HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 7 days ,moderate grade associated with chills and rigors,no h/o increased sweating or rash. No h/o cough .No H/o burning micturition present.No h/o increased frequency of micturition .No h/o vomiting/loose stools/vomiting

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 consious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE:78bpm
BP130/80
RR14
TEMPERATURE afebrile

PLATELET COUNT	:	139000/cumm [150000_500000/cumm]

02-11-2014

PACKED CELL VOLUME	:	45.5% [40_54%]
PLATELET COUNT	:	133000/cumm [150000_500000/cumm]

03-11-2014

PACKED CELL VOLUME	:	43.2% [40_54%]
PLATELET COUNT	:	165000/cumm [150000_500000/cumm]

04-11-2014

PACKED CELL VOLUME	:	44.4% [40_54%]
PLATELET COUNT	:	223000/cumm [150000_500000/cumm]

REFERRAL
nil

TREATMENT
tab dolo 650 mg 1-1-1
tab pan 40 mg 1-0-0