vaccinated according to

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Sam moderately stated t rickets on no medical

Pl =under out +mam+moderately stunted with rickets pl vit a definition on the is on plupy nut but which is not available donot tooks for two month this child use last lacation health 10 days back at which time he begain to experanhe ce in whooping non barring non prodncte caugh a past tussible veniting the moth

Non baring non predicted caught both a past fusible venting the mother claimed he has no fever fasted

The pt was cetc 1 day back of which sme he stated to develop none bsedy

He was LRH of back at which time he started to experance episodese of non bloody non billous non projectile vomiting he had loose stools which is not similar to his bowl habit and he has recent sunkening of his eyes

He is vaccinated according to the epi schedule

He was adequately sun exposed

He is screend for rul and found to ben on reative

He has non whooping non barking

Paugh with no fast breathing

He has no of urine discoloration

History of present illness he was LRH of hrs back at which time he started to experience episodes of non bloody nonbillous non project vomiting he had loose stools which is not similar to his bowl habit he has recent sunkening of his eyes

He is vaccinated according to the

History of present illness he was last relatively healthy a day back at which the he begain to experance ahigh grade interfered fever with foat breathing

He has been having snterizing day caugh for the past of week with assidcanze

He has no hex of chuckle epodes.History of presented illness he was last relative healthy a day back at which the he began to experience

History of present illness:

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He has been having satirizing day caught for the past of week with assidcanze

He has no hex of chuckle epodes

History of presented illness he was last relative healthy a day back at which the he began to experience

Patient history he is known cardinal pl for the past 2 years and smooths on lose x 20 mg po/day ,spironoketoer 12>mg po/day and monthly benzantayin penicillin 6000.000lvim .he presented with dry cough, fast breathing ,high grade on treatment fever .he loss lematunia. Chest – Clsc let action noodle actually Final Diagnosis:SAM +CHF precipitated by caps Advice on Discharge

Treatment, appointment, referrals. He was audience for follow up properly every month and adduced not to discontinue let medication and to be so salt free digit. Revised order:Losox 20mg po pio per day Enology 2.5 mg po/day Amoxicillin Symp 250mg potlo for 10 days Patient History of illness: P. on his 3rd DOA for the dx of CHF 2 CRVHD Precipitated .A known car divan patient for the past 2year and 6 month on Lasix 20mg po BSW and spiraboladone 12.5 mg po/day and monthly presented benzyl percaline salt restriction and was adhered to his medical from currently presented with dry cough fast breathing ,high grade fever.Patient History of illness: P-HF 20 MVHD (MR, TR, MS)20 TO CRHD + Underweight a furosemide 20mg po/day spironolactone 12.5 mg po/day and monthly byzantine percaline 600,000 IV IM monthly.

Currently no new compliant, Ga comfortable and play full .Follow up P – moderately stunted + HF 20 to MVHD (MR, TR, MC) 20 TO CRHD ON spironolactone 12 mg po/day , Lasix 20mg po/day .Object: conscious not on discreetly Mt -15 kg Hsm best heard at Usb and approx.Mid diastolic No edema Assist = hymnody manically table Plan =refill see after 01 month

P1 -1st DOA for the diagnosis of type l DMT after he presented with failure to suck sweeting and sleepiness of 06 hrs duration he is a known types dm for the past 06 months on center 2/1 and regular 1/1 he had no hx of abnormal body movement.

History of present illness:

ASS'T

hypo glycoma +type dm known type I dm taking NPH and regular presented with sweeting and decreasing mentation of 6 hours' duration.

Patient history:

Known type I DM patient for the post 03 month on medication present with cough fast breathing grunting and high grade intermittent fleshy of o2 days duration. he also has initially and abdominal paint 2 days a HREE admission. plan continuous anti habit, injection month RBS . P-5th DOA for the DX of sever CAD + HAAD + solve DHN + type 1 dm. developed middle DKA 2 days after Admission.

E- after he presented with failure to suck sweeting and sleepiness of 06 hrs duration he is a known types DM.

History present illness:

p-mvhd 20TO CRHD on besthestime penciling. currently s-anon new complained. Adhered to her coeducation, no history of types or typed.

History present illness:

She is a known cardiac patient for the last 1 year on medication. warranty she came for follow up she had with hx of drudge's continuation. She had no shortness of birth, orthopnea pno or less swelling. she has no fever chills or never, she is not salt add.

History present illness:

She is a known cardiac patient for the last 1 year on medication. warranty she came for follow up she had with hx of drudge's continuation. She had no shortness of birth, orthopnea pno or less swelling. she has no fever chills or never, she is not salt add.

7th day of admission for the dx of hf 20 mvhd 20 crho +under wt . this is 2 years old female patients and she was a known cardiac patient for the last 1 year on chloric H and she was on Lasix 20mg po bid and spinors lector 25mg /day and bazanthyl penicillin 600,000IV/month currently present in fast breathing BT no cough 50b, orthopea,pno and leg sandhog . adherent to her medication, fully vaccinated according to the EPI schedule.

Transfer note:

From critical to wing p-on 2nd DOA for the di org ref 20 to CVRD fund rule patient since back on chronic following. currently she come with fast breathing but no cough SOB crhopross, copsweeling or pno.

History present illness:

She is a known cardiac patient since a year back and on monthly Bpencilline, basic long probed. she complains fast breathing at ordinary activity's but SOB chromate, pno cough on she snith on salt free dirt, no hx fever, no hx of disunion medication. warranty she came for follow up she had with hx of drudge's continuation. She had no shortness of birth, orthopnea pno or less swelling. she has no fever chills or never, she is not salt add.

History present illness:

Patient with present with low grade intermittent fever associated with low grade pain which involved the ankle which followed by the knee buts cough dry spree orthopnea pno palpitation.

History present illness:

The patient was LHR 01 month back at which fever started to experience low grade intermittent fever associated with majority joins psine which involved the ankle 1st the night then the length ankle which was followed by the knee joint. 01 weeks back the actual to have non whooping non

bunking o7 type. She has no hx tine lesson. She was no hx of abnormal body movement she is from malaria and release which but has hog attach of it.in a family size of with his mother.

History of present illness

she was long relative health two days back at with time system to experience peylumbical focus enemy abdominal path an related with mucus diagnosis of two residences with also had two residence of none progress.

With is funny vacillated

In is for six mgs currently in usually enter made of tiffin Stanley planed berry

History of present illness

Picante with none happy none banally course of days but no fasted health focused of days but no fast health for

She was given a anemically happy

She was LRH 6 days back of which time he stated to experience a cramp associated with less of appetite foul-smelling blood mixed dashes of 2episode which is fond smelling non bilious vomiting of 1 episode but no fever for which re visited HC where stool exam and done foot inspected medication for 3days of cotrimoxazole for 5days but not improvident

-He has no hx of content with tb patient or chroidcouse

-NOFX of pain during or change in urine color

History of present illness then is 3year and zonular which for ox of mam sourly currently he is on plumpy not 2seched

Sam moderately stunted rickets on no medicals

No plvmpynot

Crampy and pain and musty and musty stool

No face limiting

No couth fast breathing looks mal nourished not in deases vls

Sam t moderately stinted t rickets on no medicals no plvmpynot crampy and pain and mucus stoal

No face something

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Under reight +mam+moderately stunkd with nickeffs pl vit a defi

History of patient illness is sydnlanis diarrhea monthly byzantine pangolin 1.2 millgram Clementi s- no abnormal body moments for the past 2 years heevvt- pmlccony, ms chest has no il /securitization and clear with good air entry abdomen – no suganomgaly msk- no edema swt – no pallor, no rash cm- conscious friended asst- hemodynanzaly stable plan- cont. b. penzlhr apponte after 2 month history of patient illness: sydenham's cholera on—monthly byzantine penicillin 1.2 milligram iu im currently no new complaints no abnormal body movement she can use her hands well heent. pink conjumetilla rnis chest- clear cus- s1 and s2 well heard Abdomen – no organomgally or sign of filled collector gus- no cuatmss- no edewa cns – conscious and oriented. asst- good control plan -refill-appoint after 01 month.history of patient illness: synnhannes chorea on – monthly benzantin penicillin 1,2 millon iu im Currently no new compliant and no abnormal body movement heent. Pink conjumetilla rnis chest- clear cus- s1 and s2 well heard no org abdomen – no organomgally or sign of filled collector gus- no cuat mss- no edewacns – conscious and oreinted.asst- good control plan refill appoint after 01 months.History of patient illness: Sydenham's chorea on –monthly benzanthine penicillin 1.2 million iu im Currently – no new compliant no segue episode in the past month and no lap chest: clear with good air entry bilaterally cvs: s1 and s2 well read abd: no cvat mss: no edemainteg: no pollar cns: colclaw and orlented ass good control plan -continue byzantine injection -apooint after 01 month history of patient illness:sydenham's chorea on –moonthly benzanthine penicillin 1.2 million iu im s-no abnormal body mov't hssnt-pink conjuction chest: clear and resonant cvs: s1 and s2 well read gus- no cuat msk: no stamu cns-conssous govlentet ass't - good control history of patient illness:sydenham's chorea rx –moonthly benzanthine penicillin 1.2 million iu im s-no abnormal body mov'tAbdomen – no orgammegly Chest: clear and resonant gus- no cuat mss: no edm ass't : well controlled history of patient illness: synnhannes chorea monthly benzantin penicillin 1,2 millon iu imcurrently – no new compliant no abnormal body movement o-coll comfortable vls= stable abdommen no mass or orgemigely gus- no cval asst- inpond plan 20 descetme the phase berbertons.-post 03 months.rtc after 01 month history of patient illness: sydanance chorea on b. penicillin 1.2 million lu im monthly s no cough or edams she has global 301 type no abnormal body moments for the past 2 years color and resonantcrs- conciors ass't- importins Plan- refill appointment after 01 month history of patient illness: asset-

Sydenham diarrhea plan- phono Bal hedonic pre dissolve to be tapered after a week nb- her previous hent who lost during hormone follow up

History of patient illness:-Sydenham's chorea On –monthly benzanthine penicillin 1.2 million IU IM

Currently – no new compliant no segue episode in the past month Chest: clear with good air entry bilaterally MSS: NO edema Integ: no pollar CNS: Colclaw and oriented Ass good control Plan - Continue byzantine injection -Apooint after 01 month History of patient illness:-Sydenham's chorea On –moonthly benzanthine penicillin 1.2 million IU IM S-no abnormal body movement HSSNT-pink CONJUCTION Chest: clear and resonant CVS: S1 and S2 well-read GUS- NO CUAT MSK: NO stamp CNS-CONSSOUS govlentet Asset - good control History of patient illness: Sydenham's chorea monthly benzanthine penicillin 1.2 million IU IM S-no abnormal body movement HEENT-pc and HIS GI- NW LAP Check clean Cus- s1 and s2 well hardNo normal ABD – no orgammegly Chest: clear and resonant GUS- NO CUAT MSS: NO edm Asset : well controlled History of patient illness: Synnhannes chorea monthly benzantin penicillin 1,2 millon IU IM Currently – No new compliant No abnormal body movement call comfortable vls=stable Abdommen no mass or orgemigely GUS- no cval ASST- inpond Plan 20 descetme the phase berbertons. Post 03 months.RTC after 01 monthHistory of patient illness: Sydanance chorea On B. Penicillin 1.2 million lu IM monthly S no cough or edams she has global 301 type no abnormal body moments for the past 2 years Chest – color and resonant Crs- conscious Asset- Importiant Plan- Refill Appointment after 01 month History of patient illness: Ass't- Sydenham hora Plan- phenobalhitonic pre dissolve to be tapered after a week her previous hint who lost during hormone follow up.

Chief complaint cough of one week duration.

History of present illness this patient was LRH one week back at which time. She experienced a non-barking, non-productive, whooping type of episodic cough with associated urge to vomit after coughing. She has associated decrement of appetite but no fever.

She has no history of contact with a chronic cougher or a known TB patient.

She has completed her vaccination for her age.

She was exposed to sunlight since 15 days of birth with applied buffer. She was exclusively breast fed for the first six months of age with six per day with night feed.

She has history for allergy to amoxicillin syrup and respiratory.

Chief complaint cough of one week duration. History of present illness this patient she was LRH healthy two weeks back at which time she started to have non barking ,non whooping, cough with associated. Breathing otherwise no rash all was exchisive breast fed for six months how un family diet.

She is fully vaccinated. She next private chronic and was told to have alleys to amocacillin.

Chest expectation over posterior lung field bolograph.

Abdomen flat feat moves with respiratory. No mass, no organomgally.

History of present illness: she was long relative health two days back at with time system to experience pail musicale focuses many abdominal path a related with mucus diagnosis of two residences with also had two residences.

Present with a non-whooper none belong cough 04 days but no fast breathing or fever. She was given amoxicillin group 05 days but hx did not had.

Chief complaint came for chromic follow-up. History of present illness p-CRVHD (MR,TR,MS) an Lasix 20mg po bid. Spironolactone 25 mg po l day. Monthly plaiting penicillin 1.2 million lu iv stat. Chief complaint came for chromic follow-up. History of present illness p-MVHD (MR, TR,MS ) an Lasix 20mg po Bid. Spironolactone 25 mg po l day bighting penicillin 1.2 million IV .monthly.

History of present illness:

P- type 1 DM on s- no new complains Abd NO ornamentally ,no sing of flosconta. no stemma

History of present illness:

This patient was LHR 02 week back at which time he started to experience excessive water incus. Excessive urination with this he lost significant but un revised lost with consequential. This is 14 years old note child is presented with polydipsia and poly undid of 03week duration he has un unified weight loss he has no fever cough cheats pain; he has no unary simpered.

This patient was about Persia of 8 days and 3 nights. he has no fever cough, he had no palpitation or apnea. he had no screened for fill, he has no vaccinated.

This child is having relatively 02 months back at which time he started to experience polydipsia. The problem was about 8-10xdays and 3-4 x night. The polydipsia was problem 5ml/ day. He had significant weight loss within 02 weeks. He had no hx of recent frame, he had no hx drug inside. He has not family hx. He is the 4th child for the parents.

Chief complaint cough of one month duration. History of present illness this patient is presented with whooping. On barking cough with associated possessives vomiting.

She has no eyes fast breathing or granting. Her elders are also coughing.

No family hx of asthma

No chocking episode. She is vaccinated according to the EPI. GA conscious and healthy looking.

Gus female types of genitalia no skin rash or pallor and no edema.

Chief complaint diarrhea of one day duration.

History of present illness this patient relatively healthy before one day at which he stated to expanded diarrhea to episode per day but no vomiting associated to this shells expired high fever and her Mohan. She hx no his faith to snack.

She has no contact with chronic cough or known TB patient.

