DIAGNOSIS
DENGUE FEVER

COMPLAINTS
C/O FEVER SINCE 2 DAYS AND BODYACHE SINCE 2 DAYS

HISTORY OF PRESENTING ILLNESS
THE PATIENT WAS APPARENTLY NORMAL 2 DAYS BACK WHEN HE DEVELOPED FEVER THAT WAS HIGH GRADE AND ASSOCIATED WITH BODY ACHE. THERE IS NO H/O COUGH/VOMITING/LOOSE STOOLS.
THE PATIENT GIVES H/O BURNING MICTURITION

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- 74 bpm BP- 120 /80 mmHg TEMP - 98.6F RR-18 CYCLES / MIN PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WIT TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED PALLOR,ICTERUS, CUANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

TREATMENT

INJ EMESET 4 mg IV
T. DOLO 650 mg
T. SUPRADYN