HISTORY OF PRESENTING ILLNESS
Patient complains of fever since 1 week, acute in onset , gradually progressive, high grade, associated with chills. Patient gives h/o constipation since 4 days. Patient also complains of vomiting since 1 day, non blood stained, non bilious. No h/o pain abdomen. No c/o loose stools. No c/o cough/ breathlessness.

PAST HISTORY
No history of DM, 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 consious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE -88 bpm
BP -130/80 m Hg
RR -16 breaths per minute
TEMPERATURE -99.4 F

HAEMOGLOBIN : 13.5g/dl [14_18g/dl]
PLATELET COUNT : 91000/cumm [150000_500000/cumm]

21-11-2014
PLATELET COUNT : 88000/cumm [150000_500000/cumm]
22-11-2014
PLATELET COUNT : 67000/cumm [150000_500000/cumm]
Colour
23-11-2014
PLATELET COUNT : 64000/cumm [150000_500000/cumm]
23-11-2014
24-11-2014
PLATELET COUNT : 79000/cumm [150000_500000/cumm]

REFERRAL
nil

TREATMENT-
MICU CARE
4 PINTS PLATELET TRANSFUSION
Inj.Mocef 2 gm IV BD
Inj.Emeset 4 mg IV BD
Inj.Magpep 40 mg IV OD
Cap.Bacelac TID
Saline nnebulization TID
T.Doxy 100 mg BD
T.Optineuron OD
T.Dolo 650 mg TID
T.Magpep 40 mg OD