CHIEF COMPLAINTS
Fever since 2 days
Headache since 2 days

HISTORY OF PRESENTING ILLNESS
patient was apparently normal 2 days back when he developed fever which was sudden in onset , low grade type , intermittent in nature , gradually progressive. Associated with chills and rigors.
Patient also complains of headache , throbbing type , present over the frontal region.
patient also complains of generalized weakness.
no h/o abdominal pain /vomitting
no h/o cough / breathlessness
no h/o burning micturition / hematuria
newly detected diabetes mellitus at the time of admission.

PAST HISTORY
No history of 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:90bpm
BP :120/80mmhg
RR:20/min
TEMPERATURE:99F

07-06-2015 : Haemoglobin : 10.6g/dl, Leukocyte Count Total : 3100/cumm, Mchc : 31.9g/dl, Mch : 26.1pg, Mcv : 81.8fl, Packed Cell Volume : 33.1%, Platelet Count : 138000/cumm, Red Blood Cell

09-06-2015 : Haemoglobin : 10.3g/dl, Platelet Count : 88000/cumm, Packed Cell Volume : 31.0%,

10-06-2015 : Packed Cell Volume : 33.5%, Platelet Count : 72000/cumm, Plasma Glucose Fasting : 140mg/dl,

11-06-2015 : Haemoglobin : 11.3g/dl, Packed Cell Volume : 34.0%, Platelet Count : 61000/cumm,

12-06-2015 : Haemoglobin : 11.8g/dl, Packed Cell Volume : 36.0%,

TREATMENT
IVF DNS/NS @ 100ml/hr
Inj hydrocortisone 100mg IV stat
T.Pan 40mg (b/f) 1-0-0
T.Becosules 0-1-0
T.Glycomet R 500MG 1-0-0
Herpes ointment
NEBDuolin

Syp viscodyne 2tsp 1-1-1
T.dolo 650mg sos