Abdomen no ognomegaly and sigh fluid collection

History of present illness this patient was one day back with time. No exam a conscious admit to critical.

Currently he has one episode GTC seizure with past one month despite excellent adherence for the medication.

Chest is clear and resonant.

CVS sound is ell heard. Assist good controlled.

Currently he has one episode GTC seizure with past one month despite excellent adherence for the medication.

Chest is clear and resonant.

CVS sound is ell heard. Assist good controlled.

Plan appoint after one month.

The child not available. Father refill the medication assist.

Plan refill and advice on adherence, appointed for two months.

History of present illness abnormal body movement despite adherence to his medication (phenytoin)

Has no hx of fever. Has no hx of cough. Has no hx of neck stiffness.

Plan add phenobarbital 50milligram po BID

Follow up: repeated seize for two days. No improvement with phenobarbital

History of present illness he is presented with abnormal body movement.

During the episodes the develop.Plan appoint after one month.

History of present illness

she was RRH 3days back at which time started to experience crimpy power abdominal pain which is content associated with low grade intermittent fever loss of appetite but no vomiting fine here abdominal distension of constipation. she also has burning sensation ganitutive during urination, she has no hx of cough content with TB patient, no hx fast breathing grunting, no hx of pain during.

History of present illness

she was LRH a week back at which time started to experience intermittent free with associated loss of appetite but no vomiting fine here abdominal distension of constipation.

Patient History: this a 2-6/0 old phase pe presented with fast breathing coghihgt prede affected feves.he was re reputedly treated for CAP and Asthma. For the postly Patient p: E stable Patient Lab.Data -CXR Normal -CBC Norma Course in the hospital Adapted to was treated with coughs t solbutowl Final Diagnosis: SCAP t Asthma (Aato exacerbation of ASTHN Advise on Discharge (Treatment, appointment, referrals..) -salbutamol riff PRN -Amoxicillin syrup PRN -prodigals for 5 days 10mg po/day -link to chronic follow Chief Complaint: cough of 02 days duration stable Patient Lab.Data -CXR Normal -CBC Norma Course in the hospital Adapted to was treated with coughs t solbutowl Final Diagnosis: SCAP t Asthma (Aato exacerbation of ASTHN Advise on Discharge (Treatment, appointment, referrals..) -salbutamol riff PRN -Amoxicillin syrup PRN -prodigals for 5 days 10mg po/day -link to chronic follow Chief Complaint: cough of 02 days duration

Systemic onset JIA on methotrexate 7.5 milligram of a weeks. It has joint swelling of the wrist of finger joints of both hands.no fever.no abdomen pain, vomiting of diarrhea. No abdomen, swelling, distension. Swelling and mild tenderness of both wrist and finger joints. Taper the dose of methotrexate to 3.75 milligram.po weekly and the dose of Ibuprofen to 159 Mg po BID after R1 consultation and appoint after one month. He has no fever. No limitation of movement.

Ingested right sclera with exudative discharge and pink conjunctiva. His chest is clear and resonant. Abd. Flat and moves with respiration and no organomegalls. No edema or joint swelling or deforming. Come after a week after. No joint limitation. Currently no joint pain or swelling , no fever and no limitation of movement. Abdomen flat and moves with respiration and no organomegally of sign egfnrd collection. It is no edema or joint swelling or deforming and no puller. Taper the dose of methotrexate 7.5 milligram po of a weekly and the dose of ibuprofen to

150 milligram po BID after R1 consultation and appoint after one month. No joint pain swelling ,fever and abdominal. He has pain and vomiting. Heavily looter.

Currently he has been complains joint smelling order right and left ankle ass with he has low grease intermittent fever and has also pain over his external but on other complaint. Objective comfortable not on CPD and consesing. Full abd mover with respiration and no palmar pallor. Swollen ankle joint but no tenderness to touch ,no other swollen areas. Continue with ibuprofen and methotrexate. Advise on the adherence. Mcaidx jump. Come if he has any problems. Patients history presented with high grade fever rash , joint pain and swelling of 14 months duration.

He had also skin resin to his right lower extremity. Patient P:E was sick looking stable visual signs, non-tender, non-erythematous bilagesm knee and ant joins swellings plus 3x4 cm crusted skin resin. Course in the hospitals admitted and methotrexate prednisolone and cephalexin started and discussing improved . Advise on charge it advice to come back if there is any problem. Methotrexate, prednisolones, cephalexin and Maalox given and appointed after a month. resented with bilateral ankle and knee joint swelling with pain and neck pain. No hx2 trauma ,vaccinated fully. O-Fick looking nourished. After he presented with HGIF fever associated with radish ,flat skin version over his back and upper extremities associated with join pain and swelling which initially stored form his lower extremities and later involved his upper extremities. For those complaints he has been visiting LHC and hospitals repeatedly and was given ibuprofen and unspecified injection and he was having temporary relief. But , it did not go away completely. Chest has good air entry. bilateral ankle and knee join swelling which is non tender , non-erythematous. Dis charge analysis geuediplococci.

Patients history he was LRH 15 months back at which time he started to experience knee joint swelling and pain which later progress to all joints associated with pain and high grade fever. For above complaint he visited this hospital and give ibuprofen but got no improvement .

currently he also developed laver extremities swelling .but no facial puffiness reddish discoloration of mine or decreased mine output. He has no hx of fast breaking or cough. He has no contact hex with chronic conger or knew TB patient. He can play with his peers competitively. He has no hex of trauma to the site .he is vaccinated according to EPI schedule. He can run by himself and can control mine. Currently he is on family diet with good appetite.

The Patient was last relatively healthy of which time he states to exposure joint pain on the enable knee and elbow joints with swelling more on the left enable difficulty on weekly. Which worse

late in the NTLSA gravening and release in the afternoon. In addition to those he also has low grade initiate fever with associated night sweetly no chins or Regus. He can run.

History of present illness, this person was LKH 03 weeks back at which time he started to have high grade intermittent fever in chills but no higher. Migrators joint pain of one year duration. He was last relatively realthy.one year back at which time .he started to expanse migrators joint pain which started from his ankle and inter phelynyeal joint and cyigbtes to involves wrist, knee, elbow, with in the past one year associated with the several joint pain.

He also has joint swelling and high grade intermit fever with chills, rigors .he also has heanatuhs but frequency urgency. He was thing ibuprofen PRN

He has no dyspnea, orthopnea, PND

He has no any skin lesion or high

He has no abnormal body moreover. He has no leg swelling, fecal puffers. He has no falls vaccinated according to EPI schedule. He is grade one student with good performance .physical examiner says health, not in CPD, concinslaler .no edema, joint swelling, tenderness or limitation of fever.

Came for follow up. intermittent joint pain.no deform it. taking ibuprofen 400 mg. family history of similar users.so not sick looking, not joint smelling

The fever is prominent during night time propose night smoothing. Associated with this he has abdominal pain, decreased appetite and significant un formalized weight loss. He has hx contention chronic cougher. But he has joint pain and back pain. Clear in good air entry. Full and move respired.

History of present illness modeless exacerbation of daily intermittent as thing. On salbutamol puff PRAL.

She was daze cough of one day duration, but no fast breathing granting of fever she has also on wised wheezing episode. but got impaired. good air entry birth, sigh well heard. Fail control.

Pln- salbutamol puff advices to identify exacebose factual

History of present illness a known asthmatic at for the past one month(a month before. She was offed for moderate exacerbation of mild intermittent a asthma on salbutamol puff pain. In the past one month GA stable

Chest no sign of distress and no wheeze crept. Assistant his improving and finally appoint after one month. Patient history presented with exacerbation of shortness of breath growing LGIF of

one day duration .since three days back she was haring common cold like symptoms known mild intermittent asthma pt for the past three years was on off but discontinued follows since one year back because she was told to be enough and she is well. She has three admissions this year only and has symptoms one up to two weeks ,was using salbutamol puff.

Patient laboratory data PRN but has finished if three months back immediately after her last admission .Course in the hospital chest flaring of noses .

Final diagnosis moderate exacerbation of mild intermittent asthma. Advice on discharge given amoxicillin syrup for six days. Prednisone one milligram per kilogram for four days. Salbutamol puff QID basis for three days and then PRN. Appointed after two weeks on chronic follows.

Chief complaint shortness of breath of one day duration. History of present illness this is one day back at which time. She started to have shortness of breath grunting and LGIF since three days back. She was having common cold like symptoms like cough sneezing.

She is know mild intermittent asthmatic pt since three years back she follow up , but she stopped follow since one year back because she was told enough by physicians .

No family hx of asthma. She ,has repeated attack and admission 3x this year.

Assit moderate exacerbation of mild intermittent asthma.

Chief complaint shortness of breathing one days durations.

History of present illness this is sign old female child known mild intermittent asthma on follow up presented with SOB, associated grunted , fast breathing and low grade intermittent fever one days duration. The follow up discontinue one days back but had granted admission three years.

No family lx of asthma. No hx of contact from chronic cougher or known lap pts.

She is a well growing for her peers. Chief complaint cough of one day duration.

History of present illness this patient was best relatively healthy one day back of which time to time noticed, non-whooping cough which moistened days for with associated fast breathing with audile breath send uneager send congestion , les muffles also repeats longed fever, but no vomiting , grunting.

She is a known esthetic patient for the past three years with repeated hospital admissions on hospital was treated for preumesia and asthma and treated with spends salbutamol puff impelled ,

History of present illness this patient was last relatively healthy two day at which time she stated to have day cough which is intermittent ,associated with high grade intermittent fever and fest beefy

History of present illness this patient was LRH 3 days cack at which time she started to experience difficulty of swallowing of three days duration with associated with grade intermittent fever cough and heavy nose. she lives that house with three people and she eats bread with rice, patient start injira with made of tonsils, she eats 3c days with normal size plates.

Vaccinated acc to ale and can speak fluently with 3 word sentences, can run, climb upstairs, a stairs, down stairs

HEENT- inflamed tonsils with involvement of posterior tongue.

History of present illness is 4 years old female child presented cough and fast breathing of one days duration. In association to this she has hx of sneezing, nose and low grade fever. She has hx of non-luminous, non-projection vomiting. She lies hx of repeated hospital admission for the same emplace. She has no hx of abnormal body. She has no hx of diarrhea. She has hx of contact to chronically coughing person. She has no hx of checking episode.

No family hx of asthma or no self hx of allergy vaccinated according to EPI schedule . she had been in chronic follow up in this hospital and followed for 3 month then told to be no longer needed the follow up 2009. She Is screamed for RUI told to be NR . she uses EBF for the first 6 month of lifein know on family diet. Lives in afamily site of with single room house with no window only one door and separate kitchen.

No sign of fluid collection and no edema or deformity. She has been admitted to our hospital repeatedly with diapauses of hyperactive airway disease and pneumonias. She does not have checking episode.no family history of asthma. She has been on chronic follow up for HAAD for about three months and was told she no cougher needed follow up in 2009.

She is on chronic follow up for HAAD find the age of 2 years who has a monthly follow up at this hospital on salbutamol puff permed. She did not have increased recumbent of attack recently. She is the first child the family who has vaccinated according to EPI schedule. She is currently family diet.

History of present illness this patient was one day. She began to experience non-product, non-whopping, non-baker. Cough with associated high grade intermittent fever. But no vomiting.

She has no fast breathing or grunting. She has no hx of for adenine pain. She is known HAAD patient on salbutamol puff PRN base patient for the past 2 years. She is no family diet. She can run by herself. She can communicate with any one.

History of present illness a known a HDDA patient for the past one year on salbutamol puff and on choric follow up and adherent to her mediator.

Currently presented with non-whooping , non –barking cough associate with low grade fever, fast breathing, but no chest pain. she has no crying during Mie hum urgency them.

A known HAAD patient on salbutamol puff PRN currently presentd with cough, fast breathing , low grade fever and abnormal breath sound. Continue on salbutamol puff for 4 hours, hydrocrtizone , crystalline pencillin until 72 hours from admission then PoABx.

History of present illness this baby is a known mild intermittent asthma patient on salbutamol puff PRN. Currently presented with cough fast breathing, low grade fever and abnormal breath sound. She has flu like illness since 3 days back. she has no family hx of asthma. She has no hx of eczema. She has episode of vomiting after frequent coughs. She is fully vaccinated according to EPI schedule. She has 2 episodes of attacks over the past month. She is on family diet currently. She plays with her peers without limitation . the mother had gave her salbutamol puff every 20 minutes since 4 am to night. She is screened for RNI and VR..

Abdominal full, that moves with respiration. No organometallic, no of fluid collection. Plan is CBC, salbutamol puff, hydrocortisone, crystalline penicillin.

Moderate exacerbation of intermittent asthma by common cold +current pneumonia. Treatment low order and salbutamol 6 puffs for 20 minutes with hydrocortisone 52 mg . History of present illness this 3 years old female was best relatively healthy. 2 days back she started to have sneezing and rhinorrhea and later followed by a day non-barking, non-whooping cough with associated fast breathing, but no history of fever. She also has hx of similar symptoms. Three times in the past 2 years for the dx of active airway disease and pneumonia. For this she was being given.

History present illness:

This is also a 10 years old male child presented with dry intermittent cough at a week duration with associated his grade into if the fever and night sweating. He also has cylobalized through types of head-on. Lose of appetite Wight lose. He has no content TB patient. he has HX of frequency argons desired. But no urine cot or clones/ he has no to mile 1x of asthma. He is vaccinated according to EPI schedule. LAB: miming behavioral few scale of 07g.

History of present illness:

History of present illness:

History of present illness a known asthmatic at for the past one month (a month before. She was offed for moderate exacerbation of mild intermittent a asthma on salbutamol puff pain. In the past one month GA stable

Chest no sign of distress and no wheeze crept. Assistant his improving and finally appoint after one month. Patient history presented with exacerbation of shortness of breath growing LGIF of one-day duration. since three days back she was haring common cold like symptoms known mild intermittent asthma pt for the past three years was on off but discontinued follows since one year back because she was told to be enough and she is well. She has three admissions this year only and has symptoms one up to two weeks ,was using salbutamol puff.

Patient laboratory data PRN but has finished if three months back immediately after her last admission. Course in the hospital chest flaring of noses .

Assit moderate exacerbation of mild intermittent asthma.

Chief complain: to medical board

History of present illness:p :generatsed tonic epilepsy on pheny tozn 100mg pa b&d .she is a known epirepatic patient for the past two years .the last sezzure was one month back due to drug discontinustion .she had poor adherence to following because of geographical barrier.she needs to have amedical certificate to attend her education at gonder fassileted preparatory school and to have frequent following .plan consult opp senior to limik her medical boarder .

To medical board: this addvant is an 11 grade student and earlexic on follow up here now she is not adhentiant far follow up because she is at sllow far home.

History of present illness: p=dpilolsy.

