HISTORY OF PRESENTING ILLNESS
Patient c/o fever since 1 day, high grade,intermittent, associated with chills and rigors
She also c/o vomiting , vomitus contain food particles, not blood or bile stained
She also c/o headache since 1 day,frontal region
No h/o burning micturition
No h/o diarrhoea
No h/o abdominal pain

PAST HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD

FAMILY HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

PERSONAL HISTORY
Diet: Mixed. Appetite: Good. Sleep: Adequate. Bowel and Bladder: Regular. No substance abuse.

GENERAL EXAMINATION
Patient is consious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE: 80/min
BP:120/80mmhg
RR:15/min
TEMPERATURE:98.6F

HAEMOGLOBIN	: 11.1g/dl [12_15g/dl]
PACKED CELL VOLUME	: 33.8% [36_47%]
PLATELET COUNT	: 220000/cumm [150000_500000/cumm]
PACKED CELL VOLUME	: 32.7% [36_47%]
30-10-2014	
HAEMOGLOBIN	: 10.3g/dl [12_15g/dl]
PACKED CELL VOLUME	: 31.0% [36_47%]
PLATELET COUNT	: 157000/cumm [150000_500000/cumm]
31-10-2014	
HAEMOGLOBIN	: 10.9g/dl [12_15g/dl]
PACKED CELL VOLUME	: 33.1% [36_47%]
PLATELET COUNT	: 142000/cumm [150000_500000/cumm]

TREATMENT
T.DOLO 650MG 1-1-1
T.RANTAC 150MG 1-0-1
INJ.EMESET 4MG IV SOS
IVF DNS/NS @100ML/HR