COMPLAINTS
FEVER X3DAYS
HEADACHE X 3DAYS

HISTORY OF PRESENTING ILLNESS
PATIENT COMES WITH COMPLAINS OF FEVER SINCE 3 DAYS, HIGH GRADE, ASSOCIATED WITH CHILLS, INTERMITTENT, ASSOCIATED WITH HEADACHEH/O COUGH WITH MINIMAL EXPECTORATION/ NO H/O BREATHLESSNESS/CHEST PAIN
NO H/O HEMATURIA/DYURIA
NO H/O DECREASED URINE OUTPUT
H/O LOOSE STOOLS SINCE 1 DAY

GENERAL EXAMINATION
BP-120/80MMHG PULSE-100/MIN TEMP-AFEBRILE RR-20

PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WIT TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED
PALLOR,ICTERUS, CUANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION

12-06-2015 : Haemoglobin : 14.4g/dl, Leukocyte Count Total : 4300/cumm, Mchc : 33.9g/dl, Mch : 32.4pg, Mcv : 95.6fl, Packed Cell Volume : 42.3%, Platelet Count : 49000/cumm, Red Blood Cell

TREATMENT
TB DOLO650MG BD
CAP BACELAC TID
INJ TIM 100MG BD
INJ OPTINEURON 1 AMP OD
SYP VICODYN BD
TAB ULTRACET 1 STAT
INJ MIXTARD (30/70) 24-0-12

TB LOREL 2MG SOS