

#### COMPLAINTS

fever  
nausea  
loss of appetite  
generalised bodyache since 3 days

#### PAST HISTORY

no h/o dm, htn, tb

#### 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 - 99.9F RR-16 CYCLES / MIN

#### LAB INVESTIGATION

**14-05-2015** : Haemoglobin : 14.3g/dl, Leukocyte Count Total : 2800/cumm, Mchc : 33.1g/dl, Mch : 30.5pg, Mcv : 92.1fl, Packed Cell Volume : 43.2%, Platelet Count : 143000/cumm, Red Blood Cell

**15-05-2015** : Haemoglobin : 14.6g/dl, Packed Cell Volume : 43.6%, Platelet Count : 138000/cumm,

**16-05-2015** : Haemoglobin : 14.4g/dl, Platelet Count : 86000/cumm, Packed Cell Volume : 43.3%,

**17-05-2015** : Haemoglobin : 15.1g/dl, Packed Cell Volume : 46.2%, Platelet Count : 73000/cumm,

#### TREATMENT

IV fluids

Tab Dolo 650mg TID

Tab Rantac 150mg 1-0-1

Tab Supradyn 0-1-0

Tab Atarax 10mg stat