HISTORY OF PRESENTING ILLNESS
Patient came with complaints of fever since 5 days , high grade assocaited with chills. No diurnal variation. Fever associated with headache . No nausea/vomiting.
No altered sensorium.
No co generalised body pain.
No cough/breathlessness.
C/o maculopaular rash in bilateral lower limb.

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. 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
PULSE80/min
BP 120/70 mm Hg
RR 16 cycles/min

HAEMOGLOBIN	:	11.0g/dl [12_15g/dl]
PACKED CELL VOLUME	:	33.9% [36_47%]
PLATELET COUNT	:	103000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	9.9g/dl [12_15g/dl]
PACKED CELL VOLUME	:	29.6% [36_47%]
PLATELET COUNT	:	92000/cumm [150000_500000/cumm]

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HAEMOGLOBIN	:	10.1g/dl [12_15g/dl]
PACKED CELL VOLUME	:	30.5% [36_47%]
PLATELET COUNT	:	113000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	9.9g/dl [12_15g/dl]
PACKED CELL VOLUME	:	29.7% [36_47%]
PLATELET COUNT	:	131000/cumm [150000_500000/cumm]

TREATMENT
Tab. Pantolex 40 mg 1-0-0
Tab.Dolo 650 mg SOS
IVF NS/DNS @ 125 cc/hr