COMPLAINTS: FEVER WITH CHILLS - 3 DAY

HISTORY OF PRESENTING ILLNESS:

PATIENT WAS APPARENTLY NORMAL 3 DAYS BACK WHEN HE DEVELOPED FEVER, HIGH GRADE ASSOCIATED WITH CHILLS.
NO H/O VOMITING

NO H/O ABDOMINAL PAIN NO H/O URINARY COMPLAINTS NO H/O LOOSE STOOLS

NO H/O CHEST PAIN, BREATHLESSNESS AND COUGH

GENERAL EXAMINATION:

PR- 80 bpm, BP- 130/80 mmHg, TEMP - 98.6F, RR-18 CYCLES / MIN. PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WITH TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED. PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION:

12-06-2015: Serum Total Protein: 7.32g/dl, Serum Albumin: 4.70g/dl, Serum Globulin: 2.6g/dl, Serum Total Bilirubin: 1.17mg/dl, Serum Conjugated Bilirubin: 0.35mg/dl, Serum Unconjugated-Bilirubin: 0.82mg/dl, Serum Ast (Sgot): 18IU/L, Serum Alt (Sgpt): 14IU/L, Serum Alkaline Phosphatase: 59IU/L, Serum A/G Ratio: 1.8units, Serum Urea: 24mg/dl, Serum Creatinine: 1.24mg/dl, Serum Sodium: 132mEq/L, Serum Potassium: 3.26mEq/L, Serum Chloride: 95.2mEq/L,

13-06-2015: Haemoglobin: 13.1g/dl, Platelet Count: 183000/cumm, Packed Cell Volume: 39.5%,

14-06-2015: Haemoglobin: 13.0g/dl, Packed Cell Volume: 40.3%, Platelet Count: 151000/cumm,

15-06-2015: Haemoglobin: 13.9g/dl, Packed Cell Volume: 44.1%, Platelet Count: 142000/cumm,

TREATMENT:

TAB. DOLD 650 MG