COMPLAINTS FEVER-2 WEEKS

HISTORY OF PRESENTING ILLNESS

THE PATIENT WAS APPARENTLY NORMAL 2 WEEKS BACK WHEN HE DEVELOPED FEVER , HIGH GRADE, CONTINUOUS. NO H/O BURNING MICTURATION.

NO H/O COUGH

PATIENT WAS EMPIRICALLY TREATED AS MALARIA IN AN OUTSIDE HOSPITAL

PERSONAL HISTORY
SLEEP - NORMAL
APPETITE - NORMAL
DIET - MIXED
BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION
PR- 88bpm
BP-120/\$0 mmHg
TEMP- 98.6F
RR-18 CYCLES / MIN
MATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED TO TIME, PLACE AND PERSON
MODERATELY BUILT AND NOURISHED
PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION

20-05-2015: Haemoglobin: 12.7g/dl, Leukocyte Count Total: 6400/cumm, Mchc: 32.3g/dl, Mch: 28.4pg, Mcv: 87.8fl, Packed Cell Volume: 39.4%, Platelet Count: 252000/cumm, Red Blood Cell Count: 4.49million/cumm, Neutrophils: 39%, Lymphocytes: 60%, Eosinophils: 01%, Monocytes:

22-05-2015: Platelet Count: 142000/cumm,

23-05-2015: Platelet Count: 114000/cumm, Dengue Rapid (Ns1, Igm, Igg) NS1 ANTIGEN POSITIVE, IgM ANTIBODY: NEGATIVE, IgG ANTIBODY: NEGATIVE, COMMENTS: This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA.,

TREATMENT TAB.DOLO 650MG 1-1-1 TAB.MALARID DS 0-1-0 TAB.PAN 40MG 1-0-0(B/F)