DIAGNOSIS
DENGUE FEVER

COMPLAINTS
FEVER SINCE 2 DAYS

HISTORY OF PRESENTING ILLNESS
PATIENT CAME WITH THE COMPLAINTS OF FEVER SINCE 3 DAYS. HIGH GRADE, INTERMITTENT, ASSOCIATI
CHILLS AND RIGORS. NO DIURNAL VARIATION. HE ALSO COMPLAINS OF GENERALISED BODY ACHE AND
HEADACHE, BIFRONTAL, NON RADIATING SINCE 2 DAYS. HISTORY OF MULTIPLE JOINT PAIN PRESENT SIN
DAYS, MORE IN THE KNEE AND ANKLE JOINTS, AGGRAVATES ON WALKING. NO RELIEVING FACTORS.
NO HISTORY OF COUGH WITH EXPECTORATION
NO HISTORY OF PAIN ABDOMEN/VOMITING/LOOSE STOOLS
NO HISTORY OF BURNING MICTURITION/DECREASED URINE OUTPUT
NO HISTORY OF ANY DRUG INTAKE
NO HISTORY OF RASHES

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 DECREASED SLEEP DISTURBED BOWEL AND BLADDER REGULAR NO SUBSTANCE A

GENERAL EXAMINATION
PATIENT IS CONSCIOUS AND COOPERATIVE . WELL ORIENTED TO TIME, PLACE AND PERSON.
MODERATELY BUILT AND NOURISHED.
NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY OR OEDEMA
BP -110/80MMHG RR -16CPM PULSE-102/MIN TEMPERATURE-100.6°F

TREATMENT
IVF DNS/RL AT 100ML/HOUR
INJ. MOCEF 2 GM IV BD
INJ. METROGYL 100ML 1-1-1
INJ DEXONA 8MG IV 1-1-1
T TRANOSTAT 1-1-1
T TAXIM O 200MG 1-0-1
T. CALPOL 500MG 1-1-1
T. RANTAC 150MG 1-0-1
T. SUPRADYN 0-1-0
T.CETIRIZINE 10MG 0-0-1
C. BECELAC 2-2-2
STEAM INHALATION WITH KARVOL 1-1-1
K2 CREAM FOR L/A BD
BOTROCLOT NASAL DROPS 3-3-3

ED WITH

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BUSE