CHIEF COMPLAINTS
FEVER - 3 DAYS
VOMITING - 3 DAYS
LOOSE STOLS - 3 DAYS

HISTORY OF PRESENTING ILLNESS
PATIENT WAS APPARENTLY NORMAL 3 DAYS AGO WHEN HE DEVELOPED FEVER NOT ASSOCIATED WITH CHILLS AND RIGORS.LOW GRADE, INTERMITTENT IN NATURE.PATIENT ALSO C/O VOMITING - 3 DAYS,NON PROJECTILE,CONTAINED RECENT FOOD PARTICLES ,NOT BLOOD OR BILE STAINED.PATIENT C/O LOOSE STOOLS - 3 DAYS ,MULTIPLE EPISODES,WATERY IN CONSISTENCY AND NOT BLOOD STAINED ASSOCIATED GENERALISED WEAKNESS AND BODYACHE.
NO H/O BREATHLESSNESS
NO H/O ANY URINARY SYMPTOMS.
NO H/O SYNCOPE,NECK STIFFNESS,JONT PAIN,BLEEDING MANIFESTATIONS.

PAST HISTORY - NO H/0 DM/HTN/ TB/ ASTHMA/ IHD.

FAMILY HISTORY- NO H/O DM/ HTN/ TB/ ASTHMA/ IHD IN FAMILY.

PERSONAL HISTORY- DIET-MIXED; APPETITE-GOOD; SLEEP-ADEQUATE; BOWEL & BLADDER-REGULAR

GENERAL PHYSICAL EXAMINATION
PATIENT WAS CONSCIOUS, CO-OPERATIVE, WELL ORIENTED TO TIME PLACE AND PERSON. MODERATELY BUILT & NOURISHED.
NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA.

BP : 120/80 MMHG
PULSE : 78 BPM
TEMP : 101 F
RR : 18 /MIN

TREATMENT
IVF DNS/NS
INJ EMESET IV 4MG
T CALPOL 500 MG
INJ PAN 40 MG OD
T. RANTAC 150 MG 1-0-0 (B/F)