HISTORY OF PRESENTING ILLNESS
Patient c/o loose stools since 3 days, watery, had several episodes per day
H/o fever present, high grade, intermittent
Patient also c/o vomiting since 3 days, non projectile, 4-5 episodes per day, contents mainly food particles, not blood or bile stained.
No h/o headache, no h/o burning micturition
Patient also c/o pain abdomen since 3 days
no h/o altered bowel habits.

PAST HISTORY
No similar history in the past.
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. 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:76/min
BP:120/80mmhg
RR:18/min
TEMPERATURE:98.6F

HAEMOGLOBIN	:	11.9g/dl [12_15g/dl]
PACKED CELL VOLUME	:	35.4% [36_47%]
PLATELET COUNT	:	101000/cumm [150000_500000/cumm]

TREATMENT
1 DOLO 650MG 1 STAT
1 RANTAC 150MG 1 STAT
IVF DNS @ 100ML/HR
CBECELAC 2 STAT
INJ EMESET 4MG IV STAT
INJ PAN 40MG IV STAT