CHIEF COMPLAINTS
Fever x 3 days
Giddiness since 3 day

HISTORY OF PRESENTING COMPLAINTS
Patient c/o Fever since 3 days with chills and rigors, intermittent , high grade
H/O Headache since 3 days frontal,nonradiating
H/O generalised body ache present
H/O giddiness present
No h/o burning micturition
No h/o cough with expectoration,
No h/o abdominal pain
No h/o urine output
No h/o breathlessness ,bleeding manifestations

PAST HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD

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 consious and cooperative, well oriented to time, place and person
. Moderately built and nourished.
Pallor present
No , icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE 80bpm BP 120/80 mmhg RR 20cpm TEMPERATURE 104 F

TREATMENT
Syrup Potklor 10 ml TID
C Becelac 2-2-2
T Calpol 500 mg TID
T Pan 40 mg 1-0-0
Inj Dexona 8 mg
NS/DNS@75ml/hour