

DIAGNOSIS:
DENVUE FEVER WITH THROMBOCYTOPENIA

COMPLAINTS:
Fever x 4 days
Headache x 4 days

HISTORY OF PRESENTING ILLNESS:
Patient came with c/o fever since 4 days ,moderate grade associated with chills and rigors,no h/o excessive sweating or rash.Also c/o headache,bifrontal,throbbing type. No h/o cough .No H/o burning micturition present.No h/o increased frequency of micturition .No h/o vomiting/loose stools/vomiting.

Past History
No similar history in the past.
No h/o diabetes mellitus, hypertension, bronchial asthma, tuberculosis or epilepsy.

Family History
Nothing significant.

Personal History
Diet-Mixed
Sleep- Adequate
Appetite- Adequate
Bowel and bladder habits-Regular
No substance abuse.

General Physical Examination
Patient is moderately built and nourished.
Conscious and oriented to time, place and person.
No pallor, icterus, clubbing, cyanosis, lymphadenopathy and pedal oedema.
Pulse-88bpm
BP-120/80mm of hg
RR-18 breaths/min
Temp-99.6°F

TREATMENT:
IV FLUIDS
T.Dolo 650mg SOS
T.Pan 40mg1-0-0