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**DIAGNOSIS**

DENGUE FEVER

**CHIEF COMPLAINTS**

Fever with chills x 4 days

**HISTORY OF PRESENTING ILLNESS**

Patient came with complains of fever with chills since 4days associated with generalised myalgia and headache. No h/o loose stools, pain abdomen, chest pain, breathlessness, cough or burning micturition.

**PAST HISTORY -**

Nothing significant

**FAMILY HISTORY-**

nothing significant.

**PERSONAL HISTORY-**

diet-mixed; appetite-good; sleep-adequate; bowel and bladder-regular.

BP : 120/80 mmhg

PULSE : 72 bpm

TEMP : 99 F

**SYSTEMIC EXAMINATION**

Patient was conscious, co-operative, well oriented to time place and person. moderately built & nourished.

No pallor, icterus, clubbing, cyanosis, lymphadenopathy, edema.

**TREATMENT**

C BACELAC 2-2-2

T ACILOC RD 1-0-0 B/F

T DOLO 650 1-1-1

