HISTORY OF PRESENTING ILLNESS

patient gives a h/o fever since 3 days.it was not associated with chills or rigors.she was on treatment for the same.she gives a h/o generalizd fatigue.no h/o nausea or vomiting.no h/o loose stools.no h/o cough with expectoration.no h/o bleeding manifestations.no h/o burning micturiton.blood investigations have been performed from outside.

PAST HISTORY

history of appendicectomy 3 months back

no h/o dm,htn,tb

FAMILY HISTORY

nothing significant

PERSONAL HISTORY

sleep - normal appetite - decreased diet - mixed bowel and bladder - regular,

GENERAL EXAMINATION

patient was conscious, cooperative, well oriented with time, place and person.
moderately built and nourished
pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent
PR-80 bpm BP- 110/80mmHg TEMP - 98.6F RR-16 CYCLES / MIN

11-06-2015 : Haemoglobin : 15.2g/dl, Leukocyte Count Total : 4900/cumm, Mchc : 32.1g/dl, Mch : 27.7pg, Mcv : 86.3fl, Packed Cell Volume : 47.3%, Platelet Count : 222000/cumm, Red Blood Cell

12-06-2015 : Haemoglobin : 14.3g/dl, Packed Cell Volume : 43.3%, Platelet Count : 201000/cumm,

13-06-2015 : Haemoglobin : 13.7g/dl, Packed Cell Volume : 42.3%, Platelet Count : 177000/cumm,

TREATMENT

tab dolo 650 mg 1-1-1
iv fluids NS/DNS 75ml/hr
tab magpep 40mg 1-0-0
inj emeset 4mg IV SOS