CHIEF COMPLAINTS

Fever since 5 days Cough since 2 days

HISTORY OF PRESENTING ILLNESS

patient was apparently normal 4 days back when he developed fever which was sudden in onset, low grade type, intermittent in nature, gradually progressive. Associated with chills and rigors.

Patient also complains of cough since the past 2 days not associated with expectoration.

patient also complains of generalized weakness.

no h/o abdominal pain /vomitting

no h/o cough / breathlessness

no h/o burning micturition / hematuria

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:90bpm

BP :120/80mmhg

RR:20/min

TEMPERATURE:99F

LAB INVESTIGATION

11-06-2015: Haemoglobin: 12.7g/dl,

32.7g/dl, Mch : 28.2pg, Mcv : 86.3fl, Packed Cell Volume : 38.7%, Platelet Count : 83000/cumm, Red Blood Cell Count : 4.49million/cumm, Neutrophils : 64%, Lymphocytes

12-06-2015: Haemoglobin: 12.6g/dl, Packed Cell Volume: 38.0%, Platelet Count:

60000/cumm,

13-06-2015: Haemoglobin: 13.0g/dl, Packed Cell Volume: 39.5%, Platelet Count:

75000/cumm,

14-06-2015: Haemoglobin: 12.5g/dl, Packed Cell Volume: 38.8%, Platelet Count:

110000/cumm,

15-06-2015: Haemoglobin: 12.6g/dl, Packed Cell Volume: 38.9%, Platelet Count:

139000/cumm,

TREATMENT

IVF DNS/NS @ 75ml/hr T.Calpol 500mg 1-1-1 T.Pan 40mg (b/f) 1-0-0 T.Optineuron 0-1-0 Inj Emeset 4mg SOS RT.Nicardia 20mg 1-0-0