Chief complaint to medical board

History of present illness p:- generalized tonic colonic epilepsy on-phenytoin,100mg,po,bio she is a known epileptic patient for the past two years. The last seizure was one month back due to follow up because of geographical barrier she needs to have a medical certificate to attend her education at gender, fassiceded preparatory school and to have frequent follow up. Plan consult opp senior to link her to medical board. To medical board this advent is an 11 grade student and easel on follo up here now she is not advent for follow up because she is at slew for home we recommend her to chord she went to joint her shield here for cultch she is abroad letter.

History of present illness p:- generalized tonic colonic epilepsy on-phenytoin,100mg,po,bid career 15 has samba episode of seizur e. 45 rr =88 rr=22 tes=3bt meant ple con,nf las mels chest eha 8 reasons cys=s1&s2 heed hoard

Chief complain: to medical board

History of present illness:p :generatsed tonic epilepsy on pheny tozn 100mg pa b&d .she is a known epirepatic patient for the past two years .the last sezzure was one month back due to drug discontinustion .she had poor adherence to following because of geographical barrier.she needs to have amedical certificate to attend her education at gonder fassileted preparatory school and to have frequent following .plan consult opp senior to limik her medical boarder .

To medical board: this addvant is an 11 grade student and earlexic on follow up here now she is not adhentiant far follow up because she is at sllow far home.

History of present illness: p=dpilolsy.

History present illness:

This is a known JIA patient on ibuprofen, parodies Lon for the rest a three week. He currently presented with difficulty of unration. Auenisted with those he had burning seriations while unionization and intermittent stream. He had low grade intermittent fever.

History present illness:

The patient was LHR a year back at which fever started to experience a joint pain starting from the knee joint healthy which then progress to the antler point and the to the wrest joint with in the past year. Associated with this he had also a high grade intermittent fever with night sweat but no chills or rigor. The patient wornness during the night time. he also had joint swelling in the respective safes. He also had difficulty of walking when the illness occurs. He does not remember any hx of sore throne attack. He has no hx of dyspnea, orthopnea or PNO. He has hx of day cough since two months back.

History of present illness:ass to super infefed T .capitex 12/11/18 .plan griseoflovin 500mg pd neafe* 6wk.2 ketocongles shampro 2*/wk cephalexin 500mg potid*1wk.30-1-11. Ass?ip assmnial pli of 01 week.lod also as cepart up test .no fever .no cosper/rst brective.no diarcee /vomiting.no abdominal crapy /eyltometory.

History of present illness:

assist super manifested patient capitates. plan grilse of vines 500mg pd nest.2% KETOCONCIOUS SHAMPRO 2X WK CEPHALEXIN 500MG POTID . AUT NO fever , no vomiting , no asthmas Crip no diarrhea

History of present illness ali to super infested copies plan griseefluvin 500mg po note X6WK 2 percent ketocongol schema 2X/WK comphelexin 500mg

History of present illness:

He presented with a dry non hooping non balking cough of 3 days fast breathing but no grunting, fever. He had reputed episodes of sand compliant for which he has told to have Pannonia and treated reputedly and improved. No hx contact with TB pk. NO hx of vomiting, diarrhea, difficulty of shallowing. Screened for RVI and found to be 1*1R. fully vaccinated according to EPI schedule. No family hx of Asthma. He was on EBF fill 6month and started on complementing feeding at 6month.

History of present illness:

This is 2 years old male presented of blood on it with diarrhea which is 3-4x/day non full Smalling and with vomiting of episodes. He has earned today but no imitability. He is EBF for the 1st 6month and start compliant feeding. He fully vaccinated.

History of present illness:

He was LHR three day back at which time he sta4rted to experience non whoop and clone barking cough which worsen during night time associated is fast breathing and low grade intermitted fever but no sweating. He has loss of appetite three episodes of vomiting of ingested matter. He has no hx of contact with TB patient. He has no hx of caking. He was vaccinated according to the ERPI schedule. He was exclusively breast feed full age seven year six month and complementary feed and started is gruel and low milk believe in iron corrugate house having a room they have separate kitchen.

History of present illness:

This baby was last relatively healthy three days' bac k at which time he started to experience non Throop is non baring day cough with exacerbate at night with associated rally move and sneezing. He also has low grade intermittent fever but no chills or vigor or any fast breathing. He was vaccinated according to the ERPI schedule.

History of present illness:

He presented with a dry non hooping non balking cough of 3 days fast breathing but no grunting, fever. He had reputed episodes of sand compliant for which he has told to have Pannonia and treated reputedly and improved. No hx contact with TB pk. NO hx of vomiting, diarrhea, difficulty of shallowing. Screened for RVI and found to be 1*1R. fully vaccinated according to EPI schedule. hemodynumically stable.

council refill for one month.

council adherance

advice on danger scram

salt free diet or milks.

history of present illness of diagashic kephoscalios,phnumina , HIV

curretly no new complaint

adherent and hermedrate.cost conscious make distress.

Chief complaint fever and fast breathing of two days duration.History of present illness this is patient was apparently health two days back at which time. She began to experience watery, mucoid diarrhea three up to four days associated with she has abdominal peril, but no vomiting .she has low grade fever since a week back.She has no cough, caught, fast breathing. She has no coifing during maturation, hemofulten. She has no sickening of eye ball.She fully vaccinated. She is EBF for six month, then complementary feeling started.She started to walk at age of 12 month, diarrhea of currently come ran can talk wanly. Heent no sucking of eyeball.Chief complaint vomiting and diarrhea of two days durations.History of present illness this patient was LRH was at which time. She started to experience three to four days vomiting of injected matter and three up to four times watery, non-mucoid, non-bloody diarrhea with associated eagerness to drink but no sickening of eyes, changes in mentation's or decreased urine output. She has hx of low grade fever but no cough, fast breathing.She was vaccinated according to EPL schedule. She started to walk alone at one year of age. Chief complaint cough of one week durations. History of present illness this is diarrhea and one month old child presented three non-whooping, non-berthing of one week duration. Associated with this she has also high grade interment even with test one or everything but has promotion. She has also projective non vomiting ingested matter but no diarrhea or sunken of eye bet. She has no number of decrease.She can walk by herself.She was one unity six month and compliantly feed

-she has no contact with a known TB pt (a chronic cough she screened for RVS a year bacle and found to be NR Chief complaint: Fever of 3 days duration History of present illness : presented with high grade with chest and gisags associated with this see had cough which is non whopping ,non barking and ginger The has no he of difficult of falling She is vaccinated according loops She has no crying during mictugession She has no neck of abnormal body moment Chief complaint: foreign body of the air way of 1 day duration History of present illness : This passent was here 1 day back at which time she experienced an known foreign body insertion to the left ear with associated ear pulling she has no ear discharge or fever -she has history of sneezing and whiner rhea-she is fully vaccinated BIE conscious and alert HEENT-no visible discharge at ear ,no swelling Pink conjunctiva, NIS LGS-no LAP Chest –clear and resonant CVS- s1 and s2 well heard Abd-no organometallic no sign of fluid collator GUS –normal semala type of geitalia IS – no rash or pallor MSS- n edema CNS –conscious and aler1 Asset : foreign body in the ear common cold Plan :link to ENT, Homa remediesChief complaint: low grade fesses of 05 days History of present illness: presented in low grade with it fever with associated gunny nose and day with cough. Her family had similar episodes otherwise see ly no feat breath grunting or vomiting can run by lucent

Chief complaints follow up 01 days duration History of present illness this is 3+2 years oald female child from kg-12 who has last relation health aday back at which time she experienced high grade estimated fever and decreased appetite she wsa exclusively be level week seemly fact for 6 months she was vaccinated accel day to EPI schedule she was sun light exposed she is aKJ 1 student with good appetite to go school she is third child a family size of 6 have seapartual hauze from kitchen and toilet the father they have enough income to support their family Chief complaints cough of 1 week duration History of present illness she was last relatively healthy one week back at which time she began to experience non whooping non backing associated productive cough with fast breathing associated with she has a low grade fever and episodes of non projectile non below vomiting of ingested matter no grunting diarrhea or abdominal distension she has no hx of a schema she has no hx of contact with a known IB patient or chronic cougher she has hx of runny nose sneezing RS no flaring no sc/IC retraction bronchial breath sound over the right fosterior lowe one third fine crepitating over the right posterior lower one third of the lun Chief complaints cough of 10 week duration History of present illness she was 01 week back at which time she started to experience interminet cough associated with vomiting infested matter of 03 episodes

since 03 days she started to experience a loss of appetites she has ergness to drink and limitability no hx of abnormal body movement no hx of diarrhea of abnormal pails

Currently presented with non-whooping , non –barking cough associate with low grade fever, fast breathing, but no chest pain. she has no crying during Mie hum urgency them.

A known HAAD patient on salbutamol puff PRN currently presentd with cough, fast breathing , low grade fever and abnormal breath sound. Continue on salbutamol puff for 4 hours, hydrocrtizone , crystalline pencillin until 72 hours from admission then PoABx.

History of present illness this baby is a known mild intermittent asthma patient on salbutamol puff PRN. Currently presented with cough fast breathing, low grade fever and abnormal breath sound. She has flu like illness since 3 days back. she has no family hx of asthma. She has no hx of eczema. She has episode of vomiting after frequent coughs. She is fully vaccinated according to EPI schedule. She has 2 episodes of attacks over the past month. She is on family diet currently. She plays with her peers without limitation . the mother had gave her salbutamol puff every 20 minutes since 4 am to night. She is screened for RNI and VR..

Abdominal full, that moves with respiration. No organometallic, no of fluid collection. Plan is CBC, salbutamol puff, hydrocortisone, crystalline penicillin.

CIC

He has Epigastria pain

He has also Tenderness at

He take for three day duration

The end 07 sternum

Assessment dyspepsia

History of present illness modeless exacerbation of daily intermittent as thing. On salbutamol puff PRAL.

She was daze cough of one day duration, but no fast breathing granting of fever she has also on wised wheezing episode. but got impaired. good air entry birth, sigh well heard. Fail control.

Pln- salbutamol puff advices to identify exacebose factual

History of present illness a known asthmatic at for the past one month(a month before. She was offed for moderate exacerbation of mild intermittent a asthma on salbutamol puff pain. In the past one month GA stable

Chest no sign of distress and no wheeze crept. Assistant his improving and finally appoint after one month. Patient history presented with exacerbation of shortness of breath growing LGIF of one day duration .since three days back she was haring common cold like symptoms known mild intermittent asthma pt for the past three years was on off but discontinued follows since one year back because she was told to be enough and she is well. She has three admissions this year only and has symptoms one up to two weeks ,was using salbutamol puff.

Patient laboratory data PRN but has finished if three months back immediately after her last admission .Course in the hospital chest flaring of noses .

Final diagnosis moderate exacerbation of mild intermittent asthma. Advice on discharge given amoxicillin syrup for six days. Prednisone one milligram per kilogram for four days. Salbutamol puff QID basis for three days and then PRN. Appointed after two weeks on chronic follows.

Chief complaint shortness of breath of one day duration. History of present illness this is one day back at which time. She started to have shortness of breath grunting and LGIF since three days back. She was having common cold like symptoms like cough sneezing.

She is know mild intermittent asthmatic pt since three years back she follow up , but she stopped follow since one year back because she was told enough by physicians .

No family hx of asthma. She ,has repeated attack and admission 3x this year.

Assit moderate exacerbation of mild intermittent asthma.

Chief complaint shortness of breathing one days durations.

History of present illness this is sign old female child known mild intermittent asthma on follow up presented with SOB, associated grunted , fast breathing and low grade intermittent fever one days duration. The follow up discontinue one days back but had granted admission three years.

No family lx of asthma. No hx of contact from chronic cougher or known lap pts.

She is a well growing for her peers. Chief complaint cough of one day duration.

History of present illness this patient was best relatively healthy one day back of which time to time noticed, non-whooping cough which moistened days for with associated fast breathing with audile breath send uneager send congestion , les muffles also repeats longed fever, but no vomiting , grunting.

She is a known esthetic patient for the past three years with repeated hospital admissions on hospital was treated for preumesia and asthma and treated with spends salbutamol puff impelled ,

History of present illness this patient was last relatively healthy two day at which time she stated to have day cough which is intermittent ,associated with high grade intermittent fever and fest beefy

History of present illness this patient was LRH 3 days cack at which time she started to experience difficulty of swallowing of three days duration with associated with grade intermittent fever cough and heavy nose. she lives that house with three people and she eats bread with rice, patient start injira with made of tonsils, she eats 3c days with normal size plates.

Vaccinated acc to ale and can speak fluently with 3 word sentences, can run, climb upstairs, a stairs, down stairs

HEENT- inflamed tonsils with involvement of posterior tongue.

History of present illness is 4 years old female child presented cough and fast breathing of one days duration. In association to this she has hx of sneezing, nose and low grade fever. She has hx of non-luminous, non-projection vomiting. She lies hx of repeated hospital admission for the same emplace. She has no hx of abnormal body. She has no hx of diarrhea. She has hx of contact to chronically coughing person. She has no hx of checking episode.

No family hx of asthma or no self hx of allergy vaccinated according to EPI schedule . she had been in chronic follow up in this hospital and followed for 3 month then told to be no longer needed the follow up 2009. She Is screamed for RUI told to be NR . she uses EBF for the first 6 month of lifein know on family diet. Lives in afamily site of with single room house with no window only one door and separate kitchen.

No sign of fluid collection and no edema or deformity. She has been admitted to our hospital repeatedly with diapauses of hyperactive airway disease and pneumonias. She does not have checking episode.no family history of asthma. She has been on chronic follow up for HAAD for about three months and was told she no cougher needed follow up in 2009.

She is on chronic follow up for HAAD find the age of 2 years who has a monthly follow up at this hospital on salbutamol puff permed. She did not have increased recumbent of attack recently. She is the first child the family who has vaccinated according to EPI schedule. She is currently family diet.

History of present illness this patient was one day. She began to experience non-product, non-whopping, non-baker. Cough with associated high grade intermittent fever. But no vomiting.

She has no fast breathing or grunting. She has no hx of for adenine pain. She is known HAAD patient on salbutamol puff PRN base patient for the past 2 years. She is no family diet. She can run by herself. She can communicate with any one.

History of present illness a known a HDDA patient for the past one year on salbutamol puff and on choric follow up and adherent to her mediator.

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Abdominal full, that moves with respiration. No organometallic, no of fluid collection. Plan is CBC, salbutamol puff, hydrocortisone, crystalline penicillin.

Moderate exacerbation of intermittent asthma by common cold +current pneumonia. Treatment low order and salbutamol 6 puffs for 20 minutes with hydrocortisone 52 mg . History of present illness this 3 years old female was best relatively healthy. 2 days back she started to have sneezing and rhinorrhea and later followed by a day non-barking, non-whooping cough with associated fast breathing, but no history of fever. She also has hx of similar symptoms. Three times in the past 2 years for the dx of active airway disease and pneumonia. For this she was being given.

