HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 3 days back when he developed fever, insidious in onset, intermittet. Fever decreases on medication but then reappears.
Patient also c/o headache and bodyache since past 3 days
No h/o cough, cold
No h/o vomiting
No h/o burning micturition

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 - 80bpm
BP-130/80mmhg
RR -17 cycles/min
TEMPERATURE- 99F

HAEMOGLOBIN	:	15.6g/dl [14_18g/dl]
PACKED CELL VOLUME	:	46.2% [40_54%]
PLATELET COUNT	:	157000/cumm [150000_500000/cumm]
17-11-2014		
HAEMOGLOBIN	:	15.0g/dl [14_18g/dl]
PACKED CELL VOLUME	:	44.6% [40_54%]
PLATELET COUNT	:	131000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	15.2g/dl [14_18g/dl]
PACKED CELL VOLUME	:	45.5% [40_54%]
PLATELET COUNT	:	119000/cumm [150000_500000/cumm]

TREATMENT
IVF DNS/NS @ 100ML/HR
T. DOLO 650 MG TID
T. PAN 40 MG OD