

#### CHIEF COMPLAINTS

Fever since 3 days  
Body ache since 3 days  
Headache since 3 days  
Cough since 3 days

#### HISTORY OF PRESENTING ILLNESS

The patient was apparently normal 3 days back when she developed fever, insidious in onset, gradually progressive.  
It was of high degree and associated with chills. No diurnal variation and relieved on medication.  
Patient also complains of cough with minimal expectoration  
Patient also complains of associated body ache, which was generalised in nature.  
She also complains of headache associated with fever, bifrontal and throbbing type of pain, it relieved on medication.  
No h/o fever with chills, no h/o vomiting or nausea  
No h/o decreased urine output, no h/o cough with expectoration  
No h/o abdominal pain or loose stools

#### PAST HISTORY

h/o chikungunya 8 years back  
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: decreased  
Sleep: Adequate.  
Bowel and Bladder: Regular. No substance abuse.

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Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.

No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema

PULSE 72 bpm BP-110/70 mm hg RR-17 cpm TEMPERATURE -afebrile

**16-06-2015** : Haemoglobin : 10.1g/dl, Neutrophils : 61%, Lymphocytes : 36%, Eosinophils : 02%, Monocytes : 01%, Basophils : 00%, **Other Cells Method** : Manual -, Leukocyte Count Total : 2200/cumm, Platelet Count : 160000/cumm, **Malarial Parasite Fluorescent (Mp Ft)** presence of

**17-06-2015** : Haemoglobin : 11.0g/dl, Packed Cell Volume : 34.6%, Platelet Count : 125000/cumm, **Peripheral Smear Report No H/3775/15, Impression** : Mild microcytic hypochromic anemia with neutropenia.,

#### TREATMENT

Cap Doxy xl 100 mg 1-0-1  
Syp Ascoryl 2tsp-2tsp-2tsp  
C Doxt sz 1-0-1  
T Pan 40 mg 1-0-0  
Inj Emeset 4 mg iv sos  
T Dolo 500 mg sos