CHIEF COMPLAINTS
Fever since 1 week

HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 1 week ago when he developed fever, intermittent , associated with chills.It subsides on medications. History of headache present. History of one episode of vomiting present. Vomitus contained food particles, not blood or bile stained. No history of abdominal pain or loose stools. No history of burning micturition.No history of cough with expectoration.

PAST HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD
No history of malaria in the past

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 conscious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE - 80bpm
BP- 120/80mm Hg
RR - 16cpm
TEMPERATURE -98.6F

17-12-2014

HAEMOGLOBIN	: 12.9g/dl [14_18g/dl]
PACKED CELL VOLUME	: 39.1% [40_54%]
PLATELET COUNT	: 39000/cumm [150000_500000/cumm]

18-12-2014

HAEMOGLOBIN	: 13.2g/dl [14_18g/dl]
PACKED CELL VOLUME	: 40.1% [40_54%]
PLATELET COUNT	: 58000/cumm [150000_500000/cumm]

19-12-2014

HAEMOGLOBIN	: 13.5g/dl [14_18g/dl]
PACKED CELL VOLUME	: 40.9% [40_54%]
PLATELET COUNT	: 96000/cumm [150000_500000/cumm]

T.Calpol 500mg 1 SOS
IVF DNS/NS at 100ml/hour
Inj. Pantoprazole 40mg IV OD
Inj. Emeset 4mg IV SOS
T.Rantac 150mg 1-0-1