COMPLAINTS
fever x 3 days
body pain x 3 days
headache x 3 days

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
patient was conscious, cooperative, well oriented with time, place and person.moderately built and nourished
pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent

PR-80 bpm BP- 110/70mmHg TEMP - 98.6F RR-18 CYCLES / MIN

LAB INVESTIGATION

13-02-2015 : Haemoglobin : 11.0g/dl, Leukocyte Count Total : 8700/cumm, Mchc : 33.0g/dl, Mch : 28.2pg, Mcv : 85.5fl, Packed Cell Volume : 33.3%, Platelet Count : 248000/cumm, Red Blood Cell

TREATMENT
iv fluids
inj pan 40 mg iv stat
tab pan40 mg 1-0-0
tab dolo 650 mg sos
inj avil 1 amp iv stat