CHIEF COMPLAINTS
Fever since 2 days
headache since 2 days

HISTORY OF PRESENTING ILLNESS
patient was apparently normal 2 days back following which he developed fever, intermittent in nature, high grade, associated with chills.
He also gives H/O headache - severe, throbbing in nature.
No H/o variation with posture
H/O generalised bodyache present.
No H/O vomiting, loose stools, burning micturition, blurring of vision

PAST HISTORY
K/C/O type 2 Diabetes Mellitus since 2 years, is on T.Glycophage G1 1-0-1 (not taken medication since 2 days)
No H/O Hypertension, Ischaemic Heart Disease, Asthma

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 = 78/min BP = 130/80mmHg RR = 12/min TEMPERATURE = afebrile

LAB INVESTIGATION

**10-06-2015 :** Platelet Count : 105000/cumm, Plasma Glucose Fasting : 246mg/dl, Whole Blood Glycated Hb (Hba1c) : 10.7%,

**11-06-2015 :** Serum Hdl Cholesterol : 15mg/dl, Serum Triglyceride : 160mg/dl, Serum Total Cholesterol : 155mg/dl, Serum Ldl Cholesterol : 101mg/dl, Serum Vldl : 32mg/dl, Haemoglobin : 14.4g/dl, Platelet Count : 114000/cumm, Packed Cell Volume : 42.3%, Urine Total Protein-Spot : 7.5mg/dl, Urine Creatinine (Spot) : 39.2mg/dl, Protein/Creatinine-Ratio : 0.2units,

**12-06-2015 :** Haemoglobin : 14.3g/dl, Platelet Count : 74000/cumm, Packed Cell Volume : 42.7%,

**13-06-2015 :** Haemoglobin : 14.6g/dl, Platelet Count : 72000/cumm, Packed Cell Volume : 44.2%, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites NEGATIVE, **Urine Blood** Negative, **Urine Ketone Bodies** Negative, **Ph** 6.0, **Urine Protein** Positive(+), **Urine Sugar (Qualitative)** Yellow ppt, **Colour** Pale Yellow, **Transperancy** Slightly turbid, **Specific Gravity** 1.010, **Bile Salts** Negative, **Bile Pigments** Negative, **Urine Microscopy** RBCs Nil, Pus Cells : 2-3, Epithelial Cells : Occasional, Crystals : Negative, Casts : Nil, Others : NIL,

**14-06-2015 :** Haemoglobin : 14.2g/dl, Platelet Count : 115000/cumm, Packed Cell Volume : 43.2%,

REFERRAL
Opthalmology Reference for fundoscopy to rule out diabtetic retinopathy.

TREATMENT
IV fluids
T.Rantac 150mg 1-0-1
T.Optineuron 0-1-0
T.Calpol 500mg 1-1-1
T.Glyciphage 1- 1/2 - 1/2
T.Meftal spas SOS
Inj.Emeset 4mg TID