COMPLAINTS
FEVER- 3 DAYS
MALAISE-4 DAYS

HISTORY OF PRESENTING ILLNESS
THE PATIENT WAS APPARENTLY NORMAL 3 DAYS BACK WHEN HE DEVELOPED FEVER,MALAISE.
THE FEVER WAS ASSOCIATED WITH CHILLS.

PAST HISTORY
NO H/O DM , HTN OR IHD

FAMILY HISTORY
NOTHING SIGNIFICANT

PERSONAL HISTORY
SLEEP - NORMAL
APPETITE - NORMAL
DIET - MIXED
BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION
PR-78 bpm
BP-120/90 mmHg
TEMP - 98.6F RR-18 CYCLES / MIN
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WTO TIME, PLACE AND PERSON
MODERATELY BUILT AND NOURISHED
PALLOR,ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION

03-06-2015 : Haemoglobin : 13.6g/dl, Leukocyte Count Total : 6400/cumm, Mchc : 33.6g/dl, Mch : 30.2pg, Mcv : 89.7fl, Packed Cell Volume : 40.3%, Platelet Count : 40000/cumm, Red Blood Cell Count : 4.49million/cumm, Neutrophils : 25%,

04-06-2015 : Haemoglobin : 13.1g/dl, Packed Cell Volume : 39.4%, Platelet Count : 52000/cumm, Platelet Count : 70000/cumm,

05-06-2015 : Haemoglobin : 12.6g/dl, Packed Cell Volume : 37.7%, Platelet Count : 92000/cumm,

06-06-2015 : Haemoglobin : 12.8g/dl, Packed Cell Volume : 38.0%, Platelet Count : 134000/cumm,

TREATMENT
IVF NS@50CC/HR
INJ.PAN 40MG IV 1-0-0
INJ.OPTINEURON 1AMP IV OD
TAB.ATEN 25MG 1-0-0
TAB.DOLO 650MG 1-0-1