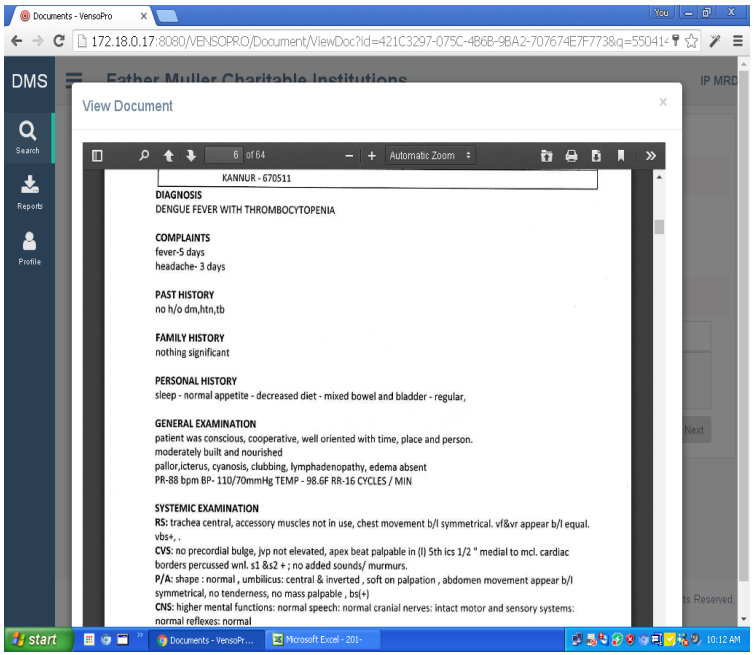
Documents - VensoPro
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Automatic Zoom
KANNUR - 670511
DIAGNOSIS
DENGUE FEVER WITH THROMBOCYTOPENIA
COMPLAINTS
fever-5 days
headache- 3 days
PAST HISTORY
no h/o dm,htn,tb
FAMILY HISTORY
nothing significant
PERSONAL HISTORY
sleep - normal appetite - decreased 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-88 bpm BP- 110/70mmHg TEMP - 98.6F RR-16 CYCLES / MIN
SYSTEMIC EXAMINATION
RS: trachea central, accessory muscles not in use, chest movement b/l symmetrical. vf&vr appear b/l equal.
vbs+, .
CVS: no precordial bulge, jvp not elevated, apex beat palpable in (l) 5th ics 1/2 " medial to mcl. cardiac
borders percussed wnl. s1 &s2 + ; no added sounds/ murmurs.
P/A: shape : normal , umbilicus: central & inverted , soft on palpation , abdomen movement appear b/l
symmetrical, no tenderness, no mass palpable , bs(+)
CNS: higher mental functions: normal speech: normal cranial nerves: intact motor and sensory systems:
normal reflexes: normal
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10:12 AM