CHIEF COMPLAINTS
FEVER- 4 DAYS

HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 4 days, intermittent ,high grade, asssociated with chills and rigors
h/O dry cough No h/o vomiting h/o nausea and headache
no h/o abdominal pain/diarrhoea/fever/sore throat/burning micturition

PAST HISTORY
not a k/c/o HTN,PTB,BA,DM

vitals
PULSE 80/min
BP 130/80 mm HG
RR 20/min

TEMPERATURE 101

LAB INVESTIGATION

14-06-2015 : Haemoglobin : 16.3g/dl, Neutrophils : 42%, Lymphocytes : 56%, Eosinophils : 01%, Monocytes : 01%, Basophils : 00%, **Other Cells** Method : Manual -, Leukocyte Count Total : 5200/cumm, Platelet Count : 15000/cumm, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites Negative, Serum Creatinine : 0.92mg/dl, **Abo Grouping & Typing** TEST RESULT O Rh(D) POSITIVE,

15-06-2015 : Haemoglobin : 16.1g/dl, Packed Cell Volume : 48.6%, Platelet Count : 18000/cumm,

16-06-2015 : Haemoglobin : 14.2g/dl, Packed Cell Volume : 43.1%, Platelet Count : 28000/cumm,

17-06-2015 : Haemoglobin : 13.8g/dl, Packed Cell Volume : 41.5%, Platelet Count : 74000/cumm,

18-06-2015 : Haemoglobin : 13.5g/dl, Packed Cell Volume : 40.7%, Platelet Count : 124000/cumm,

TREATMENT
IVF NS @ 75ml/hr IV
T.Dolo 650 mg 1 SOS
Tess ointment L/A
3 pints of platelet conc transfused