CHIEF COMPLAINTS

FEVER- 5 DAYS HEADACHE SINCE 5 DAYS BODYPAIN SINCE 5 DAYS

HISTORY OF PRESENTING ILLNESS

Patient came with c/o fever since 5 days, intermittent ,high grade, associated with chills and rigors

h/o nausea and vomiting present

h/o headache present

h/o bodypain since 5 days.

no h/o cough/expectoration/abdominal pain/diarrhoea/sore throat/burning micturition

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: normal Sleep: Adequate.

Bowel and Bladder: normal

GENERAL EXAMINATION

Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished

no pallor, no icterus, cyanosis or oedema, clubbing, lymphadenopathy absent

vitals

PULSE 80/min

BP 130/80 mm HG

RR 20/min

TEMPERATURE -101F

LAB INVESTIGATION

25-06-2015: Serum Urea: 17mg/dl, Serum Creatinine: 0.72mg/dl, Serum Sodium:

133mEq/L, Serum Potassium: 4.00mEq/L, Serum Chloride: 95.6mEq/L, Serum Ast (Sgot)

: 197IU/L, Serum Alt (Sgpt) : 140IU/L, Abo Grouping & Typing TEST RESULT B Rh(D)

POSITIVE,

26-06-2015: Haemoglobin: 14.8g/dl, Platelet Count: 41000/cumm, Packed Cell Volume

: 44.2%,

27-06-2015: Haemoglobin: 14.8g/dl, Platelet Count: 89000/cumm, Packed Cell Volume

: 44.1%,

TREATMENT

IVF NS @ 75ml/hr

T.Calpol 500mg SOS

T. Attarax 25mg 0-0-1

T. Optineuron

T. Magpep 40mg