DIAGNOSIS
DENGUE FEVER

COMPLAINTS
FEVER SINCE 4 DAYS

HISTORY OF PRESENTING ILLNESS
PATIENT CAME WITH H/O FEVER SINCE 4 DAYS.HIGH GRADE WITH CHILLS
GIVES HISTORY OF 1 EPISODE OF VOMTING

NO OTHER COMPLAINTS

PAST HISTORY
NOT SIGNIFICANT

FAMILY HISTORY
NOT SIGNIFICANT

PERSONAL HISTORY
SLEEP- NORMAL
APPETITE- NORMAL
BOWEL AND BLADDER HABITS-REGULAR

SYSTEMIC EXAMINATION
PATIENT CONSCIOUS, CO OPERATIVE, WELL ORIENTED TO TIME PLACE AND PERSON.
NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY AND EDEMA
PULSE-88BPM
BP -130/80MMHG
CVS: S1 S2 HEARD, NO MURMURS
RS: VBS +, NO ADDED SOUNDS
PA: SOFT, NO TENDERNESS
CNS: HMF NORMAL. NO FND

TREATMENT
IVF NS/DNS-100ML/HOUR
T.DOLO 650MG
T.BEPLEX FORTE
INJ.PAN 40MG