**CHIEF COMPLAINTS**
H/O LOOSE STOOLS- 1 DAY

**HISTORY OF PRESENTING ILLNESS**
patient who was normal 1 day back when she developed loose stools 1 day back, 3 episodes, no blood/mucus in stools, associated with epigastric pain and nausea
no h/o fever

**PAST HISTORY**
no similar complaints in the past
not a k/c/o dm,htn

**FAMILY HISTORY**
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

**PERSONAL HISTORY**
Diet: Mixed.
Appetite: Good.
Sleep: Adequate.
Bowel and Bladder: Regular.
No substance abuse.

**GENERAL EXAMINATION**
Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.
No pallor, icterus, cyanosis or oedema,clubbing ,lymphadenopathy absent
vitals
PULSE 80/min
BP 100/60 mm HG
RR 20/min
TEMPERATURE 98.6

**TREATMENT**
Inj.Emeset 4mg iv
Inj. Pan 40mg IV bd
T.Ciplox 500mg bd
Cap.Bacelac tid