COMPLAINTS
FEVER- 5 DAYS
HEADACHE- 5 DAYS
BODY ACHE- 5 DAYS

HISTORY OF PRESENTING ILLNESS
THE PATIENT WAS APPARENTLY NORMAL 5 DAYS BACK WHEN HE DEVELOPED FEVER,BODY PAIN AND MALAICE.
THE FEVER WAS ASSOCIATED WITH CHILLS

PAST HISTORY
NO H/O DM , HTN OR IHD

PERSONAL HISTORY
SLEEP - NORMAL
APPETITE - NORMAL
DIET - MIXED
BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION
PR-78 bpm
BP-120/90 mmHg
TEMP - 98.6F RR-18 CYCLES / MIN
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WTO TIME, PLACE AND PERSON
MODERATELY BUILT AND NOURISHED
PALLOR,ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION

03-06-2015 : Haemoglobin : 14.0g/dl, Leukocyte Count Total : 3300/cumm, Mchc : 33.8g/dl, Mch : 29.8pg, Mcv : 88.1fl, Packed Cell Volume : 41.3%, Platelet Count : 87000/cumm, Red Blood Cell Count : 4.69million/cumm, Neutrophils : 43%, Lymphocytes : 57%, Eosinophils : 00%, Monocytes :

04-06-2015 : Haemoglobin : 13.6g/dl, Packed Cell Volume : 40.9%, Platelet Count : 82000/cumm,

05-06-2015 : Haemoglobin : 13.1g/dl, Packed Cell Volume : 39.5%, Platelet Count : 74000/cumm,

06-06-2015 : Haemoglobin : 12.4g/dl, Neutrophils : 17%, Lymphocytes : 70%, Eosinophils : 08%, Monocytes : 05%, Basophils : 00%, **Other Cells** Method : Manual -, Leukocyte Count Total : 6100/cumm, Packed Cell Volume : 37.7%, Platelet Count : 99000/cumm,

TREATMENT
TAB.DOLO 650MG 1-0-1
TAB.RANTAC 150MG 0-0-1