DIAGNOSIS;
DENGUE FEVER

COMPLAINTS:
Fever x 7 days
Headache x 4 days

HISTORY OF PRESENTING ILLNESS:
Patient came with c/o fever since 7 days ,moderate grade associated with chills and rigors,no h/o increased sweating or rash.Also c/o headache,bifrontal,throbbing type
No h/o cough .
No H/o burning micturition present.
No h/o increased frequency of micturition .
No h/o vomiting/loose stools or abdominal pain.

Past History
No similar history in the past.
No h/o diabetes mellitus, hypertension, bronchial asthma, tuberculosis or epilepsy.

Family History
Nothing significant.

Personal History
Diet-Mixed
Sleep- Adequate
Appetite- Adequate
Bowel and bladder habits-Regular
No h/o substance abuse.

General Physical Examination
Patient is moderately built and nourished.
Conscious and oriented to time, place and person.
No pallor, icterus, clubbing, cyanosis, lymphadenopathy and pedal oedema.
Pulse-88bpm
BP-120/80mm of hg
RR-18 breaths/min
Temp-99.6*F

TREATMENT:
T.Dolo 65omg SOS
T. Atarax 10mg 1-0-1
IVF NS/DNS
T. Pan 40mg 1-0-0