#### CHIEF COMPLAINTS

Fever since 2 days Headache since 2 days

### HISTORY OF PRESENTING ILLNESS

patient was apparently normal 2 days back when he developed fever which was sudden in onset, low grade type, intermittent in nature, gradually progressive. Associated with chills and rigors.

Patient also complains of headache, throbbing type, present over the frontal region.

patient also complains of generalized weakness.

no h/o abdominal pain /vomitting

no h/o cough / breathlessness

no h/o burning micturition / hematuria

newly detected diabetes mellitus at the time of admission.

#### PAST HISTORY

No history of Hypertension, Tuberculosis, Asthma or IHD

## **FAMILY HISTORY**

No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

#### PERSONAL HISTORY

TEMPERATURE:99F

Diet: Mixed. Appetite: Good. Sleep: Adequate. Bowel and Bladder: Regular. No substance abuse.

### **GENERAL EXAMINATION**

Patient is considus and cooperative, well oriented to time, place and person.

Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema PULSE:90bpm

BF:120/80mmhg

RR:20/min

07-06-2015 : Haemoglobin : 10.6g/dl, Leukocyte Count Total : 3100/cumm, Mchc : 31.9g/dl, Mch : 26.1pg, Mcv : 81.8fl, Packed Cell Volume : 33.1%, Platelet Count : 138000/cumm, Red Blood Cell

09-06-2015 : Haemoglobin : 10.3g/dl, Platelet Count : 88000/cumm, Packed Cell Volume : 31.0%, 10-06-2015 : Packed Cell Volume : 33.5%, Platelet Count : 72000/cumm, Plasma Glucose Fasting : 140mg/dl,

11-06-2015: Haemoglobin: 11.3g/dl, Packed Cell Volume: 34.0%, Platelet Count: 61000/cumm,

12-06-2015: Haemoglobin: 11.8g/dl, Packed Cell Volume: 36.0%,

# TREATMENT

IVF DNS/NS @ 100ml/hr Inj hydrocortisone 100mg IV stat T.Pan 40mg (b/f) 1-0-0 T.Becosules 0-1-0 T.Glycomet R 500MG 1-0-0 Herpes ointment NEBDuolin

yp viscodyne 2tsp 1-1-1 .dolo 650mg sos