COMPLAINTS
Fever x 5 days

HISTORY OF PRESENTING ILLNESS
Patient gives a h/o fever since 5 days.it was insisdious in onset and was of high grade type.it was associated with chills and rigors.it decreased on treatment.
no h/o nausea/vomting
no h/o burning micturition
no h/o loose stools
no h/oabdominal pain
no h/o cough with expectoration
no h/o chest pain/palpitations
no h/o breathlessness

PAST HISTORY
no h/o diabetes mellitus,hypetension,tuberculosis

FAMILY HISTORY
nothing significant

PERSONAL HISTORY
sleep - normal appetite - decreased diet - mixed bowel and bladder - regular,

GENERAL EXAMINATION
patient was conscious, cooperative, well oriented with time, place and person.
moderately built and nourished
pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent
PR-80 bpm BP- 110/80mmHg TEMP - 98.6F RR-16 CYCLES / MIN

TREATMENT

IVF FLUIDS 2 PINTS DNS AT 75ML/HR
TAB DOLO 650MG 1-1-1
TAB RANTAC 150MG 1-0-1
TAB OPTINUERON 0-1-0