HISTORY OF PRESENTING ILLNESS
The patient came with complaints of fever since 2 days high grade, associatd with chills and rigors, present throughout the day, relieved on taking medications. She also complaints of generalised weakness. She also givesa h/o one episode of vomiting, of which the vomitus contained food particles, non bilious and non blood stained, and non projectile. no history of any bleeding episodes.

PAST HISTORY
No history of any similar complaints in the past

FAMILY HISTORY
No h/o any similar complaints in the family

PERSONAL HISTORY
Diet: Vegetarian.
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 80bpmin
BP 120/80mmHg
RR 18breaths/ min
TEMPERATURE 101*F

06-11-2014

HAEMOGLOBIN	:	12.0g/dl [12_15g/dl]
PACKED CELL VOLUME	:	35.5% [36_47%]
PLATELET COUNT	:	207000/cumm [150000_500000/cumm]

TREATMENT
Tab. Rantac 150mg 1-0-1
Tab. Calpol 1-1-1

COURSE