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Automatic Zoom

KANNUR - 670511

**DIAGNOSIS**  
DENGUE FEVER

**COMPLAINTS**  
fever and headache since 6 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 n  
pallor+icterus, cyanosis, clubbing, lymphadenopathy, edema absent  
PR-80 bpm BP-120/80mmHg TEMP - 98.6F RR-18 CYCLES / MIN

**SYSTEMIC EXAMINATION**  
NS: trachea central, accessory muscles not in use, chest movement b/l symmetrical. v/tur appear b/l equal. vhr+.  
CVS: no precordial bulge, jvp not elevated, apex beat palpable in II 5th Ics 1/2" medial to mcl. cardiac borders percussed wnl.  
s1 & s2 + no added sounds/ murmurs.  
P/A: shape: normal, umbilicus central & inverted, soft on palpation, abdomen movement appear b/l symmetrical, no tenderness, no mass palpable, btl+  
CNS: higher mental functions: normal speech: normal cranial nerves: intact motor and sensory systems: normal reflexes: normal

**LAB INVESTIGATION**  
22-05-2015 : Haemoglobin : 12.3g/dl, Leukocyte Count Total : 13200/cumm, Mchc : 32.6g/dl,  
Mch : 27.7mc, Mcv : 85.0fl, Packed Cell Volume : 37.8%, Platelet Count : 61000/cumm, Red Blood

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Microsoft Excel - 2013

9:59 am

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