

COMPLAINTS:

FEVER SINCE 1 WEEK
COUGH AND CORYZA SINCE 1 WEEK
BREATHLESS SINCE 1 DAY
VOMITING SINCE 1 DAY

HISTORY OF PRESENTING ILLNESS:

PATIENT WAS APPARENTLY NORMAL 1 WEEK BACK WHEN SHE DEVELOPED FEVER, LOW GRADE, INTERMITTENT, NOT ASSOCIATED WITH CHILLS AND RIGORS, ASSOCIATED WITH COUGH AND CORYZA. COUGH WAS ASSOCIATED WITH EXPECTORATION, WHITE, MUCOID SPUTUM WHICH WAS ASSOCIATED WITH BREATHLESSNESS SINCE 1 DAY.

PATIENT C/O VOMITING 4 EPISODES, CONTAINING FOOD PARTICLES, NON BILE STAINED.
H/O NAUSEA +.

H/O LOOSE STOOLS 2-3 EPISODES

NO H/O ABDOMINAL PAIN.

NO H/O URINARY COMPLAINTS

NO H/O CHEST PAIN

NO H/O RASH, BLEEDING TENDENCIES

PAST HISTORY:

K/C/O ALLERGIC BRONCHITIS, TYPE II DIABETES MELLITUS

PATIENT PREVIOUSLY ON TAB GLYCOMET GP 3

TAB DIABIC M

TAB DERIPHYLLINE R 150MG

ESI FLO ROTA CAP

NO H/O DM, HTN OR IHD

FAMILY HISTORY:

NOTHING SIGNIFICANT

PERSONAL HISTORY:

SLEEP - NORMAL, APPETITE - NORMAL, DIET - MIXED, BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION:

PR- 80 bpm, BP- 130/80 mmHg, TEMP - 98.6F, RR-18 CYCLES / MIN.

PATIENT IS CONSCIOUS, COOPERATIVE, WELL ORIENTED WITH TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED.

PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

TREATMENT:

INJ MAGPEP 40MG 1-0-0

INJ EMESET 4MG SOS

SYP BROZEDEK SF 2 TSP 1-1-1

INJ CEFTRIAXONE 1GM IV 1-0-1

BUDECORT NEB 1-0-1

DUOLIN NEB 1-0-1

TAB DERIPHYLLINE R 150MG 1-0-1

TAB DIABIC M 1-1-1

INJ CEFABACT 1-0-0

INJ H ACTRAPID 18-18-16U S/C