HISTORY OF PRESENTING ILLNESS:
Patient is a k/c/o type DM and HTN comes with complains of fever with chills since 3 days.Fever was high grade, intermittent associaated with bodyache.H/o backache present.
No h/o burning micturition.
Patient also c/o cough with expectoration since 3 days, expectorant scanty, mucoid, non foul smelling
No h/o abdominal pain
No h/o nausea, vomiting

PAST HISTORY:
K/C/O type 2 DM and HTN since 5 years, on regular medication
No history 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 consious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE:88bpm
BP:150/100mmhg
RR:16/min
TEMPERATURE:98.6F

HAEMOGLOBIN	:	12.8g/dl [14_18g/dl]
PLATELET COUNT	:	175000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	12.1g/dl [14_18g/dl]
PACKED CELL VOLUME	:	35.6% [40_54%]
PLATELET COUNT	:	150000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	12.4g/dl [14_18g/dl]
PACKED CELL VOLUME	:	35.2% [40_54%]
PLATELET COUNT	:	143000/cumm [150000_500000/cumm]
31-10-2014		
HAEMOGLOBIN	:	11.5g/dl [14_18g/dl]
PACKED CELL VOLUME	:	34.0% [40_54%]
PLATELET COUNT	:	91000/cumm [150000_500000/cumm]

REFERRAL:
OPTHALMOLOGY-NORMAL

TREATMENT:
T.CALPOL 500MG 1-1-1
IVF NS@75ML/HR
INJ.H.ACTRAPID 12-12-12
T.RANTAC 150MG 1-0-1
SALINE NEB TID
T.OLMEZEST BETA 1-0-0
T.DOXY 100MG 1-0-1
SYP.DIGENE GEL 2TSP 1-1-1