

#### HISTORY OF PRESENTING ILLNESS

PATIENT WAS APPARENTLY NORMAL 4 DAYS AGO WHEN HE DEVELOPED FEVER ASSOCIATED WITH CHILLS AND RIGORS, high GRADE, INTERMITTENT IN NATURE. ASSOCIATED GENERALISED BODYACHE. NO H/O BREATHLESSNESS. NO H/O PAIN ABDOMEN OR LOOSE STOOLS, VOMITING. NO H/O ANY URINARY SYMPTOMS. NO H/O RASHES OR BLEEDING MANIFESTATIONS

**PAST HISTORY** - NO H/O DM/HTN/ TB/ ASTHMA/ IHD.

**FAMILY HISTORY**- NO H/O DM/ HTN/ TB/ ASTHMA/ IHD IN FAMILY.

**PERSONAL HISTORY**- DIET-MIXED; APPETITE-GOOD; SLEEP-ADEQUATE; BOWEL & BLADDER-REGULAR

#### GENERAL PHYSICAL EXAMINATION:

PATIENT WAS CONSCIOUS, CO-OPERATIVE, WELL ORIENTED TO TIME PLACE AND PERSON. MODERATELY BUILT & NOURISHED. NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA.

BP : 120/80 MMHG

PULSE : 78 BPM

TEMP : 101 F

RR : 18 /MIN

#### LAB INVESTIGATION

**11-02-2015** : Packed Cell Volume : 49.2%, Platelet Count : 141000/cumm,

Cells : 1-2, Crystals : Negative, Cells : 1-2, Cells : 1-2

**12-02-2015** : Haemoglobin : 15.5g/dl, Packed Cell Volume : 46.0%, Platelet Count : 130000/cumm,

**13-02-2015** : Haemoglobin : 16.2g/dl, Packed Cell Volume : 48.7%, Platelet Count : 120000/cumm,

#### REFERAL

NIL

#### TREATMENT

IVF DNS/NS

T CALPOL 500 MG TID