CHIEF COMPLAINTS
FEVER-4 DAYS

HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 4 days, intermittent ,high grade,not asssociated with chills and rigors
h/o urinary urgency and hesitancy
no h/o vomiting/nausea/ headache
no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

PAST HISTORY
k/c/o DM since 6 years on T.Metformin
k/c/o HTN/IHD sinc3 6 years on medication
not a k/c/o ptb,ba

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

PERSONAL HISTORY
Diet: Mixed.
Appetite: normal
Sleep: Adequate.
Bowel and Bladder: decreased urine putput and constipation
no substance abuse

GENERAL EXAMINATION
Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.

vitals
PULSE 80/min
BP 190/100mm HG
RR 20/min
TEMPERATURE 101

LAB INVESTIGATION
08-06-2015 : Haemoglobin : 11.2g/dl, Leukocyte Count Total : 4700/cumm, Mchc : 29.5g/dl, Mch : 24.8pg, Mcv : 84.1fl, Packed Cell Volume : 38.1%, Platelet Count : 135000/cumm, Red Blood Cell Count : 4.53million/cumm, Neutrophils : 81%,

TREATMENT
T.Dolo 650 mg 1-1-1
T.Supradyn 0-1-0
T.Rantac 150mg 1-0-1
T.Telsar 40mg1-0-0
T.Cilacar 10mg 0-0-1/2
T.Novastat CV 10mg 0-0-1
T.Clinidipine 10mg 0-0-1
T.Metformin 500mg1/2-0-1/2