COMPLAINTS FEVER WITH CHILLS

HISTORY OF PRESENTING ILLNESS

PATIENT WAS DIAGNOSED WITH DENGUE FEVER AND TREATED FOR THE SAME WAS SYMPTOMATICALLY BETTER AND WAS DISCHARGED. PATIENT COMPLAINED OF FEVER WITH CHILLS AND VOMITING. HAD 2 EPISODES OF VOMITING.VOMITUS CONTAINS FOOD PARTICLES, NOT BLOOD / BILE STAINED .NO H/O LOOSE STOOLS, COUGH WIYH EXPECTORATION, PAIN ABDOMEN

PAST HISTORY NO IHD, TB, BRONCHIAL ASTHMA

FAMILY HISTORY NIL 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 -80BPM
BP -110/70MMHG

14-06-2015: Platelet Count: 105000/cumm, Malarial Parasite Fluoroscent (Mp Ft) presence of parasites Negative,

15-06-2015: Haemoglobin: 15.8g/dl, Neutrophils: 75%, Lymphocytes: 12%, Monocytes: 12%, Basophils: 00%, Other Cells Method: Manual -, Leukocyte Count Total: 8100/cumm, Packed Cell Volume: 49.0%, Platelet Count: 101000/cumm, 16-06-2015: Haemoglobin: 15.0g/dl, Packed Cell Volume: 46.2%, Platelet Count: 159000/cumm,

TREATMENT
T.DOLO 650MG 1-1-1
IV FLUIDS NS/DNS AT 75ML/HOUR
INJ.PERINORM 1 AMP BD
STEAM INHALATION WITH KARVOL PLUS
T.EBART
INJ.AUGMENTIN 625MG 1-1-1