

#### COMPLAINTS

Fever with chills, joint pain and generalized weakness for 1 week

#### 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- 110/70mmHg TEMP - 100 F RR-16 CYCLES / MIN

#### LAB INVESTIGATION

09-06-2015 : Haemoglobin : 9.9g/dl,

33.3g/dl, Mch : 28.2pg, Mcv : 84.7fl, Packed Cell Volume : 29.6%, Platelet Count : 111000/cumm, Red Blood Cell Count : 3.5million/cumm, Neutrophils : 79%,

10-06-2015 : Haemoglobin : 10.6g/dl, Packed Cell Volume : 32.0%, Platelet Count : 66000/cumm,

11-06-2015 : Haemoglobin : 10.9g/dl, Packed Cell Volume : 32.3%, Platelet Count : 29000/cumm, Serum Urea : 10mg/dl, Serum Creatinine : 0.56mg/dl,

12-06-2015 : Haemoglobin : 9.9g/dl, Packed Cell Volume : 30.3%, Platelet Count : 27000/cumm, Haemoglobin : 9.9g/dl, Packed Cell Volume : 30.5%, Platelet Count : 45000/cumm,

14-06-2015 : Platelet Count : 80000/cumm,

15-06-2015 : Haemoglobin : 9.6g/dl, Packed Cell Volume : 29.4%, Platelet Count : 124000/cumm,

#### TREATMENT

T.Dolo 650mg 1-1-1

T.Supradyn 0-1-0

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T.Rantac 150mg 1-0-1

IV fluids DNS/NS at 100ml/hr