HISTORY OF PRESENTING ILLNESS
The patient was apparently normal 5 days ago. She complains of fever, high grade, continuous, associated with chills.
No history of burning micturition or night sweats.
History of associated myalgia and headache since 2 days. headache was diffuse and of severe, throbbing type.
No history of retroorbital pain, petechial resh, bleeding gums, melena.
No history of vomiting, loose stools.
No history of cough, breathlessness, chest pain.
For the above complains, the patient consulted a nearby doctor and was told to have dengue and was refered here for further evaluation.

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: Reduced.
Sleep: Adequate.
Bowel and Bladder: Regular.
No substance abuse.

GENERAL EXAMINATION
Patient is moderately built and nourished.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE - 90 bpm
BP - 140/90 mm Hg
RR- 18/min
TEMPERATURE- 100ºF

LAB INVESTIGATION

10-05-2015 : Haemoglobin : 12.4g/dl, Leukocyte Count Total : 1900/cumm, Mchc : 33.5g/dl, Mch : 28.9pg, Mcv : 86.2fl, Packed Cell Volume : 36.9%, Platelet Count : 129000/cumm, Red [illegible] **Abo Grouping & Typing** TEST RESULT A2 RH(D) POSITIVE ,

11-05-2015 : Haemoglobin : 12.9g/dl, Platelet Count : 121000/cumm, Packed Cell Volume : 38.1%, **Peripheral Smear Report No** H/2975/15 , **Impression** : Normocytic normochromic blood picture with neutropenic leucopenia. ,

12-05-2015 : Haemoglobin : 9.1g/dl, Packed Cell Volume : 27.3%, Platelet Count : 73000/cumm,

13-05-2015 : Haemoglobin : 12.6g/dl, Packed Cell Volume : 37.1%, Platelet Count : 102000/cumm,

Chest X-ray- normal
ECG- normal

REFERRAL
Gynaecology- in the view of perivaginal itching and burning sensation
Advice- Candid ointment for L/A

TREATMENT
IV Fluids NS/DNS- 75 ml/hr
tab. Ciplox 500 mg 1-0-1
Tab. Optineuron 0-1-0
Tab. Pan 40 mg 1-0-0