HISTORY OF PRESENTING ILLNESS
Patient gives complaints of fever since 3 days,high grade,intermittent in nature associated with chills and rigors.Patient also complaints of headache,sudden in onset bilateral.No history of cough with expectoration,breathlessness,loose stools,pain abdomen,vomiting.No history of any bleeding manifestations.

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.
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 bpm
BP -110/80 mmHg
RR -16cpm
TEMPERATURE-98.6°F

HAEMOGLOBIN	: 12.0g/dl [12_15g/dl]
PACKED CELL VOLUME	: 36.4% [36_47%]
PLATELET COUNT	: 114000/cumm [150000_500000/cumm]

22-12-2014

HAEMOGLOBIN	: 12.0g/dl [12_15g/dl]
PACKED CELL VOLUME	: 36.3% [36_47%]
PLATELET COUNT	: 89000/cumm [150000_500000/cumm]

23-12-2014

HAEMOGLOBIN	: 11.9g/dl [12_15g/dl]
PACKED CELL VOLUME	: 35.5% [36_47%]
PLATELET COUNT	: 68000/cumm [150000_500000/cumm]

TREATMENT
IVF DNS/NS
Inj Perinorm 4mg SOS
T Pan 40 mg 1-0-0
T Dolo 650 mg 1-1-1
T Atarax 10 mg 1-1-1