HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 5 days back when she developed fever, moderate grade, associated with chills, intermitternt with evening rise of temperature.
H/o vomiting since 2 days , non projectile , 2-3 episodes containing food particles . No h/o blood in vomitus
No h/o abdominal pain
No h/o burning micturition
No h/o chest pain, breathlessness

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. No substance abuse.

GENERAL EXAMINATION
Patient is consious and cooperative, well oriented to time, place and person. Moderately built and nourished.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE 80/min
BP 110/80 mm Hg
RR 16 /min

PLATELET COUNT	:	128000/cumm [150000_500000/cumm]
PLATELET COUNT	:	139000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	13.0g/dl [12_15g/dl]
PACKED CELL VOLUME	:	39.0% [36_47%]
PLATELET COUNT	:	141000/cumm [150000_500000/cumm]

REFERRAL
nil

TREATMENT
tab. Calpol 500 mg 1-1-1
Inj. Mocef 2g IV BD
Inj. Pan 40 mg IV OD
Inj. Emeset 4 mg IV SOS
Tab. Magpep 40 mg 1-0-0