HISTORY OF PRESENTING ILLNESS

Patient complaints of fever since 4 days, intermittent in nature, no chills or rigors, associated with headache. Patient also complaints of bodyache since 4 days. No complaints of vomiting, abdominal pain. No h/o loose stools/ dysuria. No c/o chest pain/ cough/ wheeze. No c/o bleeding. No c/o decreased urine output.

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. No pallor, icterus, cyanosis clubbing, lymphadenopathy or oedema

PULSE -87 bpm
BP -150/100 mm Hg
RR -16 breaths per minute
TEMPERATURE-98.6 F

HAEMOGLOBIN : 15.7g/dl [14_18g/dl]
[illegible] [4.5_6million
PACKED CELL VOLUME : 46.6% [40_54%]
PLATELET COUNT : 129000/cumm [150000_500000/cumm]
[illegible]
PACKED CELL VOLUME : 44.6% [40_54%]
PLATELET COUNT : 127000/cumm [150000_500000/cumm]
28-10-2014
PACKED CELL VOLUME : 42.6% [40_54%]
PLATELET COUNT : 106000/cumm [150000_500000/cumm]
29-10-2014
PACKED CELL VOLUME : 42.5% [40_54%]
PLATELET COUNT : 84000/cumm [150000_500000/cumm]

TREATMENT

IVF DNS/NS @ 100 CC/HR
T.Dolo 650 mg TID
T.Magpep 40 mg OD
C.Beplex forte OD