COMPLAINTS
FEVER WITH CHILLS- 5 DAYS

HISTORY OF PRESENTING ILLNESS
THE PATIENT WAS APPARENTLY NORMAL 2 WEEKS BACK WHEN HE DEVELOPED FEVER , HIGH GRADE, CONTINUEOUS.
NO H/O BURNING MICTURATION.
NO H/O COUGH

PAST HISTORY
NO H/O DM , HTN OR IHD

FAMILY HISTORY
NOTHING SIGNIFICANT

PERSONAL HISTORY
SLEEP - NORMAL
APPETITE - NORMAL
DIET - MIXED
BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION
PR- 88bpm
BP-120/80 mmHg
TEMP - 98.6F
RR-18 CYCLES / MIN
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED TO TIME, PLACE AND PERSON
MODERATELY BUILT AND NOURISHED
PALLOR,ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION

21-05-2015 : Haemoglobin : 16.1g/dl, Leukocyte Count Total : 4800/cumm, Mchc : 33.2g/dl, Mch : 30.3pg, Mcv : 91.2fl, Packed Cell Volume : 48.5%, Platelet Count : 44000/cumm, Red Blood Cell

22-05-2015 : Platelet Count : 29000/cumm, Platelet Count : 19000/cumm,

23-05-2015 : Haemoglobin : 15.2g/dl, Neutrophils : 66%, Lymphocytes : 21%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual 00, Leukocyte Count Total : 3700/cumm, Packed Cell Volume : 45.2%, Platelet Count : 44000/cumm,

24-05-2015 : Platelet Count : 97000/cumm,

TREATMENT
TAB.DOLO 650MG 1-1-1
TAB.ATERAX 10MG 1-1-1
TAB.PAN 40MG 1-0-0(B/F)
IVF DNS/NS AT 100CC/HR