HISTORY OF PRESENTING ILLNESS
Patient c/o fever since 3 days, sudden onset, high grade, intermittent in nature, associated with chills and rigors.\
no h/o burning micturition
no h/o abdominal painNo h/o diarrhoea
No h/o headache
He also c/o generelised body ache since 3 days
No h/o weakness of the body

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:80bpm
BP:120/80mmhg
RR:18/min
TEMPERATURE:98.6F

| | |
|---|---|
| HAEMOGLOBIN | : 14.6g/dl [ 14_18g/dl ] |
| LEUKOCYTE COUNT TOTAL | : 6500/cumm [ 4000_11000/cumm ] |
| PLATELET COUNT | : 123000/cumm [ 150000_500000/cumm ] |
| PACKED CELL VOLUME | : 46.6% [ 40_54% ] |

**20-11-2014**

| | |
|---|---|
| HAEMOGLOBIN | : 14.7g/dl [ 14_18g/dl ] |
| PACKED CELL VOLUME | : 47.0% [ 40_54% ] |
| PLATELET COUNT | : 131000/cumm [ 150000_500000/cumm ] |

TREATMENT
TMULTIVITAMIN
T.RANITIDINE
INJ.ONDANSETRON
T.PARACETAMOL
C.DOXYCYCLINE