HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 1 day ago when she developd fever , high grade , intermittent . associated with chills and rigors.No history of vomiting. no history of loose stools. No history of abdominal discomfort. No history of burning micturition. No history of cough with expectoration.

PAST HISTORY
Patient lives in Germany . She came to India 3 months ago.
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 - 78bpm
BP- 120/80mm Hg
RR - 16cpm
TEMPERATURE -98.6F

HAEMOGLOBIN	:	12.4g/dl [12_15g/dl]
PACKED CELL VOLUME	:	37.0% [36_47%]

[redacted] | NAME : Ms.R

PLATELET COUNT	:	225000/cumm [150000_500000/cumm]
06-11-2014		
HAEMOGLOBIN	:	12.8g/dl [12_15g/dl]
PACKED CELL VOLUME	:	38.3% [36_47%]
PLATELET COUNT	:	170000/cumm [150000_500000/cumm]
07-11-2014		
HAEMOGLOBIN	:	12.1g/dl [12_15g/dl]
PACKED CELL VOLUME	:	36.6% [36_47%]
PLATELET COUNT	:	174000/cumm [150000_500000/cumm]

TREATMENT
T. Dolo 650mg 1-1-1
IVF DNS @75ml/hour
T.Rantac 150mg 1-0-1
Inj. Emeset 4 mg IV SOS
Inj. Dexa 8mg IV stat