COMPLAINTS
fever, nausea, vomiting since 3 days

PAST HISTORY
no h/o dm,htn,tb

FAMILY HISTORY
nothing significant

PERSONAL HISTORY
sleep - normal appetite - decreased 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- 110/80mmHg TEMP - 98.6F RR-16 CYCLES / MIN

LAB INVESTIGATION

04-06-2015 : Haemoglobin : 10.0g/dl, Leukocyte Count Total : 1600/cumm, Mchc : 33.0g/dl, Mch : 25.8pg, Mcv : 78.3fl, Packed Cell Volume : 30.3%, Platelet Count : 133000/cumm, Red Blood Cell

[illegible] levels may be low in early infection. Please confirm by ELISA.,

06-06-2015 : Packed Cell Volume : 31.8%, Platelet Count : 123000/cumm, Packed Cell Volume : 30.2%, Platelet Count : 114000/cumm,

08-06-2015 : Haemoglobin : 10.1g/dl, Packed Cell Volume : 30.5%, Platelet Count : 127000/cumm,

CHEST XRAY
normal

TREATMENT
iv fluids
tab dolo 650mg 1-1-1
t.magpep 40 mg 1-0-0
inj emeset 4mg sos