HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 2 days ago when he developed fever associated with chills.No h/o burning micturation,pain abdomen.

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: 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 -78 bpm BP120/80mmhg- RR - 16cpm TEMPERATURE -98.6F

INVESTIGATION

04-03-2015 : Haemoglobin : 15.4g/dl,

05-03-2015 : Platelet Count : 96000/cumm, Dengue Rapid (Ns1, Igm, Igg) **NS1 ANTIGEN POSITIVE, IgM ANTIBODY : POSITIVE,** IgG ANTIBODY : NEGATIVE, COMMENTS : This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA.,

06-03-2015 : Platelet Count : 126000/cumm,

05-03-2015 : Usg Abdomen IMPRESSION: - NO SONOLOGICAL ABNORMALITY DETECTED.
04-03-2015 : Xray Chest Pa NORMAL CHEST RADIOGRAPH

ECG:wnl

REFERRAL -none

TREATMENT
04-03-2015 ACILOC RD .. (TAB), CALPOL .. (TAB),
05-03-2015 ACILOC RD .. (TAB),