HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 3 days back when he developed fever, insidous in onset, intermittent, high grade associated with chills and rigors. Also associated with generalised body pain and headache.
No h/o loose stools, abdominal pain, rashes, burning micturition.

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
PULSE-100bpm
BP-120/80mmHg
RR-18/min
TEMPERATURE - afebrile

HAEMOGLOBIN : 14.3g/dl [14_18g/dl]

PLATELET COUNT : 100000/cumm [150000_500000/cumm]

PACKED CELL VOLUME : 43.3% [40_54%]

PLATELET COUNT : 99000/cumm [150000_500000/cumm]

29-10-2014

PLATELET COUNT : 105000/cumm [150000_500000/cumm]

30-10-2014

PLATELET COUNT : 103000/cumm [150000_500000/cumm]

REFERRAL
nil

TREATMENT
iv fluids
T. Dolo 650mg
T. Supradyne