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DIAGNOSIS
DENGUE FEVER

CHIEF COMPLAINTS
FEVER WITH CHILLS SINCE 4 DAYS

HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 3 days, intermittent associated with chills
He also c/o loose stools since 3 days
h/o multiple episodes of vomiting since 2 days
no h/o bleeding manifestation.
No h/o abdominal pain/sore throat

PAST HISTORY :
no h/o dm/ htn

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

PERSONAL HISTORY
Diet: Mixed.
Appetite: decreased
Sleep: disturbed
Bowel and Bladder: regular
alcohol consumption +

GENERAL EXAMINATION
Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.
no pallor, no icterus, cyanosis or oedema, clubbing, lymphadenopathy absent
vitals
PULSE 80/min
BP 120/80 mm HG
RR 20/min
TEMPERATURE 98.6 F

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