CHIEF COMPLAINTS:
FEVER SINCE 2 DAYS

HISTORY OF PRESENTING ILLNESS:
PATIENT CAME WITH COMPLAINTS OF FEVER SINCE 2 DAYS ,INTERMITTENT,ASSOCIATED WITH CHILLS,NO SPECIFIC PATTERN,NO H/O HEADACHE,COUGH,EXPECTORATION,VOMITING,LOOSE STOOLS,HAEMATURIA,SEIZURES,RASHES,ABDOMINAL PAIN.

PAST HISTORY:NO HISTORY OF DM,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 CONSCIOUS AND COOPERATIVE, WELL ORIENTED TO TIME, PLACE AND PERSON.
MODERATELY BUILT AND NOURISHED. NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY OR OEDEMA
PULSE - 90/MIN BP- 90/70MMHG RR - 20CPM TEMPERATURE -98.6F

18-11-2015 : Haemoglobin : 13.7g/dl, Packed Cell Volume : 41.3%, Platelet Count : 81000/cumm, **Urine Blood (Hb And Derivatives)** Negative, **Urine Ketone Bodies** Negative. **Ph** 5.0 **Urine Protein**

TREATMENT:
IVF NS/DNS@ 100ML/HR
T.CALPOL 500MG 1-1-1
T.CTRA 20MG 1-0-0