RX Omeprazole 20 mg OP Bio For 10 days

MTS syrup 1 TSP PO TID for 05 days only

Currently beneath penicillin 0.6 mill in solution.no new complaint.

Chest clean and resonance.

Abdomen no tuberculosis mass on organism. Mss no denim.

Ass : good condition.Plan: Repeat echocardiograph. Consider byzantine penicillin 0.6 mill refill. Appoint after 01 month tilapia. Clc=came for follow.

P=MUHD 2 degree to CRUHD on Lasix 20 milligram po BFD.

Spironolactone 25 milligram po per aday Benz pelican 600,000 IU IM stat.

S=no fever , 50B , cough and no body swelling.

Chief complaint came for follow up

History of present illness underweight plus moderately wasted plus CHF 2 degree CRMUHD,CMR,AR,MS,AS1 PPT big thematic re corrance on Lasix 20 mg po BID.

Spironolactone 25 mg po per a day. aspirin completed, did not take byzantine penicillin .

Currently she has no leg swelling , shortness of breath. her lazy fatigability happens with Strenuous exercise .

GLA= conscious and comfortable.

HEENT = small papules over the scalp area itchy. pink conjunctiva and NIS.

Chest= clear and resonant.

CVS= MR, MS , AR

Abdomen=full moves with respiration , no organomegahy.

GUS= no CVAT, INT =NO Panor. MSS= no edema , CNS = conscious

Assists= improving and the plan = refill the medication byzantine penicillin 600,000 IU advanced on diet and follow up link to derma.

The history of present illness:under weight plus moderate weight plus CHF 2 degree CPULCD(MR, C2 pillowsMR,AR,MS,AS1 ppt between Pharmacia recurnance on Lasix 20 milligram po BID.. Spironolactone 20 milligram per a day. Aspirin 162 milligram po per day.

s- has no hx of fast lane thing, leg swelling. chest of the patient clean and resonant .

patient history five year female from maksegnit presented with fever of moderation hx of with sore throat a weak before. She also had migratory joint pain ,dry cough ,fast breathing, orthopnea of 2 pillows easy fatigability at sub ordinary activities with palpitation .

course in the hospital she was admitted Lasix , spiracle ampicillin, cloxacillin ,

was given she was put on INO2 ,BEDNEST, head elevating salt free diet. Prednisolone tapered and aspirin started.

Condition on discharge Final diagnosis underweight plus moderately wasted plus CHF 2 degree CMVWD (MD, AR, MS, AS ) plus precipitated by IE plus rheumatic recurrence

Advice on discharge ( treatment ,appointment, referrals) she was appointed after 2 weeks.
Lasix spironolactone and aspirin given.
added order
cloxacillen 200milligram10 QID
eftriaxone 325 milligram LV BID
CLOXACILLIN 200 LV QLD
Spironolactone 25 milligram po daily and Lasix 15 milligram po QID
Aspirin 162 milligram po QID. Plump met 3500 kcal per day.
New order of the patient .put her on INO2.bed rest, no salt added diet. head elevation to 30 degree .secure rn line. Crystalline 650,000 Rn , Dn , even 4 hours . Lasix 15 milligram Dn, BID .spironolactone , 25 milligram

History of patient: He presented with shortness of breathing at night of days Dahari action with associated with fast breathing and high graded intermittent fever but no cough. He also has possible breathing sounds. Healthily tweakable according to the EPI schedule. History of patient: This patient was LHR 3 days back of which time he started to experience non poster dependent. Non whooping productivity cough associated with high grade interment fever and fast breathing but has no bunting. he is fully vaccinated according to EPY schedule; his grandmother has asthma. he has no previous hx of feeding interruption or body swelling and wines. History of patient: This patient was last relatively healthy 08 hours back at which time no started to experiences high grade persistent fever. 01 hours back he had 1 episode of witnessed abnormal body movement generalized panic genic type with up rolling of eye end drooling of salvia.no hx of vomiting diarrhea abnormal pain or distention.no hx of fast breathing, cough. He is fully vaccinated according to EPI scheduler.

Patient History Palpitation of 02 months duration known caldiac pational for the past of year on lassix 20mg D0 b10 ,sp, lonolaotone 25 mg po/day /monthly bent thing injection monthly follow up and on salt free diet.Wiientely placated with palpitation and disposal ordinary activities.Advice on Discharge -link to cardiac clinic advice on drug adhoonece and diey (salt free) monthly benzantine injection History of present illness:This is 11 years female pt comes from kola deba presented migratory joint paint involving the elbow, knee and hip joints but she did not have any

joint swelling or skin change . Associated with high grade intertratement fever without might sweating.

A weeks back prior to the above complaints she has so are throat with difficulty of swallowing of solid foods she also has poor appetite associated with loss of unquantified.2year back she was diagnosed with CRHO after presentine with similar illness and put on follow up but disappear from the follow up.-she has no w of E-dyspnea she has dark discoloration of urine she is from malicious endemic area but she has not attack

History of present illness: This pt was one week's back at which time she started to experience a non migratory type of server joint pain that involving the elbow joints the knee and hip joints. But she didn't have any joint swelhing or reddish change of the skin.

2 years back she she was dx with CRHD after presenting with similar illness and put on follow up and appointes but they never come. she has with hx of dispenser PND she has with hx of leg swelling History of present illness She was apparently healthly o1 month back at which time she begun to experience abnormal pain which has on the left size associated with this she had ahigh grade intermittent fever but no might sweet chills or regions she had loss of appetite but no vomiting on diarrhea.

History of present illness is 4 years old female child presented cough and fast breathing of one days duration. In association to this she has hx of sneezing, nose and low grade fever. She has hx of non-luminous, non-projection vomiting. She lies hx of repeated hospital admission for the same emplace. She has no hx of abnormal body. She has no hx of diarrhea. She has hx of contact to chronically coughing person. She has no hx of checking episode.

No family hx of asthma or no self hx of allergy vaccinated according to EPI schedule . she had been in chronic follow up in this hospital and followed for 3 month then told to be no longer needed the follow up 2009. She Is screamed for RUI told to be NR . she uses EBF for the first 6 month of lifein know on family diet. Lives in afamily site of with single room house with no window only one door and separate kitchen.

No sign of fluid collection and no edema or deformity. She has been admitted to our hospital repeatedly with diapauses of hyperactive airway disease and pneumonias. She does not have checking episode.no family history of asthma. She has been on chronic follow up for HAAD for about three months and was told she no cougher needed follow up in 2009.

She is on chronic follow up for HAAD find the age of 2 years who has a monthly follow up at this hospital on salbutamol puff permed. She did not have increased recumbent of attack recently. She is the first child the family who has vaccinated according to EPI schedule. She is currently family diet.

History of present illness this patient was one day. She began to experience non-product, non-whopping, non-baker. Cough with associated high grade intermittent fever. But no vomiting.

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Chief complaint: Abdominal pain 7 3 days duration History of present illness: This patient was last relative healthy 3 days bacle at which time she lagon to experience crampy abdominal pain aggravated by running and received while rest and leaning forward, otherwise she had no fever ,diarrhea .abnormal dissention (constipation -she has no hx of diagintolce she has no self /family hx of DHMTN she has no self /family hx of asthma

-she has no contact with a known TB pt (a chronic cough she screened for RVS a year bacle and found to be NR Chief complaint: Fever of 3 days duration History of present illness : presented with high grade with chest and gisags associated with this see had cough which is non whopping ,non barking and ginger The has no he of difficult of falling She is vaccinated according loops She has no crying during mictugession She has no neck of abnormal body moment Chief complaint: foreign body of the air way of 1 day duration History of present illness : This passent was here 1 day back at which time she experienced an known foreign body insertion to the left ear with associated ear pulling she has no ear discharge or fever -she has history of sneezing and whiner rhea-she is fully vaccinated BIE conscious and alert HEENT-no visible discharge at ear ,no swelling Pink conjunctiva, NIS LGS-no LAP Chest –clear and resonant CVS- s1 and s2 well heard Abd-no organometallic no sign of fluid collator GUS –normal semala type of geitalia IS – no rash or pallor MSS- n edema CNS –conscious and aler1 Asset : foreign body in the ear common cold Plan :link to ENT, Homa remediesChief complaint: low grade fesses of 05 days History of present illness: presented in low grade with it fever with associated gunny nose and day with cough. Her family had similar episodes otherwise see ly no feat breath grunting or vomiting can run by lucent

Chief complaint : cough at 06 days duration

History of present illness : This pt presented with on barking but whooping types of cough associated with post tussive vomiting he also has HORF but no chills or ripor

-no ditticulty of swalling Chief compliant: cough of 06 days duration History of present illness: This pt presented with on barking but whooping types of cough associated with posttussive vomiting he also has HORF but no chills or riper -no ditticulty of walling -no disurid or urgency-no choching episoche

-no self /family hx of althma -no contact hx to TB Chief complaint : oral ulcers of 1 week duration History of present illness:Asst Aphtous ulcers E(s): He presented with multiple oral ulcers involving the tongue and buccal mucosa in the past 1wk. -He has low grade intem lttent fever no

cough ,fast breathing grouting -no diarrrea or vomiting Chief complaint : cough at 06 days duration History of present illness : This pt presented with on barking but whooping types of cough associated with post tussive vomiting he also has HORF but no chills or ripor -no ditticulty of swalling -no chocking episoche -no self (family hx of asthma) -no contact hx to TB LGS-no LAP RS-clear chest CUS-s1 and s2 are well heard ABD-no organomegally GUS-male types of genitalia Intel-no pallor Mss-no edema CNS-conscious Asset-pertussis Plan –AzithromycinChief compliant: cough of 06 days duration History of present illness: This pt presented with on barking but whooping types of cough associated with posttussive vomiting he also has HORF but no chills or riper -no ditticulty of walling -no disurid or urgency -no choching episoche

History of present illness:

This patient was LHR three days back at which time she started to experience projective non billow vomiting of injected matter 3-4x/day associated with watery diarrhea of 4x day but no hx fever, she is fully vaccinated according to EPI schedule. She was exposed for sunlight. She was screened for RVI and found to be NR. She can say mama and baba specially she can walk. She was treated reputedly with ORS and zinc.

History of present illness:

This is 16/12 years old female presented with blood tinged diarrhea of 5x/day but no fever abdominal pain or vomiting. She has no sun kinging of eye ball change in mentation. She lives in present in 1 room house. not screening for eye but no chronic diarrhea. She is vaccinated according to EPI.

History of present illness:

She was LHR or days back at which time she began to experience non bloody intermittent. She is vaccinated according to EPI.no cough or fast breathing no fever.

History of patient history illness: She is on known Coptic patient for the past 2 year and our prechamberton 50 mg morning and 25mg evening presented with abnormal body merited rash eye closure and followed by having of the exteramites .She has no DUR She has no good addhears to the medication P/E sick looking V/S bp pr 126 RR 24 T 37.8oc wt 15.7 kg HEEEN PC1 NSS Cheker clear Ass't - poor control Plan - consider inhareting the diesis of pre camber ting History of present illness:P- GTC epilepsy on morning =30kg po-evening=45kg po Currently (s) –no new coupling -no seizure History of present illness:She was last relatedly healthy

01 day back at which one the affected to experience abnormal body movement which involve the upper with uprolling of the eye and drolling of the salvia . she has also lern on conference post iffy, no tougmobile. she has no lx of cough chast pain or fever she has no lx of vomiting ordinary she was EBF till ordinary

Chest – clear ABD – NO tendernus or orgmomen Gus –NFEG D.H ANNDFU = No palloredem

Cns conscnololert ASSIST= GTC epile psy Plan –FBS-CBC DFT Staryt pheny toin 5mg /kg /day B/D 50 mg po evining 25mg po morning link to chronic following

Chief complaint fever and fast breathing of two days duration.

History of present illness this patient was LRH two days back at which time she started express an city a high grade intermittent fever with fast breathing but no gruntiy.she also had a non-produced non barking non whooping cough.

She has no history of content with a chronic cougher or a known TB patent.

She is vaccinated for her age.

She was on exclusive breast feed for sex months.

She was exposed to sunlight since ten days of days of age.

She has no history of vomiting or diarrhea.

She started weakly at 12 morning and stated talks at 10 morning.

Physical exam healthy looking.

Chief complaint diarrhea of three days duration. History of present illness LHR three days back at which time. She started to experience, non-blood mixed, and watery diarrhea as three per a day. Assisted with this she has non projective, non-mucus, vomiting for two days. She has recent snacking at the eye ball.

Vomiting according to EPL schedule. She is currently a family diet but EBL for the first six months.

History of present illness: he was last relative healthy 6 days back at which time he started to experience excessive drinking about 45 litters / day and polyuria of 78/*with weight to day ration associated with easy fatipablity to extent that unable to walk by him self .a day prior to this current admission he started by experience of breathing and grunting for which be brought here .he also complains difficulty of swallowing aday prior to this admission but no fever he has also vomiting of two epifs day .he has no cuugele.he has family he of dm (his father aunt and uncles ) .he has also abdominal pain but no diarrhed since the past of the day.

ASS'T: few gamic control, pvn –u/a –keton –ve admitted him if feature of mid ORA.

N.B: polysmptom is decreasing and ketone is –ve . and decided to continue the same dose with advise about damages and signs and adherence. The measure rises at home and to control with measured rises results on next follow-up.

Activity in tolerance related to diabetes mellitus as evidenced by inability to move by himself. Risk for impaired skin integrity related to immobility as evidenced by disruption of the skin for alteration in nutrition related to inability to obtained food as evidenced by muscle weakness.

Revised order:

In102 ,85ml of ns +85ml 05wt with 3.5ml of kcl every 023 hours. Continuous regular injection via per fuser,1.7ml 1kg 1m

History of present illness:

He was last relatively healthy 6 days back at which time he started to experience excessive drink up about 4-5 liter /day and polyuria 7.8/s with night to day radium associated with fatigability to extent that unable to walk by himself. A day prior to his current admission he started to experience fast breathing and grunting for which he brought here. He also complains difficulty of swallowing a day prior to his admission but no fever. he has also vomiting of two a pit dose has no cough, he has family hx of DM accent and uncles 50ml, he has also abdominal pain but no diarrhea since the past of 07 days.

History of present illness:

This patient is a 4 10/12 years' male patient was relatively healthy 6days back at which time he started to have excessive vaccination and eat more than pterion. he has abdominal pain. He was taken to near this hospital for better management.

