HISTORY OF PRESENTING ILLNESS
Patient was apparently well 5 days back when he developed fever with chills more during evening hours. Associated with headache and multiple joint pains No c/o vomiting. No complaint of burning micturition. No h/o cough with expectoration/ running nose. No h/o abdominal pain/ loose stools.

PAST HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD

FAMILY HISTORY
Nothing significant

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-87bpm
BP -130/90mm Hg
RR-18 breaths per minute
TEMPERATURE-102 degree F

HAEMOGLOBIN	: 14.0g/dl [14_18g/dl]
PLATELET COUNT	: 146000/cumm [150000_500000/cumm]

30-10-2014

PLATELET COUNT	: 105000/cumm [150000_500000/cumm]

31-10-2014

PLATELET COUNT	: 87000/cumm [150000_500000/cumm]

01-11-2014

PLATELET COUNT	: 118000/cumm [150000_500000/cumm]

TREATMENT
IVF NS/DNS @ 75 ml/hr
TAB. RANTAC 150MG BD
TAB. DOLO 650MG SOS