DIAGNOSIS:
DENGUE FEVER

COMPLAINTS
fever x 5 days
headache x 5 days
abdominal pain x 5 days

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
patient was conscious, cooperative, well oriented with time, place and person.moderately built and nourished
pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent

PR-80 bpm BP- 130/70mmHg TEMP - 98.6F RR- 20CYCLES / MIN

20-03-2015 : Haemoglobin : 12.2g/dl, I

21-03-2015 : Packed Cell Volume : 32.8%, Platelet Count : 93000/cumm,
22-03-2015 : Haemoglobin : 11.3g/dl, Platelet Count : 148000/cumm, Packed Cell Volume : 34.4%,

23-03-2015 : Haemoglobin : 10.9g/dl, Packed Cell Volume : 32.4%, Platelet Count : 192000/cumm, Serum Total Protein : 6.33g/dl. Serum Albumin : 3.57g/dl. Serum

TREATMENT
tab dolo 650 mg tid
inj vomiset 4 mg tid iv
inj pan 40 mg iv 1-0-0
tab pan 40 mg 1-0-0
inj emeset 4mg sos iv
tab flagyl 40 mg 1-1-1
tab magpep 40 mg 1-0-0
tab beplex forte 0-0-1
metrogyl dg gel for L/A
syp sucrafil 2 tsp 1-1-1