CHIEF COMPLAINTS
FEVER- 7 DAYS

HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 7 days, intermittent ,high grade, asssociated with chills and rigors
h/o vomiting present,multiple episodes
h/o nausea and headache
no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

PAST HISTORY

not a k/c/o HTN,PTB,BA,DM

FAMILY HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

PERSONAL HISTORY
Diet: Mixed.
Appetite: normal
Sleep: Adequate.
Bowel and Bladder: regular

GENERAL EXAMINATION
Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.
no pallor,no icterus, cyanosis or oedema,clubbing ,lymphadenopathy absent

vitals
PULSE 80/min

BP 130/80 mm HG
RR 20/min
TEMPERATURE 101

LAB INVESTIGATION
14-06-2015 : Haemoglobin : 11.8g/dl, Leukocyte Count Total : 4200/cumm, Mchc : 32.3g/dl, Mch 27.9pg, Mcv : 86.4fl, Packed Cell Volume : 36.5%, Platelet Count : 102000/cumm, Red Blood Cell

TREATMENT
IVF NS @ 75ml/hr
T.Dolo 650 mg
T.Supradyn