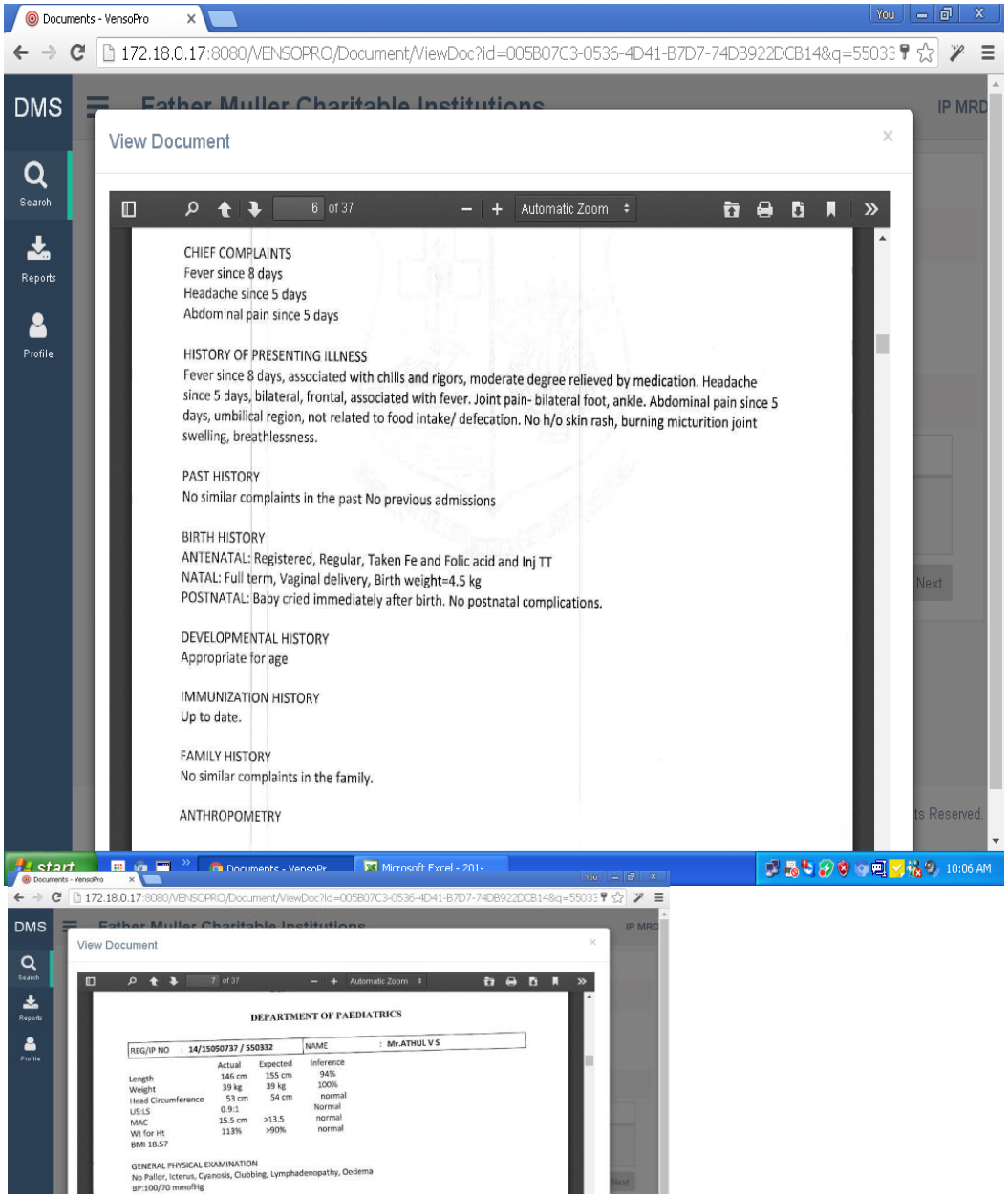
Documents - VensoPro
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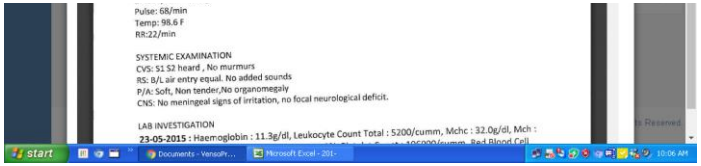
DMS
Search
Reports
Profile
View Document
6 of 37
Automatic Zoom
CHIEF COMPLAINTS
Fever since 8 days
Headache since 5 days
Abdominal pain since 5 days
HISTORY OF PRESENTING ILLNESS
Fever since 8 days, associated with chills and rigors, moderate degree relieved by medication. Headache since 5 days, bilateral, frontal, associated with fever. Joint pain- bilateral foot, ankle. Abdominal pain since 5 days, umbilical region, not related to food intake/ defecation. No h/o skin rash, burning micturition joint swelling, breathlessness.
PAST HISTORY
No similar complaints in the past No previous admissions
BIRTH HISTORY
ANTENATAL: Registered, Regular, Taken Fe and Folic acid and Inj TT
NATAL: Full term, Vaginal delivery, Birth weight=4.5 kg
POSTNATAL: Baby cried immediately after birth. No postnatal complications.
DEVELOPMENTAL HISTORY
Appropriate for age
IMMUNIZATION HISTORY
Up to date.
FAMILY HISTORY
No similar complaints in the family.
ANTHROPOMETRY
Next
10:06 AM
DEPARTMENT OF PAEDIATRICS
REG/IP NO : 14/15050737 / 550332
NAME : Mr.ATHUL V S
Actual
Expected
Inference
Length 146 cm 155 cm 94%
Weight 39 kg 39 kg 100%
Head Circumference 53 cm 54 cm normal
US:LS 0.9:1 Normal
MAC 15.5 cm >13.5 normal
Wt for Ht 113% >90% normal
BMI 18.57
GENERAL PHYSICAL EXAMINATION
No Pallor, Icterus, Cyanosis, Clubbing, Lymphadenopathy, Oedema
BP:100/70 mmofHg


Pulse: 68/min
Temp: 98.6 F
RR:22/min
SYSTEMIC EXAMINATION
CVS: S1 S2 heard , No murmurs
RS: B/L air entry equal. No added sounds
P/A: Soft, Non tender,No organomegaly
CNS: No meningeal signs of irritation, no focal neurological deficit.
LAB INVESTIGATION
23-05-2015 : Haemoglobin : 11.3g/dl, Leukocyte Count Total : 5200/cumm, Mchc : 32.0g/dl, Mch :
Is Reserved.
start
Documents - Vanaja...
Microsoft Excel - 201-
10:06 AM