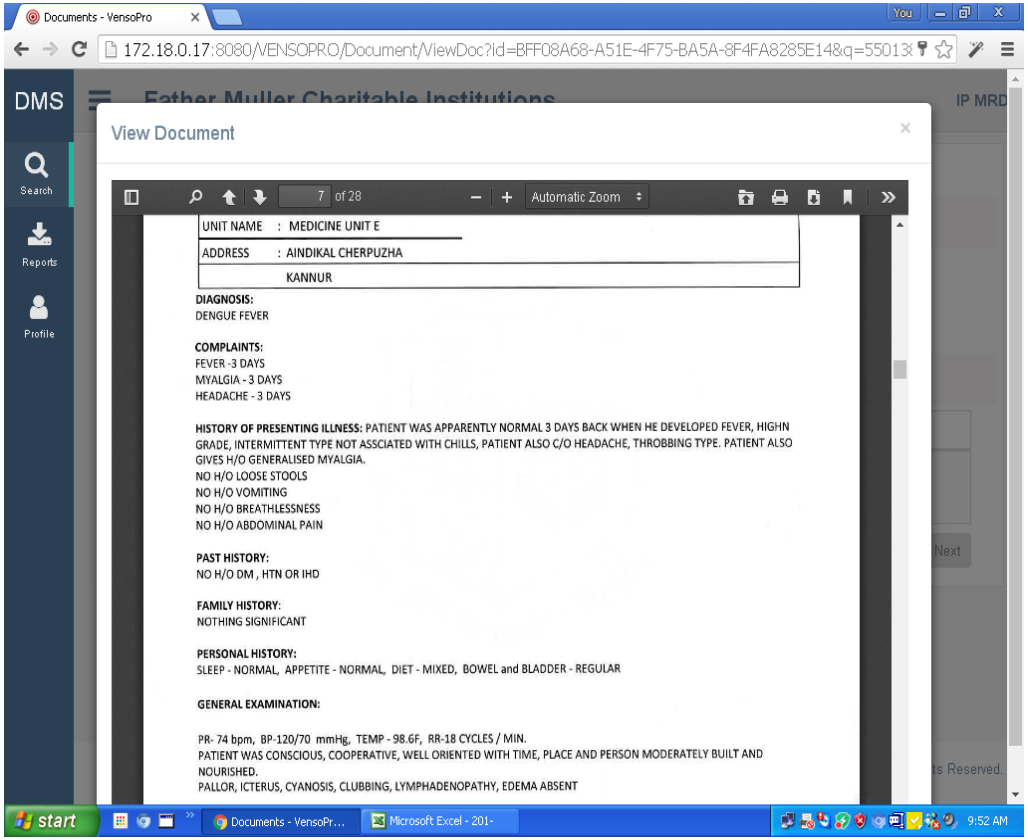
Documents - VensoPro
172.18.0.17:8080/VENSOPRO/Document/ViewDoc?id=BFF08A68-A51E-4F75-BA5A-8F4FA8285E14&q=55013
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Automatic Zoom
UNIT NAME : MEDICINE UNIT E
ADDRESS : AINDIKAL CHERPUZHA
KANNUR
DIAGNOSIS:
DENGUE FEVER
COMPLAINTS:
FEVER -3 DAYS
MYALGIA - 3 DAYS
HEADACHE - 3 DAYS
HISTORY OF PRESENTING ILLNESS: PATIENT WAS APPARENTLY NORMAL 3 DAYS BACK WHEN HE DEVELOPED FEVER, HIGHN GRADE, INTERMITTENT TYPE NOT ASSCIATED WITH CHILLS, PATIENT ALSO C/O HEADACHE, THROBBING TYPE. PATIENT ALSO GIVES H/O GENERALISED MYALGIA.
NO H/O LOOSE STOOLS
NO H/O VOMITING
NO H/O BREATHLESSNESS
NO H/O ABDOMINAL PAIN
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:
PR- 74 bpm, BP-120/70 mmHg, TEMP - 98.6F, RR-18 CYCLES / MIN.
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WITH TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED.
PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT
IP MRD
Next
start
Documents - VensoPr...
Microsoft Excel - 201-
9:52 AM