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KANNUR - 670571

DIAGNOSIS
DENGUE FEVER WITH THROMBOCYTOPENIA

CHIEF COMPLAINTS
Fever since 1 week
bodyache since 3 days
headache since 3 days
burning micturition since 1 day

HISTORY OF PRESENTING ILLNESS
patient was apparently normal 1 week back when she developed fever which was sudden in onset, low grade type, intermittent in nature, gradually progressive. Associated with chills and rigors.
patient complains of generalized body pain.
patient also gives h/o headache, throbbing type, frontal region.
no h/o abdominal pain /vomiting
no h/o cough / breathlessness
no h/o hematuria

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: decreased. Sleep: Adequate. Bowel: regular. Bladder: increased frequency of micturition. 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 90bpm
BP 130/80mmhg
RR 20/min
TEMPERATURE 99F

SYSTEMIC EXAMINATION

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