CHIEF COMPLAINTS FEVER SINC 1 WEEK

HISTORY OF PRESENTING ILLNESS

PATIENT IS CURRENTLY ASYMPTOMATIC, I WEEK AGO SHE DEVELOPED FEVER, HIGH

GRADE, INTERMITTENT ASSOCIATED WITH CHILLS.

PATIENT ALSO DEVELOPED GEBNERALIZED BODY ACHE

NO HISTORY OF ANY BLEEEDING MANIFESTATION.

NO HISTORY OF HEADACHE

NO HISTORY OF PAIN ABDOMEN

NO HISTORY OF BURNING MICTURITION

NO HISTORY OF GIDDINESS

NO HISTORY OF CHESTPAIN AND PALPITATION

NO HISTORY OF DIARRHEA

NO HISTORY OF COUGH WITH EXPECTORATION

NO HSITORY OF 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.

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 130/80MMHG

RR 18/MIN

TEMPERATURE AFEBRILE

LAB INVESTIGATION

05-12-2015: Haemoglobin: 11.9g/dl, Leukocyte Count Total: 3500/cumm, Mchc: 31.7g/dl, Mch: 23.8pg, Mcv: 75.2fl, Packed Cell Volume: 37.4%, Platelet Count: 112000/cumm, Red Blood Cell Count: 4.97million/cumm, Neutrophils: 31%,

06-12-2015: Haemoglobin: 10.7g/dl, Packed Cell Volume: 33.8%, Platelet Count:

103000/cumm,

07-12-2015: Haemoglobin: 10.9g/dl, Packed Cell Volume: 33.8%, Platelet Count:

117000/cumm,

TREATMENT IVF DNS/NS @75ML/HR INJ EMESET 4MG IV SOS T.DOL 650G SOS