CHIEF COMPLAINTS
FEVER SINCE 1 WEEK.

HISTORY OF PRESENTING ILLNESS
PATIENT PRESENTS WITH COMPLAINTS OF HIGH GRADE FEVER SINCE 1 WEEK ASSOCIATED WITH CHILLS AND RIGORS.
H/O GENERALIZED WEAKNESS.
NO H/O NAUSEA/ VOMITING/ PAIN ABDOMEN.
NO H/O BURNING MICTURITION.
NO H/O COUGH WITH EXPECTORATION/ BREATHLESSNESS/ CHEST PAIN.
NO H/O JOINT PAIN WITH RASHES.

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: DECREASED
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.
ICTERUS PRESENT. NO PALLOR, CYANOSIS, CLUBBING, LYMPHADENOPATHY OR OEDEMA.
DEVIATION OF ANGLE OF MOUTH TO THE LEFT SIDE.
PULSE 82 BEATS/MIN
BP 180/100 MM HG
RR 20 BREATHES/MIN
TEMPERATURE 103 DEGREES F

TREATMENT
IVF
TAB. FAMCYCLOVIR 250MG 1-0-1
TAB. WYSOLONE 20MG 1-0-0
TAB. DOLO 650MG 1-1-1
TAB. ENAM 2.5MG 0-0-1
CAP. BEPLEX FORTE 1-0-0
LARINATE SP KIT
INJ. ARINATUM 120MG IV STAT, AFTER 12 HOURS, AFTER 24 HOURS
INJ. H - ACTRAPID 14-14-14
INJ. INSULITARD 0-0-10 U
INJ. PANTOP 40MG 1-0-0