HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 5 days back when he developed fever which is associated with chills and rigors,no diurnal variation. Patient also complaints of generalised bodyache since 5 days,headache and multiple joint pain since 5 days. No history of burning micturition, breathlessness,hematuria,chestpain .

PAST HISTORY
No similar history in the past
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: disturbed
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 -96/min BP -90/70 mm Hg,right arm supine position RR-16/min,abdominothoracic type TEMPERATURE -101°F

HAEMOGLOBIN : 15.4g/dl [14_18g/dl]

PLATELET COUNT : 130000/cumm [150000_500000/cumm]

29-10-2019

HAEMOGLOBIN : 14.1g/dl [14_18g/dl]

PACKED CELL VOLUME : 42.5% [40_54%]

PLATELET COUNT : 104000/cumm [150000_500000/cumm]

[illegible]

HAEMOGLOBIN : 15.0g/dl [14_18g/dl]

PACKED CELL VOLUME : 45.3% [40_54%]

PLATELET COUNT : 86000/cumm [150000_500000/cumm]

REFERRAL
Nil

TREATMENT
IVF NS/ DNS @ 100 ml/hr
Inj Emeset 4 mg IV Q8H
Inj Pantodac 40 mg IV stat
Tab Crocin 500 mg 1-1-1
Tab Supradyn 0-1-0