History of present illness: he was last relative healthy 6 days back at which time he started to experience excessive drinking about 45 litters / day and polyuria of 78/*with weight to day ration associated with easy fatipablity to extent that unable to walk by him self .a day prior to this current admission he started by experience of breathing and grunting for which be brought here .he also complains difficulty of swallowing aday prior to this admission but no fever he has also vomiting of two epifs day .he has no cuugele.he has family he of dm (his father aunt and uncles ) .he has also abdominal pain but no diarrhed since the past of the day.

History of present illness: This is a known cardiac patting for smoothed as mother B finality book in low she him no leseiiy SOB PND offetnes exestiones she himes himitys of average to dray -she him job print hi gh greed tower any book which server by itself she him cough but he cellar cot She has agate body movement - she has yellow declaration agrate slowely She has degrade amis of a change colore of hark patient Pc solution looks wrong destreab VB PRgo b/n RR .21 TO270 HEENT Pink congugative -non creative sdage -wetberical miscase N.scand Cheet creat decent Which application affects are puerperia feel genders -s,ps2 well hard This is hams well hard At apex quality to well -to Kaila -no through hearer -pHs ,as me please (5th ice media to mid caloricity him ) Bat –no problem Gauley -no sign of the collection In-no plain pal mix Mss needier Cons commission ASS VHD (Methodism)+contents of Plan continues B patent line mark -patent with constant(condition ) contents of effects of there is MR and support no affects of as there is continues opposition diagram History of present illness Re assis –RVHD CMR) Reference from operation deep For Bascules Co sub or hopes PND loose ells himself may joint pain before Ayeses whre as unreels and relse by Useful cohistory of store tris Cn chemicalloyalty

History of present patient illness 3 years old male patient calculate crh shortest bracket at waste associated with palpitation and orthopnods .Health problem and identified C/C Dys speen of 7 days duration HPI –this pt was LRH of days bank of which true he begin to experience shortest of breath. he has also sore throat 1wk back after 1wk he developers execute at high and does not sleep mitual pillow he has a/c migratory joint carry pain.ASSET: NYHA,CHF2,VHD

History of present illness:3 years old male present who was CRH 2 week back at which time he started to experience shortness of breath at lost associated with palpation and orthopnods of 2 pious. The sob exactly at nits combine he loss in flat position. He has no a week back.

Healthy problem identification:C/C- dyspnea of 07 days' duration HPI this patient was LHR 07 days which time the he begins to experience shortness of breath he loss also loss hx of sore throat 1week back after week he develops the present complain. the dishpan exacts bate at height and does not sleep without pillow he was also migratory joint pain.

History of patient illness he was last relatively heathy three days back at which time. His mother noticed lesson tongue which was panful associated with loss of apple his mother also noticed a

small non painful mobile mass on his left latex neck with no discharge. He has no hasp of cough, fever or contact with chronic cougher or know tb patient. He has no husky.

Heent there is none scropccble person on the lunge and appetgdiicte.

Is non tender with no discharge respochgsyslem. clear chest and good air entry.

Abdomen abdomen mares with respiration.

Organs are not pclpclde.

Chief complaint cough of 2 months durations. History of present illness this patient was LRH 2month back at which time she started to experience productive cough with whitish sputum but no fast breathing ,fever she has loss of appetize and significant but unquantified weight loss size fat this she went to latch where unspecified medication was given took it for10 days, got receive but again recur.1 weck back she to experience productive cough with bloody sputum of2 episodes, fast breathing LGIF BUT no dispend orthopnea or and for this she went to LHE unspecified injection was given and referred to gwtt .no contact with chgonit cougher or known TB. she has no BOV , patient,tinnitus,vegtigo .she is not screened for rvi but has no chronic discharged or HIV attack.

History of present illness:

This patient was LHR 4 days back at which time he started to experience with whooping cough with post tussive vomiting, redness of the face, runniness, unqualified but significant Wight loss. 1 month back he had whooping cough where he was given unspecified startup and got revise. He has contact hx with a known TB patient whom as on medication and he is her neighbor 4-month back. he has fam hx of asthma. He has no swelling over the neck, axilla or grain area. He is not screened for RVI but has no chronic diarrhea or HZr attack.

ASS't

Conjunctive +VRTE

Has low grade fever, has Passy discharge drug morning, has no cough, fast brailing, has no vomiting

History of present illness:

This is a 1-month old child presented with enter treatment small skin lesions over RT secrete area but no associated fever no hx of lessen on other sinter. He is on EBF until now, he is vaccinating for his age, he can snz supports

Chief complaint: foreign body of the air way of 1 day durationHistory of present illness : This passent was here 1 day back at which time she experienced an known foreign body insertion to the left ear with associated ear pulling she has no ear discharge or fever -she has history of sneezing and whiner rhea -she is fully vaccinated - BIE conscious and alert HEENT-no visible discharge at ear ,no swelling Pink conjunctiva, NIS LGS-no LAP Chest –clear and resonant CVS- s1 and s2 well heard Abdomen -no organometallic no sign of fluid collator GUS –normal semala type of geitalia IS –no rash or pallor MSS- n edema CNS –conscious and aler1Asset : foreign body in the ear common coldPlan :link to ENT, Homa remedies Chief complaint: low grade feses of 05 days History of present illness: presented in low grade with it fever with associated gunny nose and day with cough.Her family had similar episodes otherwise see ly no feat breath grunting or vomiting-can run by lucent

History of present illness:

Ass't: atypical pneumonia evidence cough us 3 days no fever contents with TB patient no diarrhea, vomiting no headack, vaccinated, good growth development hx /well looking.

History of present illness:

This is a 10 years old female baby from azezo kebele 20 who was lack relatively healthy a week back at which them she the exchange dry non who again non balking cough associated with the she had decrease appetite. She has no content is deasil cough on known TB patient.

History of present illness:

Ass't: atypical pneumonia evidence cough us 3 days no fever contents with TB patient no diarrhea, vomiting no headack, vaccinated, good growth development hx /well looking.

History of present illness:

This is a 10 years old female baby from azezo kebele 20 who was lack relatively healthy a week back at which them she the exchange dry non who again non balking cough associated with the she had decrease appetite. She has no content is deasil cough on known TB patient.

Chief complaint vomiting and diarrhea of three days durations.

History of present illness this patent was LPH three days back at which he started tb experience a non-projective non billions non blood, vomiting of three per day and a non-blood, mucus ,water diarrhea of two per day. He also experienced decrement of appetite, sickening of eye bass but no eagerness to drink. He was vaccinated for his age. He was exclusively breast fed for the first six

mother of life 8 per days including night feeding.  He was stated on complementary food of enjira , nice and porridge two per day  and sometimes cow milk.

Respiratory chest is clear and added sound.

Abdomen tympanic and number fluid collection.no palpable mass or organ. Skin pinch returns fast.

No swelling or edema.

Plan pethaneteasone and nocte one .liquid paraffin cream.

Chief complaint vomiting and diarrhea of three days durations.

History of present illness this patent was LPH  three days back at which he started  tb experience a non-projective non billions non blood, vomiting of three per day and a non-blood, mucus ,water diarrhea of two  per day. He also experienced decrement of appetite, sickening of eye bass but no eagerness to drink. He was vaccinated for his age. He was exclusively breast fed for the first six mother of life 8 per days including night feeding.  He was stated on complementary food of enjira , nice and porridge two per day  and sometimes cow milk.

Respiratory chest is clear and added sound.

Abdomen tympanic and number fluid collection.no palpable mass or organ. Skin pinch returns fast.

No swelling or edema.

Plan pethaneteasone and nocte one .liquid paraffin cream.

History of present illness:

This is 8month old female child from gonder-k-18 who was last relatively healthy 05 days back at which time she started to express cough and fever of 05-day duration. She has no contact hx with chronical, she has no feeding interruption aero sweating, she is vaccinated according to her age, she has can sit un supported, she has no decreased appetite, she is 3rd child for the family no cough in the asthma, she has no qualify hx of asthma

Asset= Percussing + pneumonia

Evidence cough with post tissue vowifm, high fever. contact to with coughing child, vaccinated, good growth and developed hx

History of present illness:This patient was 2RH 04 days back at which fine started to experience interprets  of the trunk and which was botching his parents. he also developed a rash involving his face trunk and extremities. He has no family hx of the same illness and he has toy of asthma.

Physical exam healthy looker not cardio spending destem.History of present illness:This is 1 9/12 years old male child from Gonder w/w was last relatively healthy 3 days back and there started to experience non barking non whooping lough associated with fast breathing and preventing. he has high grade intermittent sever. He has no hx of ear pulling or discharge. He has no difficulty of breast feeding and he has no hx crying during maturation. P/E GA =conscious not in distress. History of present illness:This patient LB+1 4 days back at which time he steelier to experienced non baring non whooping cough, associated with fail breathing ,gsuoling. He is fully vaccinated according to the ESI. he was on EBE for the 1st 6 month of his life . he was admitted to this hospital 2weeks for HAAD each tire he stay fell abime 3 days and discharged improved with salbutamol pug to be applied at home.

Chief complaint cough two weeks duration.

History of present illness this patient was will two weeks backs of we time she stratified to experience balking working day cough waited with positive waiting but no fact beating of filer

No hx of checking episode

No hx of contain with a know tr pt

She plain well with her pears she is grade two student which has good school performance

P/c 6a_contunious dolente

curred

Heem=peenls

165=nocap

Rs =cheet is clean

Cus=no coat

Inter=no palles

Mass=noedems

Cns=alest

Chief complain ch=forcing=boy we has zbek ely_elys

Patient history a074b pic female presented with forcing body mats of both the plans

Asscifiled with redom

By used to apply h|w redi cet but not emended

Which as +a ug eczema one is Abe home once artiness neat trauma

Meet use the ran dome

No family he allergic re=|clink anthems

No family  z chronic limes  like om|hsw

P/c  v=ob=dj  6/6  6/6

General light refine central way metric digitally=left ous

Sce/eb

Wee directed lid

Us fine page=lay refine/fobs

Allergic  lerjefiuc has

Palm=runic  jamming

Cold compose

Sun  grease

Chief complaint faculae to control nine of  laic doily

History of present illness this is azyold  feral pz who were a yc back at w/c fine the experience used  d7 Fichte of contains of unlined at aught but  h=07 urges as  free given as os reddish ditched

Nb hx  of chronic cash few

Nb  hx of self as  few dm

Nb hx of  bam as tiresome

Nb hx of bowel/has change

The a grade student who has medium achievement as the cleas

No hx consdipecion

p/e  conf  table of in desires  4/5 pr 24 to 36.1 wt 21.6/4

ht  asg  hc 50 cm waac 16 cm

a/m nornel

heals pc np

chest clees  resonance

ns si s2 we //he era

abdomh  no organs me

asst  leg eczema

plan  bethamethatone

apply nacte

aHistory of present illness:

This patient was LHR a month back at which time she started to experience flank pain of RT left side. The pain was intermittent associated with this she had reddish discoordination of urine but no HX of fever pain during urination or decrease in urine output for this complain she want to LHC given unspecified medication but she did not get any relief. She had no hx of loss of consciousness, she had no hx of contact with chronic cough or known TB patient, she is no screened for RUL but no hx of chronic diarrhea or HZ attacks.

History of present illness:

This patient presented a cliquey type of flank pain on the left and epigastric area with no radiation associated with she had radish discoloration, she had no hx of bowel habit change, she had no hx of cough fast breathing or grunting.

Chief complaint fall dawn injury of 01 day duration. History of present illness he is a 7 month old male infant presented fall dawn injury of 01 day duration from a height of a round 50cm after the incident cl there was on loss of consciousness or abnormal body movement, no hx bleeding or vomiting.no hx of cough. Chief complain come for follow up History of present illness p-bronchial asthma (mild intermittent asthma) on bulbutamd puff prn .currently has low grade fever and common cold like symptoms since time cough. No fast breathing and grunting. Chief complaint cough of 02 days duration. History of present illness was lrh 02 days back at which time he started to experiences non-whopping, non-baking cough emaciated with high grade implementation fever fart breathing but no grunting. He has no gamily hx of anathema. he has no hx of vomiting or diarrhea. Chief complaint fever at 3 days duration History of present illness this is a 1year and 11 month old child from Gondar kebele 16 presented with grade intermittent fever at 3 days duration with associated fast breathing and granting, associated with this he has intermittent day cough. He has not admitted to hospital before. He has not from malonic and emic area. He has no ux ,fx or crying during duration. He has no ABBM or altered menitation. He has no ear discharged or ear mulling. He is the 4th child in the family. He is on complementary feeding. He can say mama and dada, he can run well.

History present illness:

He was lost verity healthy three days back at which time he started to experience dry intermittent cough crazed with how grade for sneezing. He has no history of fast breathing. He was EBF for six months currently in addition to them breast feeding he usually eats enjera made of teff and stew mutton of rea made bean 5-6x per day. He is fully vaccinated. He is run well.

History present illness:

This patient was LHR two day back at which time he started to experience hearse hips of voice associated with low grade intermittent fever but no any hx nasal dribbling vomiting or neck stiffness. He also experiences sudden wake up from sleep and gasp for some period. He is fully vaccinated according to EPI. He was exclusively breast feed till six months and currently had additional complement any feed containing injuria made of teff and wet made of kick. Atemite and Aja and sometimes doing products. He can run play it his family has two teeth in lower and two in upper jaw.

The patent didn't come but his brother reported that he was cavarg two episode of suffure with in the past one week.Asset: poorly controlled GTC Epilepsy 20 to poor adherence. Plan: Phenytoin, 100 mg Advise strictly to be adherent Advise to come with the patient abnormal body movement of 02 years This pt was LRN 02 years Bach at which time he started to experience episodes of abnormal body movement for the past 02 years he had a follow up at a LHC and was taken phenytoin but has stopped the medication. He has no in x of drawn Fall dawn inurns of 01 day duration Hers a 7 month old male infant present in fall dawn injurn of 01day duration from a height of around 50 cm after the incidence there was no loss of consciousness or abnormal body movement No h x of breathing or vomiting No h x of coughLGS: no LAP Chest: clear and resonant Abdomen: full and soft abdomen Mss: there tenderness over it should area Asset: clavicular fracture.Plan: rt should x-ray Come for follow up P-Bronchial asthma (mild intermittent asthma) on suibutomer putt PRN Currently –has low grade fever and common cold like symptoms srcetime a lough No fast breathing and bruniting LGS – no LAP Chest – clear and good air entry Cus – s1 and s2 are well heard, no mlermur or gauop Abdomen- no organomegaly no sign of fluid collection GUS –No CUAt Mss –no edema /deformity FGS –No palmar pallor or skin rash CNS –conscious Asset: improved Plan –advice on salbutamol puff appoint after one month

Chief complaint abnormal body movement of 02 years

History of present illness this patient was LRH02 years back at which brome he started to experiences episodes of abnormal body movement for the past 02years .he had a follow up at LHC and was talky phenomena but has the medication. He has no he patient did not come but his brother represent that he was hangry two episode of seizure with in the past one week. Asesit poorly controlled poor adherence. Plan advice strzety to be adherent. Advice to come with the patient.

