HISTORY OF PRESENTING ILLNESS
Patient complains of fever since 5 days, no chills or rigors, low grade, intermittent , associated with headache and body ache. No c/o vomiting/ loose stools/ dysuria. No c/o bleeding. No c/o breathlessness/ decreased urine output.

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. 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 bpm
BP 110/70 mm Hg
RR -17 breaths per minute
TEMPERATURE-99 F

HAEMOGLOBIN	:	13.1g/dl [14_18g/dl]
PACKED CELL VOLUME	:	39.2% [40_54%]
PLATELET COUNT	:	65000/cumm [150000_500000/cumm]

01-11-2014

HAEMOGLOBIN	:	13.6g/dl [14_18g/dl]
PACKED CELL VOLUME	:	41.3% [40_54%]
PLATELET COUNT	:	52000/cumm [150000_500000/cumm]

02-11-2014

HAEMOGLOBIN	:	7.1g/dl [14_18g/dl]
PACKED CELL VOLUME	:	24.0% [40_54%]
PLATELET COUNT	:	57000/cumm [150000_500000/cumm]

REFERRAL
Nil

TREATMENT
IVF NS/DNS @ 75ml/hr
T.Dolo 650 mg TID
Inj.Magpep 40 mg OD
Inj.Emeset 4 mg IV SOS

COURSE