

Documents - Vensopro X

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**CHIEF COMPLAINTS**  
FEVER SINCE 3 days  
HEADACHE SINCE 3 days  
VOMITING SINCE 3 days

**HISTORY OF PRESENTING ILLNESS**  
Complaints of fever, high grade, not associated with chills and rigors, not subsided on medication. Associated with head ache and vomiting, 2-3 episodes non projectile, non bilious, non bile stained, non blood tinged.  
No history of cough, coryza, rash, joint pain, sore throat  
No neck stiffness  
No history of dengue in the surroundings  
No history of bowel or bladder disturbances

**PAST HISTORY**  
No similar complaints in the past  
No previous admissions

**BIRTH HISTORY**  
ANTENATAL: Registered, Regular, Taken Fe and Folic acid and Inj TT  
NATAL: Full term, Vaginal delivery, Birth weight-average  
POSTNATAL: Baby cried immediately after birth. No postnatal complications.

**DEVELOPMENTAL HISTORY**  
Appropriate for age.

**IMMUNIZATION HISTORY**  
Up to date.

**FAMILY HISTORY**  
No similar complaints in the family.

**ANTHROPOMETRY**

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**DISCHARGE SUMMARY**  
DEPARTMENT OF PAEDIATRICS

REGID NO	DATE OF BIRTH / SEX/AGE	NAME	Monitor/AMM KIDMAN
ACTUAL	EXPECTED REFERENCE		
HEIGHT 155cm	156cm	NORMAL	
WEIGHT 43kg	40-54kg	NORMAL	
BMI 18.22kg/m <sup>2</sup>	15.5kg/m <sup>2</sup>	NORMAL	

**GENERAL PHYSICAL EXAMINATION**  
No Pallor, Cyanosis, Clubbing, Lymphadenopathy, Oedema  
HR 120b/min/regularly  
Pulse 90/min  
Temp 38.0°C  
RR 22/min

**SYSTEMIC EXAMINATION**  
CVS: S1 S2 heard, No murmurs  
RS: Stertoral or crepitations: No wheezed sounds  
Pne: Rhonchus: Soft, No crackles  
Liver palpable 2cm below right costal margin  
Spleen tip palpable

