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KASARAGOD - 670511

DIAGNOSIS
DENGUE FEVER WITH THROMBOCYTOPENIA

CHIEF COMPLAINTS
FEVER- 4 DAYS

HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 4 days, intermittent ,high grade, associated with chills and rigors
h/o nausea and headache
no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition/vomiting

PAST HISTORY
not a k/c/o dm, htn,ptb,ba

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

PERSONAL HISTORY
Diet: Mixed.
Appetite: normal
Sleep: Adequate.
Bowel and Bladder: regular
no substance abuse

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 130/80 mm HG
RR 20/min
TEMPERATURE 98.6

SYSTEMIC EXAMINATION
RS-Trachea central, accessory muscles not in use, chest movements are bilaterally.Symmetrical.V/E and

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