Documents - VensoPro

172.18.0.17:8080/VENSOPRO/Document/ViewDoc?id=24C52E3A-CD5B-49AF-A947-CE8C2307A5CE&q=5500

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SEX	: FEMALE	DISCHARGED ON	: 24-05-2015 / 12:31
BED NO	: F.Med E 33	UNIT HEAD	: Dr.VENKATESHA B.M. MBBS,MD
UNIT NAME	: MEDICINE UNIT D		
ADDRESS	: MANDAPATHIL H/ SE THIR MENI,CHERUPUZHA		
	KANNUR		

DIAGNOSIS
DENGUE FEVER

COMPLAINTS
fever x 5 days
headache, , bodyar . x 5 days
vomiting, loose s :cols x 2 days

PAST HISTORY
no h/o dm,htn,b

FAMILY HISTORY
nothing significant

PERSONAL HISTOR
sleep - normal appe d e - decreased diet - mi d bowel and bladder - regular,

GENERAL EXAMINA ON
patient was conscipu cooperative, wel riented with time, place and person.
moderately built and urished
pallor,ictervs, cyanosi. lubbing, ly hadenopathy, edema absent
PR-80 bpm BP- 110/80m Hg TE - 98.6F RR-16 CYCLES / MIN

SYSTEMIC EXAMINATION
RS: trachea central, acce muscles not in use, chest movement b/l symmetrical. vf&vr appear b/l equal. vbs+, .
CVS: no precordial bulge not elevated, apex beat palpable in (i) 5th ics 1/2 " medial to mcl. cardiac borders percussed wnl.
s1 &s2 + ; no added sou / murmurs.
P/A: shape : normal , um icus: central & inverted , soft on palpation , abdomen movement: appear b/l symmetrical, no tenderness, no mass e ble , bs(+)

start

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Microsoft Excel - 201-

9:42 AM