CHIEF COMPLAINTS

FEVER- 4 DAYS

HISTORY OF PRESENTING ILLNESS

Patient came with c/o fever since 4 days, intermittent ,low grade, not associated with chills and rigors h/o cough with mucoid expectoration since 4 days no h/o vomiting/ nausea/ headache no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

PAST HISTORY

not a k/c/o dm, htn,ptb,ba

FAMILY HISTORY

No history of Diabetes Meilitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

PERSONAL HISTORY

Diet: Mixed. Appetite: normal Sleep: Adequate. Bowel and Bladder: regular no substance abuse

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

PULSE 80/min BP 140/90 mm HG RR 20/min TEMPERATURE 98.6

LAB INVESTIGATION

09-06-2015: Platelet Count : 67000/cumm, 10-06-2015: Platelet Count : 86000/cumm, 11-06-2015: Platelet Count : 98000/cumm, 12-06-2015: Platelet Count : 112000/cumm,

TREATMENT

T.Dolo 650 mg
T.Neurobion
Syp.Ascoril 5ml tid
T.Rantac 150mg
Combinist nebulization
Steam inhalation