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Automatic Zoom

ADDRESS : MLANKUZHIL HOUSE, VELLARIKUNDU POST,  
KASARAGOD - 671533

**DIAGNOSIS: DENGUE FEVER WITH THROMBOCYTOPENIA**

**CHIEF COMPLAINTS:** Fever since 3 days

**HISTORY OF PRESENTING ILLNESS**  
patient was apparently normal 3 days back when he developed fever which was sudden in onset, low grade type, intermittent in nature, gradually progressive. Associated with chills and rigors.  
patient also complains of generalized weakness.  
no h/o abdominal pain /vomiting  
no h/o cough / breathlessness  
no h/o burning micturition / hematuria

**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.  
chronic smoker 1 pack /day x 30 years.

**GENERAL EXAMINATION**  
Patient is conscious and cooperative, well oriented to time, place and person.  
Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema  
PULSE:90bpm  
BP :120/80mmhg  
RR:20/min  
TEMPERATURE:99F

**SYSTEMIC EXAMINATION**

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DEPARTMENT OF GENERAL MEDICINE

PATIENT ID : 166FE65C-AD59-4B46-967A-B23A7910ACBD

NAME : MLANKUZHIL HOUSE

ADDRESS : MLANKUZHIL HOUSE, VELLARIKUNDU POST, KASARAGOD - 671533

DATE : 10/01/2024

TIME : 10:00 AM

DOCTOR : DR. J. J. J.

CLINICAL HISTORY

Chief Complaints: Fever since 3 days, generalized weakness.

History of Presenting Illness: Patient was apparently normal 3 days back when he developed fever which was sudden in onset, low grade type, intermittent in nature, gradually progressive. Associated with chills and rigors. Patient also complains of generalized weakness.

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. Chronic smoker 1 pack /day x 30 years.

General Examination: Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema.

Vital Signs: PULSE:90bpm, BP :120/80mmhg, RR:20/min, TEMPERATURE:99F.

Systemic Examination: (Details not visible in the image)

Diagnosis: DENGUE FEVER WITH THROMBOCYTOPENIA.

Investigations: (Details not visible in the image)

Management: (Details not visible in the image)

Follow-up: (Details not visible in the image)