HISTORY OF PRESENTING ILLNESS
The patient came with complaints of fever since 4 days which was present throughout the day and was associated with chills and rigors.
No h/o runny nose,sore throat, cough or breathlessness
No h/o burning micturition or hematuria
No h/o loose stools

PAST HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD

FAMILY HISTORY
No history of similar complaints 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 80bpm
BP 120/80mmHg
RR 18 breaths/ min
TEMPERATURE 98.6*F

02-12-2014

HAEMOGLOBIN	:	11.8g/dl [12_15g/dl]
PACKED CELL VOLUME	:	36.1% [36_47%]
PLATELET COUNT	:	77000/cumm [150000_500000/cumm]

03-12-2014

HAEMOGLOBIN	:	11.6g/dl [12_15g/dl]
PACKED CELL VOLUME	:	35.7% [36_47%]
PLATELET COUNT	:	59000/cumm [150000_500000/cumm]

REFERRAL
Nil

TREATMENT
IVF DNS @ 100ml/hr
Tab. Dolo 650mg 1 sos