CHIEF COMPLAINTS
FEVER SINCE 1 DAY
GENERALISED WEAKNESS SINCE 1 DAY

HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 1 day, intermittent asssociated with chills
a/w headache, bodyache, nausea, dysuria present
no h/o bleeding manifestation.
No h/o diarrhoea/sore throat

PAST HISTORY :
K/C/O DM on GLUCONORM, TRAJENTA, MIXTARD
K/C/O IHD s/p post PCI (RCA AND LCX)
K/C/O HTN

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

PERSONAL HISTORY
Diet: Mixed.
Appetite: normal
Sleep: Adequate.
Bowel and Bladder: regular
No substance abuse.

GENERAL EXAMINATION
Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.
no pallor,no icterus, cyanosis or oedema,clubbing ,lymphadenopathy absent
vitals
PULSE 80/min
BP 120/80 mm HG
RR 20/min
TEMPERATURE 98.6 F

TREATMENT:
T. TAZLOC BETA
C. ECOSPIRIN
T. DOLO
T. PREGABALIN
T. OPTINEURON
T. RANTAC
INJ AUGMENTIN
IVF NS @ 50ML/HR