Medical history sheet of chief complaint history of present illness anti grade investment fever for four days. Has also as comfort fever and no abnormal body weight. Repeat BF when he is febrile.Chief complaint vomiting of two days duration. History of present illness he was relatively healthy 2 days back at which time he had no projective vomiting and ingested matter about 3 up to 4 periodically and frequently edging and frequently touch his abdomen but he has no diarrhea , abdominal dictator swelling. Two weeks back he was visited for the came of vomiting and diarrhea and was diagnosis as age given one and eno but no improvement but for that she was visited. he has decreasing feeling but he can feed breast well. He was vaccinated accordingly to his age and he did not cry during micturition. His forget initially associated with change feeding to fatty food. Abdomen no sign of fluid collection no organometallic or no palpable mass and np pallor.History of present illness this is also old male baby from Gondar presented with vomiting of injected matter of 2 up to episode days and watery diarrhea of two up to three days but no tensile. Associated with cough a grade intermittent fever. He is on breast feeding and supplementary feeding. He is vaccinated according to EPI schedule. He has no hx of tuop , no eaginals to drink no hx of recent sinking of eyes.no sign of fluid collection no tenderness.

History of present -02 years old for on keser 19 presented with cry dagger mscheratn,frefont uninviting best lves of detected in urination or urine coler change.

-sleha new demented 12 with output and with nu lix of fuel thrs or body swelling

-sue has is lix of for lamely vegans discharge

-su has nw lixs fever

-su is follr venerated

-su is on conplentry feeding

-Ecol-coneies /algs

V/s-hr two RP=21 T=36.6

Wr=13kg ht-876 MuAc=16 hc=4g

MEEN=PC/NIS ,rw flail farther

Lci=no LAr

CLar=Clear& resumes

Ovs=s1/s2 well heard no m/ G

Azr=with oy more fully/fluid coved

-with distended  bladed

-no Was

-snhp-rw rahsl /realm

-fuk-rwedes/defiant

cns-Fenels Frpe Moy gentle

cns-conver/hlgl

History of present illness: the picante  was LRM 01 das back  at which time he experiment of with gross instruments fever with Assonated  excesses  crass, runny we of 01 day furfur on formation cough of experiments drop action

No he 7 vomitus or freshmen

No he 7 or to chess or pulls

He is on EBF

Occident of according to  EPI salaam

He can't grit  by himsosooz

gpt  axle

VLS =PR=120  RR- 22  to 38.1%

Anth wt-6.7  wt/07-b/n 80 290%

Ht-65cm  Ht/07-b/t 3rd & 15th  contim.

Ht-45cm  hc/ozo,

HEENT-pc,NTS,NO tonsslar enlargement

LGS-no LAP

Chest-clec with gost or emty

CVS- S1&S2  well  hores

Abd- Soft

-No Orgenementfyly sign of Fiud collectr

Gus- gese type extremist gonteth

MSS-noedement

Int-no poller

CNS-Commen cold

Asst-Commen cold

Plan-porocotemol SCNP

-Reassm

-Resitont Consulted,

History of Present illess: this pt was WLH 01 day back at we them she statated to expelience non-hloild timpled.noufoussmessing watery diasshea 3-xld but no uomiting or abdowinal pain .

-She has no hxof drug intape

-No hx of tracing poisoned food or wanton

-No hx of cough or fever

-she nacho frequency or eddying during urination

-She has no sucfeuing eyeball ov eggerhets to deint

-she is uocciratted accossding to the EPI

-she roens well

PIE 6A-conscious

-Clean wound

-well demented lane

-xefiecand conet

Deep

-clean wound size

-well dieselized langue

-quite coups

-Clan coring

- deep & quite

Wnden passegle ficeply tcehnaiyne and under GA LeB Renimhia clenned with povidone 5odine and Radiant drained cant erclcired via an honzonted inflation along the fantal hine tapeteen with its eapsule

Wound classed in two lagers wound petered & patent sent sack to wand

P=phimosps + JSA *underwater + mildly molded

Rk= phimonfen 100 mg po JSD

Pcedmso fane 15 mg po por day

Currently- He still has joint parn of the Rt wrist & back pain, No fever

There is skin lesion over the hand

currently presented with Patient on Ibuprofem,prodindo loom for the rest agwks,He currently presented with difficulty of urimtion.Auewted=these he had burring sorption where urinating and antormition

Stream he had gread inter information faver thare is sot suomoning on the leaft btotal epicenths

History of present illness:

This is 11 years old child presented in localized headache of 5 days duration associated with high grade intermittent fever with child and rga. He has a lot of vomiting; he has no cough night sweet on loss of appetite. He is frame matric

Chief complaint: fever of 03 days duration History of present illness: This is a syr+2monthor toddler presented HGIF at 3 days duration but no chills or vigor, Associated he has difficulty of swallowing liner one day back no cough fast breathing.-he has no hx of ear or nestle discharge -he has no hx of urinary urgency or frequency -he has no neck stiffness or ABM -He EBE for the first 6 month and currently he is on family disease-"he is vaccinated occurring to EPI" PIE GA –health looking HEENT –pc DNIS, Erythematous tosses LGS –there is simple painless LN at the left sub mending RS-clear chestLUS –s1 and s2 are well heand ABD –no organouslegallyGUS-male types of genitasia Intel –no edema CNS-alert /conscious Asst-acuts tonsilopharygin Chief complaint: diarrhea and vomiting of 01 days History of present illness: This pt was leot relatively heating 01 days back at which began to eaprianea a nueoid yellow non blood diarrhea 4-5x days and epsode of non cilous non projective vomiting of created matter but no sunbows of eye origgerners to drink associated with he has also low grade intermit fever with proceeding plinorrea and sneezing .He has no hx of cough contact with chronic cougher or known as TB .He is fully vaccinated according to the EPI schedule . He is a family diet 4-5x /day with associated panting. He is not screened for RU but has no chronic diarrhea it of attack

Chief complaint jeerers of day duration. History of present illness he is a known cardiac that on follow up (fn le ps03 month) and on medic from co six spouted and monthly beatnik epic hill .he a monthly presented with high grade few of 01 day duration .he also his day cough mire of meek back but no associated chew of pain. he also less easy space and afhephes but no pans.

History of present illness modeless exacerbation of daily intermittent as thing. On salbutamol puff PRAL.She was daze cough of one day duration, but no fast breathing granting of fever she has

also on wised wheezing episode. but got impaired. good air entry birth, sigh well heard. Fail control.Pln- salbutamol puff advices to identify exacebose factual History of present illness a known asthmatic at for the past one month(a month before. She was offed for moderate exacerbation of mild intermittent a asthma on salbutamol puff pain. In the past one month GA stable Chest no sign of distress and no wheeze crept. Assistant his improving and finally appoint after one month. Patient history presented with exacerbation of shortness of breath growing LGIF of one day duration .since three days back she was haring common cold like symptoms known mild intermittent asthma pt for the past three years was on off but discontinued follows since one year back because she was told to be enough and she is well. She has three admissions this year only and has symptoms one up to two weeks ,was using salbutamol puff.Patient laboratory data PRN but has finished if three months back immediately after her last admission .Course in the hospital chest flaring of noses .Final diagnosis moderate exacerbation of mild intermittent asthma. Advice on discharge given amoxicillin syrup for six days. Prednisone one milligram per kilogram for four days. Salbutamol puff QID basis for three days and then PRN. Appointed after two weeks on chronic follows.Chief complaint shortness of breath of one day duration. History of present illness this is one day back at which time. She started to have shortness of breath grunting and LGIF since three days back. She was having common cold like symptoms like cough sneezing. She is know mild intermittent asthmatic pt since three years back she follow up , but she stopped follow since one year back because she was told enough by physicians .No family hx of asthma. She ,has repeated attack and admission 3x this year.Assit moderate exacerbation of mild intermittent asthma.Chief complaint shortness of breathing one days durations.History of present illness this is sign old female child known mild intermittent asthma on follow up presented with SOB, associated grunted , fast breathing and low grade intermittent fever one days duration. The follow up discontinue one days back but had granted admission three years.No family lx of asthma. No hx of contact from chronic cougher or known lap pts.She is a well growing for her peers. Chief complaint cough of one day duration.History of present illness this patient was best relatively healthy one day back of which time to time noticed, non-whooping cough which moistened days for with associated fast breathing with audile breath send uneager send congestion , les muffles also repeats longed fever, but no vomiting , grunting.She is a known esthetic patient for the past three years with repeated hospital admissions on hospital was treated for preumesia and asthma and treated with spends salbutamol puff impelled ,History of present illness this patient was last

relatively healthy two day at which time she stated to have day cough which is intermittent ,associated with high grade intermittent fever and fest beefyHistory of present illness this patient was LRH 3 days cack at which time she started to experience difficulty of swallowing of three days duration with associated with grade intermittent fever cough and heavy nose. she lives that house with three people and she eats bread with rice, patient start injira with made of tonsils, she eats 3c days with normal size plates.Vaccinated acc to ale and can speak fluently with 3 word sentences, can run, climb upstairs, a stairs, down stairs HEENT- inflamed tonsils with involvement of posterior tongue.History of present illness is 4 years old female child presented cough and fast breathing of one days duration. In association to this she has hx of sneezing, nose and low grade fever. She has hx of non-luminous, non-projection vomiting. She lies hx of repeated hospital admission for the same emplace. She has no hx of abnormal body. She has no hx of diarrhea. She has hx of contact to chronically coughing person. She has no hx of checking episode.No family hx of asthma or no self hx of allergy vaccinated according to EPI schedule . she had been in chronic follow up in this hospital and followed for 3 month then told to be no longer needed the follow up 2009. She Is screamed for RUI told to be NR . she uses EBF for the first 6 month of lifein know on family diet. Lives in afamily site of with single room house with no window only one door and separate kitchen.No sign of fluid collection and no edema or deformity. She has been admitted to our hospital repeatedly with diapauses of hyperactive airway disease and pneumonias. She does not have checking episode.no family history of asthma. She has been on chronic follow up for HAAD for about three months and was told she no cougher needed follow up in 2009. She is on chronic follow up for HAAD find the age of 2 years who has a monthly follow up at this hospital on salbutamol puff permed. She did not have increased recumbent of attack recently. She is the first child the family who has vaccinated according to EPI schedule. She is currently family diet.History of present illness this patient was one day. She began to experience non-product, non-whopping, non-baker. Cough with associated high grade intermittent fever. But no vomiting.She has no fast breathing or grunting. She has no hx of for adenine pain. She is known HAAD patient on salbutamol puff PRN base patient for the past 2 years. She is no family diet. She can run by herself. She can communicate with any one.History of present illness a known a HDDA patient for the past one year on salbutamol puff and on choric follow up and adherent to her mediator.Currently presented with non-whooping , non –barking cough associate with low grade fever, fast breathing, but no chest pain. she has no crying during

Mie hum urgency them.A known HAAD patient on salbutamol puff PRN currently presentd with cough, fast breathing , low grade fever and abnormal breath sound. Continue on salbutamol puff for 4 hours, hydrocrtizone , crystalline pencillin until 72 hours from admission then PoABx.History of present illness this baby is a known mild intermittent asthma patient on salbutamol puff PRN. Currently presented with cough fast breathing, low grade fever and abnormal breath sound. She has flu like illness since 3 days back. she has no family hx of asthma. She has no hx of eczema. She has episode of vomiting after frequent coughs. She is fully vaccinated according to EPI schedule. She has 2 episodes of attacks over the past month. She is on family diet currently. She plays with her peers without limitation . the mother had gave her salbutamol puff every 20 minutes since 4 am to night. She is screened for RNI and VR..Abdominal full, that moves with respiration. No organometallic, no of fluid collection. Plan is CBC, salbutamol puff, hydrocortisone, crystalline penicillin.Moderate exacerbation of intermittent asthma by common cold +current pneumonia. Treatment low order and salbutamol 6 puffs for 20 minutes with hydrocortisone 52 mg . History of present illness this 3 years old female was best relatively healthy. 2 days back she started to have sneezing and rhinorrhea and later followed by a day non-barking, non-whooping cough with associated fast breathing, but no history of fever. She also has hx of similar symptoms. Three times in the past 2 years for the dx of active airway disease and pneumonia. For this she was being given.

History of present illness this patient was LRH 3 days cack at which time she started to experience difficulty of swallowing of three days duration with associated with grade intermittent fever cough and heavy nose. she lives that house with three people and she eats bread with rice, patient start injira with made of tonsils, she eats 3c days with normal size plates.

Vaccinated acc to ale and can speak fluently with 3 word sentences, can run, climb upstairs, a stairs, down stairs

HEENT- inflamed tonsils with involvement of posterior tongue.

History of present illness is 4 years old female child presented cough and fast breathing of one days duration. In association to this she has hx of sneezing, nose and low grade fever. She has hx of non-luminous, non-projection vomiting. She lies hx of repeated hospital admission for the same emplace. She has no hx of abnormal body. She has no hx of diarrhea. She has hx of contact to chronically coughing person. She has no hx of checking episode.

No family hx of asthma or no self hx of allergy vaccinated according to EPI schedule . she had been in chronic follow up in this hospital and followed for 3 month then told to be no longer needed the follow up 2009. She Is screamed for RUI told to be NR . she uses EBF for the first 6 month of lifein know on family diet. Lives in afamily site of with single room house with no window only one door and separate kitchen.

Chief complaint: fever of 6 days duration History of present illness: This is a 7yr old male patient presented with HGIF but no chills or nigor.he also has headache but no vomiting or diarrhea. He also has HGIF but no chills or rigor -he complains constipation he has no neck stiffness or ABM -he has no dysuria, frequency or urgency -he has no can pain or discharge PLE GA –conscious HEENT –pc, NLS

LGS- no LAP RS-chest is clear CVS-s1 and s2 are well heard ABD –no organomegally GUS-no CVAT

INTEL-no rash Mss-needema CNS –alert

Chief complaint dog bit 02 hours duration. History of present illness this a 14 years old female patient from Gondar presented with dog bit of 2 hours duration by neighbor dog, got hurt to her left lower leg and left hand. Maclin bleeding from the site. Assist dog bit

History of present illness:

A so in mother old male affected presented is also larking cough of 3 days. no lode ABM, fully vaccinated, was on EBF for the 1st 6th months HG less around 3x stim tar refine before.

History of present illness:

This is an 8-month old male child associated cough 2 days' duration associated in sneezing and flu like symptoms the matter also complain of sweeting over fine head.

