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**DIAGNOSIS**  
DENGUE FEVER WITH THROMBOCYTOPENIA  
TYPE 2 DIABETES

**COMPLAINTS**  
fever x 5 days  
generalized body ache x 5 days

**HISTORY OF PRESENTING ILLNESS**  
Patient was apparently asymptomatic 5 days ago when she developed fever.it was high grade associated with chills.fever was intermittent in nature.no h/o cough with expectoration.no h/o running nose.no h/o abdominal pain or loose stools.no h/o dysuria.for the above complaints the patient was admitted in a local hospital for 2 days.she gives a h/o passing blackish tarry stools from 2 days ago.h/o bleeding gums on brushing present.no h/o purpuric rashes.

**PAST HISTORY**  
k/c/o of hypertension since 4 years,not on regular medication  
presently has been diagnosed with diabetes mellitus and started on insulin  
no h/o tuberculosis

**FAMILY HISTORY**  
nothing significant

**PERSONAL HISTORY**  
sleep -disturbed appetite - decreased diet - mixed bowel and bladder - regular,

**GENERAL EXAMINATION**  
patient:was conscious, cooperative, well oriented with time, place and person.  
moderately built and nourished  
pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent  
PR-84 bpm BP-120/70mmHg TEMP - 98.6F RR-16 CYCLES / MIN

**SYSTEMIC EXAMINATION**  
RS: trachea central, accessory muscles not in use, chest movement b/l symmetrical. vf&vr appear b/l equal. vbs+..  
CVS: no precordial bulge. i/v not elevated. apex beat palpable in (I) 5th Ics 1/2 " medial to mcl. cardiac borders percussed wnl.

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