HISTORY OF PRESENTING ILLNESS
PATIENT COMPLAINS OF FEVER SINCE 5 DAYS ASSOCIATED WITH CHILLS AND RIGORS
SHE ALSO COMPLAINS OF BACK ACHE AND ABDOMIONAL PAIN SINCE 2 DAYS,DIFFUSE BURNING TYPE OF PAIN AND VOMITTING, 1 EPISODE,IT WAS NON BLOOD STAINED AND NON BILE STAINED
NO H/O LOOSE STOOLS

PAST HISTORY
NO H/O DM , HTN OR IHD

FAMILY HISTORY
NOTHING SIGNIFICANT

PERSONAL HISTORY
SLEEP - NORMAL APPETITE - NORMAL DIET - MIXED BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION
PR- 82bpm BP-130/80 mmHg TEMP - 98.6F RR-18 CYCLES / MIN PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WITH TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED PALLOR,ICTERUS, CUANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

Haemoglobin : 12.9g/dl, I
, Platelet Count : 50000/cumm, :
11-02-2015 : Platelet Count : 51000/cumm,

CHEST X RAY-NORMAL
ECG-WNL

TREATMENT
T.PAN 40 MG OD
T.SUPRADYN 0-1-0
T.DOLO 650 MG SOS
T.ATARAX 5 MG 1-0-1
IVF 5D @ 50ML/HR