DIAGNOSIS
Dengue Fever

CHIEF COMPLAINTS
Fever since 3 days
Headache since 2 days
Generalised bodyache since 2 days

HISTORY OF PRESENTING ILLNESS
Patient came with complaints of fever since 3 days, insidious in onset and gradually progressive, high grade, not associated with chills or rigors. Patient also complained of headache and generalised bodyache since the last 2 days.
No history suggestive of focal neurological deficits
No h/o abdominal pain, vomiting, nausea
No h/o loose stools, constipation
No signs of meningeal irritation
No h/o chest pain, palpitations

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: 68/min
BP: 110/80mm Hg
RR: 16/min
TEMPERATURE: 99F

TREATMENT
Tab Dolo 650mg 1 SOS
Tab Pan 40mg 1-0-0 (B/F)
Inj Hydrocortisone 100mg IV Q8H
IV Fluids NS @ 100ml/h