HISTORY OF PRESENTING ILLNESS

patient was apparently normal 2 month days back when he developed fever which was sudden in onset , low grade type , intermittent in nature not associated with chills and rigors.
patient also complains cough , associated with sputum. Patient had visited a local hospital for the above complaints and was diagnosed with dengue fever , the patient had persistent elevated total counts and was referred to FMMCH for further management
patient gives h/o generalized weakness.
h/o decreased appetite
no h/o weight loss
no h/o abdominal pain /vomitting
no h/o cough / breathlessness
no h/o burning micturition / hematuria

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.
patient is an alcoholic and smoker since the past 30 years.

GENERAL EXAMINATION

Patient is consious and cooperative, well oriented to time, place and person.
Moderately built and nourished. No pallor, icterus, cyanosis, clubbing or oedema
PULSE:90bpm
BP :120/80mmhg
RR:20/min
TEMPERATURE:99F

LAB INVESTIGATION

20-06-2015 : Haemoglobin : 11.7g/dl, Leukocyte Count Total : 19500/cumm, Mchc : 32.7g/dl, Mch : 27.7pg, Mcv : 84.7fl, Packed Cell Volume : 35.7%, Platelet Count : 92000/cumm, Red Blood Cell Count : 4.21million/cumm, Neutrophils : 08%, Lymphocytes : 07%,

24-06-2015 : Platelet Count : 120000/cumm,

TREATMENT

TAB DOLO 650MG SOS
TAB MALZIX 0-1-0
IVF NS @ 75ML/HR
INJ.CEFOZANE T 1.125GM IV BD (D2)
TAB TANFIX 200MG 1-0-1 (D2)