

COMPLAINTS

fever, nausea, vomiting since 3 days

PAST HISTORY

no h/o dm,htn,tb

FAMILY HISTORY

nothing significant

PERSONAL HISTORY

sleep - normal appetite - decreased diet - mixed bowel and bladder - regular,

GENERAL EXAMINATION

patient was conscious, cooperative, well oriented with time, place and person.

moderately built and nourished

pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent

PR-80 bpm BP- 110/80mmHg TEMP - 98.6F RR-16 CYCLES / MIN

LAB INVESTIGATION

04-06-2015 : Haemoglobin : 10.0g/dl, Leukocyte Count Total : 1600/cumm, Mchc : 33.0g/dl, Mch : 25.8pg, Mcv : 78.3fl, Packed Cell Volume : 30.3%, Platelet Count : 133000/cumm, Red Blood Cell

counted, refer may occur in early infection. Please confirm by LCR.

06-06-2015 : Packed Cell Volume : 31.8%, Platelet Count : 123000/cumm, Packed Cell Volume : 30.2%, Platelet Count : 114000/cumm,

08-06-2015 : Haemoglobin : 10.1g/dl, Packed Cell Volume : 30.5%, Platelet Count : 127000/cumm,

CHEST XRAY

normal

TREATMENT

iv fluids

tab dolo 650mg 1-1-1

limgaprep 40 mg 1-0-0

inj emaset 4mg sos