He was exclusive breast feed for the 1st 6 months of he is in breast feeling celled grovel. he has no cardguath light exposure. He was last relatively healthy 03 days back at which time he started to experience dry wines the cough with high grade intermittent fever he was treated for per Tutsis so dress back. He has fully vaccinated feedback, no family member is same illness. GA= comfortable

History of present illness: This is a 1 year and 11 month old child from Gonder kebelle 16 presented with gtade intermillent fever of 3 days duration with associated fast breathing and gnnting .Associated with this he has intermittent day cough.-He was not edmitted to hospital before he is

not from maleic endemic area -he has no ux ,fx or crying during duration -he has no ABBM or altered meditation

-he has no ear discharge or ear puling -he is the 4th child in the family -he is on complementary feeding

-he can say mama and dada ,he can run well Chief Complaint: cough /8hse History of present illness: This is a 2yrs old male child presented with non-looping, on barking type of cough, fast breathing and audible breath sound of 8hrs.for the past 1yr Hamas treated with puff for the compliant of fast breathing 3x.he has also vomiting of non-bilious non project tile of 3 episode overnight no layoff contact with chronically coughing individual no hx of fever deadhead.No hx of discharge from his ear No hx of skin lesion and of asthma He is fully vaccinated according to CPI He loos on exclusion breast feeding for the 6mom then started with complementally feeding He had adequate sunlight exposure

P/E 6A =ASL in atless

Chief Complaint: cough of 01 day duration

History of present illness: He was LRH 01 day back at which time he started to experience non whooping and non-baring cough associated with fast breathing, grunting but he has no

-he has the same symptoms previously but no family his fury

-no hx of contact with chinn copha a known TB patient a known TB patient

-fully vaccinated according to EPI schedule

-EBF for the first 06 month then started family piet

Chief Compliant: left latent neck swallary 08 05 months duration

History of present illness: he was Last relatively health as months back at which tone he started to latant neck area associated with thy la also lad a low grade intermittent fever right sweating loss apetite and weight.

He lad no contact with TB patient chrowe with TB patient the was not scared for RWI but no hx 0 8 chrowe dense or herpes attack ,he has no hx 08 chronic cough

-he has no hx 08 bone -He has no hx 08 bleeding from any site he has no hx 08 Swelling at often site.

Chief compliant: fever of one day duration

Chief complaint fewer of 01 day dwaratiol

History of present illness this inmate was 01 day back at we  time the started experience alhat but no difficulties of swelling he has  hxof chia malt age discharge and shift cough

He has no  bam as upwelling of the eye.

He has no omitting as ditched

He has we are pulling or ens discharge

He in rbf and not  start complementary feeding

The is  routinely exposed for sunlight from 2:00__-3:00 for about admin  with no ointment applined

The is accinatude according to his age

The sets withapported

The ams mama hald

p/e  ga conscious

xp/s pr=108  rr=28  to=30.4 auth wf 6.8kg  ls=65cm hc=145 muac=15cm

wfa =bth 80and  lfa6th wfh 09

heent=pcpnis

rl65=no lap

rs  = cheect is leads

cvs=s1 p s2 weeheald

abd=no aigaallegally

gus  male types o genitech

image=rink.skill

mss=no edemd

cns = conscious

asst common coud

cc fwer of  01 day durfn

hip this five month old move child

prechted with high grade intemitend

everof  o1 day durgtain but  no proecheld vomiting  or cough

has no  crying ducing minefine

has no a looking of length

p/e  ga stabls

chief complaint failure to suck of hurid duration

history of present illness thise is 14hrs old neonataborn from 23 years old primigrarda whose lmnp was on hamte as making by date of 636 wk +2 days reliable she bwas having resulas anc follow up dot gc where she was given tt vaccine 2x fe and tolerant suffiemented screened for rui and vdr and found to be nr the on set of labor spontaneous and foundation of labor rchrs and rom is intrapanation

she has no hx of dysurce

she has no of four skclling virginal discharge or revers

the delivery rior spontaneous vagikel delivery resulting 3000mg a live male neonate and agar score was of and 8 at time first and five minta currently he presented withfailure of a suck but no te ver abm or grantaion ga =lethargic

not in rd

rha =140 rr=36 to 36.7

anth .wt _-3000g

length-40c

hc -35cm

heent –nis ,pc

no scalp swelling hernatoa

lgs –no laplarring

chest –no flaring of vlanase

no se /ic retract

no creption

cus -s1 and s2 wellheard

abd –soft flat move with respiration

no organomesally

no sign of fluid collection

gus -male type external genefalia

mss -no edema(deformity

ints –no pallor

cns –lethargic more –complete

grosp –strong

asset-jerm+aga+?eong

History of present illness:

This is HP: costrypration since birth, was on cow milk since at the age of 5 month, was on formula milk bgfree cow milk, no cow fast breathing ,grunting , no 20oc gz, no crying during urination.

History of present illness:

This is 7month male child presented with aloe whooping non barking cough of 1week duration with low grade fever episode of vomiting but not fast breathing grunting. He was exclusive Brest feed fill the age of 6month than currently on complements feeding. He is vaccinated according to EPI schedule. He has no family hx of asthma. He has no hx of contact with chronic couches or known TB patient.

History of present illness:

She was last relatively healthy 5 days back at which for she stored to expensive loading non cu hooping.

Non backing day cough with associated low grade fever loss of appetite and 2 episodes of no mucoid, non-bloody wisely dry loan but no vomiting. her have common cold, she is fully vaccinated according to EPI schedule, she cannot sit un supported, she can roll from side to side, she can support here load.

Evidence:

Cough of one week, no fever vomiting, no contact with 1B patient, vaccinated, good growth and development, on complemental feels, milk interruption, not in distress, well looking.

Chief complain: repened from chrowc pollow for evauation.

History of present illness:- this is avomowl type I dm patent put the post 01 month in follow up. currently presented with pory depslos polytsrict of 03 days dination at chrom follow up RRT way dinc of chevated and per rmther evacuations .patient history he presented with polthia and polydrsra of 05 day duration with associated crampy abdominal pain and single episode of vaniting of ingereted matter.since post 24 he had properssive weight loss.

History of present illness:

This patient was type I DM patient currently presented with poly debates post revise of 03 days' diabetic at chronic. Evaluation admit ion send to emergency opd.

History of present illness:

He presented with polyhydric and poly dropsies of 05day duration with associated crummy abdominal patient and single episode of vomiting of in posted matter. Since the last 2year he had propulsive weight loss nutation of 1-2 x day.

History of present illness:

An 8 years old male patient from lay armachio presented with polyhydric and polydipsia of 07 days' duration which wares send 03 days back associated with cramp abdominal podium but no vomiting or diarrhea and he has high grade decimated fever. He also has loss of appetitive and Ungurean attitude but amount of weight loss and fatigue day he has dry buccal mucosa and scnvemating of the eye. For the post 2years he has been having nocturnal 1-2x/night

History of present illness:

An 8 years old male patient from lay armachio presented with polyhydric and polydipsia of 03 days' duration. He has hx of RUQ abdominal pain and vomiting of 03 days' duration

Chief complain: repened from chrowc pollow for evauation.

History of present illness:- this is avomowl type I dm patent put the post 01 month in follow up. currently presented with pory depslos polytsrict of 03 days dination at chrom follow up RRT way dinc of chevated and per rmther evacuations .patient history he presented with polthia and polydrsra of 05 day duration with associated crampy abdominal pain and single episode of vaniting of ingereted matter.since post 24 he had properssive weight loss.

History of present illness:

A photic syndrome on pre diazole 25mg po/day currently she has fever perfume episodic buzz segmentation no vomiting.

History of present illness:P= photic syndrome open productive 45mg po day for the elements currently 5 filled porousness

History of present illness:

P= photic syndrome, productive for past 6 weeks, no fever cough, potentate

ASS't

Nephrotic syndrome 20 to ii m, no signal of respiration distress ,+ve predict and practical edema

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ASS't

Nephrotic syndrome 20 to ii m, no signal of respiration distress ,+ve predict and practical edema

History of present illness: sheiks relatively healthy ado's while ruined but no history fever or decrease in urine amount or urine color change

She cry's while urinating and feels Bette after urination

There is furl smelling urine

History of furl smiling and vagal discharge

-she wcs treated Alf's hospital for simile complicit s month back in which she was told she has and was treated and improved

G/A-she is conceal and alert

-not inferior many distress

Vs-pR-86 RR-23 to-35.6

Weight-13 lengthfers age-b/n o and 2

Lieight-99cm weight for length-b/n-2and-1

M weight for age –b/n 90 and standard

HEEnt-pink conjunctive NON iefellc scle

LCs-NOC Ap

R/S-SI clear chest good air eny

CVS-S1 and S2 are woll head

Nagcllopa mvvmvv

Abdomen-abdomen is full and moves with respirohan

-Fink scrofula

PRN

Chief complaint: cough of 2 weeks History of present illness: This patient was LRH 2wks back at which time he started to experience whooping cough. Past jussive vomiting, reddish color of the fare while coughing but no fever, fast breathing he has no chocking episode he has no fam hx of Asthma He is fully vaccinated according to EPI schedule HEENT- pink conjunctiva, NIS LGS –

no LAPRASP-cle ar and resonant CVS-s1 and s2 well heagd Abdo-no organimegally or sign of fluid collection GUS-no CVAT Mss.-no edemas Inte-no pal log Neug-conscious

History present illness:

This patient was WHR 01 day back at which time she started to experiences non blood tingled nonfood smelling watery diarrhea three day but no vomiting or abdominal pain. She has no hx drug in take. No hx of cough or fever. She has no sucking of eye ball or engagements to doing. She is vaccinated to the EPI. she runs well.

History present illness:

She was LHR one day back at which time she started to have high grade fever she also has non whooping and non-basking cough but no fast breathing. she has no hx of abnormal. She has no hx of diarrhea or vomiting.

History of present illness:

This is ASS't: Capt. direful r/o sty sked evidence. Bloody diarrhea bus no vomiting obd pain. No dispharemacy breasts milk interruption. Vaccinated EPI. On complementary feeding no sz 10c, well looking

History of present illness:

This was LHR 02 weeks back at which time she began to experience faint esthmafous skill lesson which is initially snails lost latter increase in size and contain puce there are 3 large skill lessons which is around 1*1 an raised at back (2) and left tope Aral area revised lesson which is hematocus around 2*2 an the lesson started vaccinated to according to her age and EBF

History of present illness :ass 1:Hcpt dyfentny r/o sntescesser evidence cong of 4days bloody disrrhea but no vomiting ,blood pain no dispharеas, breast milk interruption vocumated are Epi on complementary tealf no sz, 20c

Chief complaint: skin lesion of 02 daysHistory of present illness:she was LRH 02 weeks back at which time she began to experience faint emthemafond skill lesion which is initially small but lafer increase size and confach'pus' there as a 3 large skill lesion which is around |x| and raised at bone or back (2) and left toperal raised emthemafond2*2cm the lesion started from back she has cengh and sheezing snf is fewer ()

ETAT Ass bullous image try 0 the plan was to admin to wrong but pt refused due to economical redsons so domized to come on monolay with money until them po cloveaellrtm giveen

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ETAT Ass bullous image try 0 the plan was to admin to wrong but pt refused due to economical redsons so domized to come on monolay with money until them po cloveaellrtm giveen

History of present illness:

This is 1 7/12-year-old female child from g-k-16 who was LHR 01 day back at which time she experienced fast breathing cough granting with associated low grade fever and single episode of vomiting of ingested matter but no diarrhea. She was no hx of wheeze. She has no family hx of asthma. She is vaccinated for her age. She was on complementary feeding for the 1st 6 months now on family desert.

History of present illness:

This is 1 7/12-year-old female child from g-k-16 last relatively healthy 30days back duration at which time the experienced fast breathing associated with non-barking non whooping cough, low grade intermittent fever and one episode of vomiting of ingested matter but not diarrhea. She has family hx of asthma. She has hx of common cold 3 days back. No hx of contact from chronic couches on known TB patients. She was vaccinated according to EPI schedule. She was on complementary feeding (cow milk). She speaks some words like wuha, mama, baba and call the other than family members in her surroundings.

History of present illness:

This patient was LHR 1 day back at which time she tested to experience and non-basking cough a comp aired by fast breathing but no dust prune or fever. She has no priced URT meaning of survey. She is EBF for 1st 6 months. She was started on compliantly feeding on cozegam.

History of present illness:

This is 05-month old female has few cry with fast breathing of a day. Led also low grade fever, no vomiting, no family of matter.

History of present illness:

A 1month and 1week infant presented with left six submandibular scheduling of 02 days associated with low grade intermittent of fever and decreased breast feeding and excessive crying. The deliver was 1 month back in our hospital vainly with no complication. She is on exclusive breathing feeding about6.8p/ day. No hx cough fast breathing or granting. The delivery was twin the other is male and relatively healthy

History of present illness:

01 month /f Gonder on 8th soa p1= sub normalize lymphadunte p2=physiologic anemia

Chief complaint cough of 01 eek duration History of present illness this patient was LPH 01 week back at which time she experienced a non barking , non productive whooping type of episodic cough with associated urge to vomit after coughing she has associated decrement of appetite but no fever. She has no history of contact with a chronic cougher or a known tv patient she has completed her vaccination for her age she was exposed to sun light since 15 days of birth with applied buffer she was exclusive breast fed for the first 6 months of age with 6x per day with night feed she has history of allergy to a moxicillm syrup Chief compliant cough 2 weeks duration History of present illness she was lhr healthy 2 weeks back at which time started to have min backing non whooping cough associated hgif and fast breathing other wise no hash disease she was exclusive breast feeding for 6 month now un family diet she is fully vaccinated she was told to have allergy chest erpitations over posterior lure field bilaxrolly flat feat moves with no mass

Chief complaint : diaphea of 1 wk dinsation

History of present illness :this is a 6month old female child presented with non bloody foul smelling diaphes of 2 week dnsation 2 epiusodes of vomiting but no fever smekenig of eyes or loss of conscionsnpd one month before presentation she experienced failure to control flatus foe which she was given ors but not improved she is vaccinated according to her ace she is on both completely and breast feeding she has no hx of eaherness to deink

Chief complaint : failure to control qrefaced siase brife.

History of present illness :this five month old female child present with failure to control flefus sinces birth which feaping coldness .no diarehe.no vomiting.

Chief complaint : excessive crigng of 51 day, History of present illness : this is a 6month old female child presented with lx excessive crigng she has 1 no few umittise.no her of diarleen .she per focus a flatus wrie .the morle gad/she was marspad agesic at home.

History of present illness:

This is a 6month old female child presented with nonblood foul smelling diarrhea of a week duration 2 episodes' pf vomiting but no fever, smoking of eyes 02 loss of consciousness. One month before presentation she experienced failure to content flatus, for which she was given ORS not improved. She is vaccinated according to her ace. She is no hx of eagerness to client.

