HISTORY OF PRESENTING ILLNESS

The patient was apparently normal 4 days back when he developed high grade fever, intermittent in nature and associated with chills. The patient also gives history of vomiting 3-4 episodes ,vomitus contained food particles. It was non projectile vomiting , non blood tinged . History of headache present . History of burning micturation present .No history of loose stools , pain abdomen , blurring of vision , altered sensorium .

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.
History of alcohol consumption present . reformed smoker .

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-60 / min
BP - 110/70 mm Hg
RR- 18 / min
TEMPERATURE - afebrile

LAB INVESTIGATION

09-06-2015 : Haemoglobin : 14.2g/dl, Leukocyte Count Total : 6100/cumm, Mchc : 32.8g/dl, Mch : 27.2pg, Mcv : 82.9fl, Packed Cell Volume : 43.3%, Platelet Count : 61000/cumm. Red Blood

10-06-2015 : Haemoglobin : 14.5g/dl, Platelet Count : 58000/cumm, Packed Cell Volume : 43.7%,

11-06-2015 : Haemoglobin : 14.8g/dl, Platelet Count : 50000/cumm, Packed Cell Volume : 44.6%, **Urine Blood** Negative, **Urine Ketone Bodies** Negative, **Ph** 7.0, **Urine Protein** Negative,

12-06-2015 : Haemoglobin : 15.1g/dl,

TREATMENT

T. Calpol 50 mg SOS
T. Pan 40 mg 1-0-0(B/F)

T. Optineuron 0-1-0
Inj . Emeset 4 mg IV BD
IVF NS /DNS at 75 mh / hr
Syp. Sucrafil 2 tsp TID