CHIEF COMPLAINTS:
c/o fever- 1 day
c/o vomiting - 1 day

HISTORY OF PRESENTING ILLNESS:
The patient came with complaints of low grade, intermittent fever, since 1 day. Associated with chills, headache and generalized body pain.
No h/o abdominal pain
No h/o burning micturition
The patient also had c/o non projectile vomiting, 3- 4 episodes. Vomitus is non blood tinged, non bile stained
No h/o loose stools

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 h/o substance abuse

GENERAL EXAMINATION
Patient is conscious and cooperative, well oriented to time, place and person.
Moderately built and nourished.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy, oedema
PULSE 80/min
BP =110/70 mmHg
RR =18/min

TREATMENT
IV FLUIDS NS
INJ EMESET 4 MG 0-0-1
INJ PAN 40 MG IV OD
TAB DOLO 650 MG OD
TAB LEVOCET 0-0-1
TAB OPTINEURON 0-1-0
TAB PAN 40 MG 1-0-0 (B/F)