HISTORY OF PRESENTING ILLNESS
Patient complains of fever since 3 days, acute in onset, high grade, associated with chills. Patient also c/o cough with mucoid expectoration since 1 day. He also gives h/o nausea and vomiting since 1 day. No h/o loose stools/ pain abdomen.

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 -79 bpm
BP -120/80 mm Hg
RR -16 breaths per minute
TEMPERATURE -98.6 F

Serum Chloride : 95.8mEq/L [98_107mEq/L]
HAEMOGLOBIN : 13.9g/dl [14_18g/dl]
PACKED CELL VOLUME : 43.8% [40_54%]
PLATELET COUNT : 141000/cumm [150000_500000/cumm]

07-11-2014
HAEMOGLOBIN : 12.8g/dl [14_18g/dl]
PACKED CELL VOLUME : 40.1% [40_54%]
PLATELET COUNT : 130000/cumm [150000_500000/cumm]
08-11-2014
HAEMOGLOBIN : 12.6g/dl [14_18g/dl]
PACKED CELL VOLUME : 39.9% [40_54%]
PLATELET COUNT : 92000/cumm [150000_500000/cumm]
Colour

TREATMENT
IVF NS/DNS @ 125 ml/hr
T.Dolo 650 mg TID
Inj. Magpep 40 mg IV STAT and OD
T.Optineuron OD