COMPLAINTS
fever
nausea
loss of appetite
generalised bodyache since 3 days

PAST HISTORY
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 - 99.9F RR-16 CYCLES / MIN

LAB INVESTIGATION

14-05-2015 : Haemoglobin : 14.3g/dl, Leukocyte Count Total : 2800/cumm, Mchc : 33.1g/dl, Mch : 30.5pg, Mcv : 92.1fl, Packed Cell Volume : 43.2%, Platelet Count : 143000/cumm, Red Blood Cell

15-05-2015 : Haemoglobin : 14.6g/dl, Packed Cell Volume : 43.6%, Platelet Count : 138000/cumm,

16-05-2015 : Haemoglobin : 14.4g/dl, Platelet Count : 86000/cumm, Packed Cell Volume : 43.3%,

17-05-2015 : Haemoglobin : 15.1g/dl, Packed Cell Volume : 46.2%, Platelet Count : 73000/cumm,

TREATMENT
IV fluids
Tab Dolo 650mg TID
Tab Rantac 150mg 1-0-1
Tab Supradyn 0-1-0
Tab Atarax 10mg stat