History of present illness:

This is a 5 month old of female child presents with failure to control flatus since birth which feeling coldness. No diarrhea, no vomiting

History of present illness:

This is a 2 month old of female child who presents with lx of excessive change she has no fever on vomiting No diarrhea, no vomiting.

Chief complaint : diaphea of 1 wk dinsation

History of present illness :this is a 6month old female child presented with non bloody foul smelling diaphes of 2 week dnsation 2 epiusodes of vomiting but no fever smekenig of eyes or loss of conscionsnpd one month before presentation she experienced failure to control flatus foe which she was given ors but not improved she is vaccinated according to her ace she is on both completely and breast feeding she has no hx of eaherness to deink

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Chief complaint cough of two days duration.History of present illness this is a nine month old male infant presented with cough of two days duration but do fever or fast breasting .he also has mon-blood tippled watery diarrhea.No sickening of the eye.No hx of asthma.no chocking episode.Cvs clear chest. cvs are well heard and no organ magus Plan amaxicilin or ors or znc.

Chief complaint cough of two days duration.History of present illness this is an 8 months old male infant from Gondar k-10 with cough of two days duration in duration in associated with rainy nose but not fast breathing, grunting, fever no single illness in the family.He is vaccinated for his age plea.g/a is conscious not in distress. Clear and resonant good air entry.Abdomen is full moves with respiration no organogram.Assist common cold and plan reassuring.Chief complaint cough of two days duration.History of present illness. This is one months old male patients who was last relatively health two days back at which time she stand to experience, whoops, non-backing no fast breathing ,grunting or fever.Plan annexation.

History of present illness: A 2 years old child presented with green body diarrhea of 04 episodes bit no vomiting associated with this she has low grade in treatment fever.no hx of cough fast breathing or grunting, vaccinated fully according to EPI scheduling, no sun killing of eye ball or barrel change.

History of patient: She was LPH 5 hrs. back of which fine she led to have a high grade intermittent fever fast breathing but no cough, rash or diarrhea. She is fully vaccinated according to EPI , no vomiting. Assist: I/P:

History of present illness:

He is a known type I DM for the past 01 year on NPH (20/10) and on follow up at debark hospitals 03 months after he presented in polynomic and polydipsia currently he come to our hospital to started the following at our side. He has no hx of. He is fully vaccinated according to the EPI schedule. He was agreed 4 students and have good performance until a year. He is on family diet and free to ds.

History of present illness:

This is a 5month old male child presented with nonblank fever of cough in 1 week. Vaccinated in this age, no fast breathing, no part of family vomiting.

History of present illness:

This is 5month old male presented with fever 03 days' duration but no fast breathing on cough. he has no HX of change in urine color or 1 amount. He has no HX chronic cough on contact in chronic cough on known TB patients. He has no HX of vomiting or diarrhea. He is on CBF and vaccinated according to his age.

This patient presented with delayed walked but is able to crewel she is able to by herself with support but cannot stand by herself but by support. She started dent Alize 0q2 mints back at the

She used to have interrupted feeding tii she was 6 mental old her lips are dark such birth no diagnosis during feeding her matter delivered at the age of year HEENT-low settled ear flat natal bridge epicanthaly fold p-CHO (?1/50)2oc to down sundown + rockers brain to a40 years old mother cannot say baby /mama feeding interruption diagnoses there is an its Farcical one interventricular defects which measure 1.5cm and this is bidirectional flow but has predominant lest to riot shunts there is puny amulet FHN- there is thighs cardinal clubs but normal climber aionter-Enlagged cardiac with hovettel -Acute CPAS-NOparenchmal abnormal seem

History of present illness:P:84m CDA CAP Has no omit, no favor /cover/ no edema REVISED ORDER 16.2ml every 31ml (TD please 1), Zinc chloride 20mg po/day, paracetamol 30 ml po/loss, vancomycin 150mg IV TID, Centtriaxonic 150mg IV BID, PCM 150 mg QIDHistory of present illness: Subjective presented with generalized body sweeping of a man duration, objective Associated with this he had also change in hire color to white, LEG po/e conjunctive, no cap bi lateral crepitates CVS: s1 and s2 are well heard, GUS normal male type of ext. MSS grade 3 pitting edema CNS conscious and oriented. History of present illness: This is 2 years old male child presented with generalized body swelling of a mouth duration initially started from the face and progress to involve the bilateral leg within a month. Associated with he had also changed in hair color of the scalp to white type with associated sickening of the eye and irritability. He had no contact hx and reddish di colorization of the urine or recent decrement in Vop. He had no hx of feeding difficulty. History of present illness: This is 2 years old male child presented with generalized body swelling of a mouth duration initially started from the face and progress to involve the bilateral leg within a month. Associated with he had also changed in hair color of the scalp to white type with associated sickening of the eye and irritability. History of present illness: This is 2 years old male on 14th DOA for the diagnosis 07 SSAM grad 1-kwacha dermatosis AGE with no DHN Iron deficiency. After he presented with generalized body swelling of 1-month duration which initialize started from the face and progressed to in value the bilaterally within a month associated with change in color to white with associated vomiting of ingested matter of 2-3x/day with associated watery Dahari a of 2 episode per day for past one week.

Chief complaint fever and fast breathing of two days duration fast breathing.She was vaccinated according to EPL schedule. She started to walk alone at one year of age. Chief complaint cough of one week durations. History of present illness this is diarrhea and one month old child presented three non-whooping, non-berthing of one week duration. Associated with this she has also high

grade interment even with test one or everything but has promotion. She has also projective non vomiting ingested matter but no diarrhea or sunken of eye bet. She has no number of decrease.She can walk by herself.She was one unity six month and compliantly feed

Chief complaints  come for follow up

History of illness currently he protecting anchorman body movement of slower entry that lost about 3 months followed by loss of consecutiveness about  10 minutes associated with lathed drilling of saliva uprooting of the eyes wise or neck stomach or vomiting

Chief complaint come for follow up  :history of illness come 20  century pyrexia mephitis  new no new couponing chest clear and remnant patient history this is try to male high for do inlfer mified fives with chills Ensor of 2 days 30 ps side of ABM loss of consciousness with focal unary he is from me lone endemic area or lost affected was eye back stable final diagnosis cma so to cerebral melonia with icp +  pyagonic + humegisto +aspiration .

Transfer sheet problem a 5 years old boy presented with comagoto cerebral malaria toRio pyogenic meningitis ficp subjective loss  of cows coarseness of all day durectier abnormal body movement of GTC type (3x)  comatose up on admission  ches relatively decreased air entry over the right lung with narrow CVS well heard no gallop ABO moves with respiration no organomegally  ASS improving  CNS pupils mod sized and reactive nursing activity sheet bed making was done I give all prescribed medications' monitoring recording VIS she order medication monitor VIS and record portioning and bed making was done monitor VIS and record administer the prescribed medications

Add order revised order because 60mg IV B/D arfegunate 36mg POB/D start NG tube feeding 200ml

Chief complaints fever 2 days duration

History of present illness this is a 5 years old male from tuch alumaeuinu who was last relatively 2 days back at which time he started to experience high grade intermittent fever associated is sweat and riger associated with the above complaint he has also experienced tonic colonic type of abnormal body movement is up rolling of eye and drooling of salva but no vomiting or neck stiffness he is for malaria endemic area and has hxy malaria treatment 1 year back has fully vaccinated  to EPI schedule he has no hxy cough  or contacted chronic or  known tb patient he has

no self or family hxy DM he has no hxy head trauma he has drink 1 bottle of tella yesterday otherwise no hxy drug intake p/E acute seek looking

Chief complaints fever 2 days

History of present illness Progress note 5 year old boy on his second POA for the day of moderately strongest MAM + coma go to pyogenic meningitis ICP t cerebral malaria + aspiration pnelnmonia presented with aCHIF with chills regards sweating for 02 days had a generalized tonic colonic type of abnormal body movement with uprolling of the whites of the eyes and drooling of saliva with clenching of the tooth for a total of 03 epistate after the on set of the first episode of the abnormal body movement he was loss of consciousness with failure of controlling feces a year back he had hx of malaria attack and is from a malaria endemic area comatose ASL in distress looks malnowushed chest nasal flaring SC/IC retraction rhonchi all aver the anterior and posterior lung field with good air entry , irregular breathing CNS bilaterally dilated and sluggish pupil meningeal signs negative keter+3 glucose negative BF 3negative 1 positive with p falciparem

Progress note currently has regained consciousness no abnormal body movement chest relatively decreased air entry over the right lung with rhonchi GCS meningeal signs negative normo tinic extiemities

Summery of hx and physical examination grunting striler fever unconscious fact respiratory rate for the luck 01 duration this 5 year old male was unti he conglaini strider granting a fever for he lack 1 day duration diagnosis AFI R/O malaria + seller pneumonie reason for referral fler further on vecr gatien

History of present illness:

P:come go to case malaria currently he is abnormal body movement of his upper hour their lost about 10 minutes followed by loss of conscious about 10 minutes associated with he had drooling of salvia prolong of the eyes either objective.

History of present illness:

This is 7-year-old male odf patient presented with high grade intermittent fevers with kills of 2 days 30kissde of ABM loss of consciousness with focal inherences. he is from deenbia area lost affected back.

A5 years old presented with coma 20 to cerebral malaria to ratio pyogenic meningitis HICP. Loss of consciousness of 01 days' duration abnormal body movements of GTC type (3x).

He is 5 years old boy on his 2nd doe for the da of moderately started Mam +coma 20 to pyogenic meaning it is with ICP Cyberia malaria + aspiration pneumonia. presented with AHGIF with chives rigorous and sweating for 02 days, he had a generalized tonic colonic type no abnormal body movement with unrolling of the of the eyes and dooming of saliva with clenching of the tooth for a total of 03 episodes aftiy the onset of the 1st episode of the abnormal body, movement he was loss of conscious ness with fever of controlling face or urine. A year back he had hx of malarial attack and from a malaria endemic area.

Summary of hx and physical examination:

Granting striker fever unconscious fact register rate for the fact 01day duration HP: this 5 years old male patient was PH until he changes strider grunting and fever for the fact 01day duration.

History of present illness:

This is o6 month old female child pot = Ext LLH 03 days backing at which female statues not le She is 1st vices according to EPS scheduling. Not exposed.

Chief complains diarrhea of 02 days duration

History of present illness:-this patent was lrtl 02 days back at which fine he started to expiation a non water non bloody diarrhea of 2x per day associated with this he had one episode of non projector run bilious vomit he had no associated fever He was exclusive breast fed for 1st 6 month of birth x per day was started on complementary feeder on cereal gimbals 4x per day cereal gain 4x per day

he is vaccinated for his age.his mother uses tap water for cooker and clean.he has no history of loss of consequsnesc. Chief complaints left middle fingers well of 01 day duration History of present illness:1st old eaddls from gonder presents it milder finger swellency w associated erring during teach no offer associated symptoms re sustained burn luring .To list 1st whist02 which ago from a lot iron.

History of present illness:

This patient was LHR 02 days back at which time he started to expansion a non-water bloody diarrhea of 2x per day associated with this he had one episode of non-projective non bites vomiting. He had no associated. He was exclusively breast fed for 6 month of behinds 6x per day and was started on complementary feeds on create ground 4x per day. He is vaccinated for his age. His mother uses tap water for cookies and clean. He has no history of loss of consecsiveness.

History of present illness:

13/12 old child from Gonder presents with LT middle figure swelling with associated crying during four non offer associated systems let sustained button latency.

Chief complains diarrhea of 02 days duration

History of present illness:-this patent was lrtl 02 days back at which fine he started to expiation a non water non bloody diarrhea of 2x per day associated with this he had one episode of non projector run bilious vomit he had no associated fever He was exclusive breast fed for 1st 6 month of birth x per day was started on complementary feeder on cereal gimbals 4x per day cereal gain 4x per day

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cvs : hyper active primordium razed jump int :no palon ass: improved followup for confirm movements ordered sheet Revised ordered morphine ceftriaxam duty progress note

p- 3rd doa for dx of server us studied + cltf 270 crhd (mr,tr) prcipitable by serve cap r\oie dyspnea, pnd, cough and low grade fever do to have cordial do 3 months back and started on lasix and qoronoolactonal at private. history of the present illness the old female child presented with centralized body searching which start from arbitrary prescription.

History present illness:

He presented with cough of one-week duration. ion the cough is drug and non-barking a non-whooping. Associated with the cough he also experienced fast breathing BT no grunting. he also had low grade intermittent fever with no sweating. No same illness in the family. No hx of leg swelling, feeding interruption. Or diaphoresis while breast feed. No family hx of asthma. Fully vaccinated.

History present illness:

This patient was LHR a week back at which time she started to experience low grade intermittent fever associated with pain during shallowing but no cough or fast breathing. She is fully vaccinated according to EPI scheduling. She was breasted exclusively for the 1st 6month after which she was

started on Atemite as complementary and new she is on family diet. She was exposed for sun lights.

History present illness:

This patient was LHR two hours back at which time she started to experience abnormal body movement of both upper and lower extremities in unrolling of eyes and drooling of salvia she was hr. move high grade fever a day before current admission she was has hx of fever with marches and cough three days back but no fast breathing low grade intermittent fever associated with pain during shallowing but no cough or fast breathing. She is fully vaccinated according to EPI scheduling. She was breasted exclusively for the 1st 6month after which she was started on Atemite as complementary and new she is on family diet. She was exposed for sun lights. She started to walk stand a loan at 16 months of age. She had adequate sun exposure.

Chief compliant: come for follow up

History of present illness to grosser term tip Sony and

History of present illness: this neonate was round by the side of the road by the stronger and brought to this hospital. This is abandend baby brought by poloce man from sreet.

History of present illness:

This patient neonate was found by the side of the rode by strangers and brought to this hospital.

On her 21 st set for the DX of eons with mnemonic of several hyperactive abdomen baby after she was found on street.

Chief compliant: come for follow up

History of present illness to grosser term tip Sony and

History of present illness: this neonate was round by the side of the road by the stronger and brought to this hospital. This is abandend baby brought by poloce man from sreet.

this current admission he started by experience of breathing and grunting for which be brought here .he also complains difficulty of swallowing aday prior to this admission but no fever he has also vomiting of two epifs day .he has no cuugele.he has family he of dm (his father aunt and uncles ) .he has also abdominal pain but no diarrhea since the past of the day.

History of present illness:

This is a10 years old male's child presented with dry intermittent cough of week duration with association high grade information fever and sweating. He also led cylobalized type of haddock, loss of appetite. He loss no contact hx with x chronic conquest or known TB patient. He has no

family hx of asthma, he is vaccinated according to EPI schedule. He has hx of frequency argons diagrid but no urine color change. lab  memes .