CHIEF COMPLAINTS
Fever x 3 days

HISTORY OF PRESENTING ILLNESS
Patient apparently normal 3 days back when she developed fever , high grade , not associated with chills intermittent type. no h/o night sweats
Patient also c/o headache
No h/o abdominal pain,loose stools,vomiting
No h/o cough with expectoration,cold,breathlessness
No h/o body ache
No h/o decreased urine output,burning micturartion

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 62 bpm BP 130/80 mmhg RR 20 cpmTEMPERATURE 100 F

TREATMENT

IVF NS at 75 ml / hour
Inj Dexa 8 mg IV stat
T Pantodac 40 mg 1-0-0
T.Calpol 500 mg SOS
T Lorel 2 mg 0-0-1
Inj.Emeset 4 mg IV TID