COMPLAINTS
FEVER WITH CHILLS

HISTORY OF PRESENTING ILLNESS
PATIENT WAS DIAGNOSED WITH DENGUE FEVER AND TREATED FOR THE SAME WAS SYMPTOMATICALLY BETTER AND WAS DISCHARGED . PATIENT COMPLAINED OF FEVER WITH CHILLS AND VOMITING .HAD 2 EPISODES OF VOMITING.VOMITUS CONTAINS FOOD PARTICLES,NOT BLOOD / BILE STAINED .NO H/O LOOSE STOOLS,COUGH WIYH EXPECTORATION, PAIN ABDOMEN

PAST HISTORY
NO IHD, TB,BRONCHIAL ASTHMA

FAMILY HISTORY
NIL SIGNIFICANT

PERSONAL HISTORY
SLEEP-NORMAL
APPETITE-NORMAL
BOWEL AND BLADDER HABITS-REGULAR

SYSTEMIC EXAMINATION
PATIENT CONSCIOUS, CO OPERATIVE, WELL ORIENTED TO TIME PLACE AND PERSON.
NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY AND EDEMA
PULSE -80BPM
BP -110/70MMHG

14-06-2015 : Platelet Count : 105000/cumm, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites Negative,

15-06-2015 : Haemoglobin : 15.8g/dl, Neutrophils : 75%, Lymphocytes : 12%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual -, Leukocyte Count Total : 8100/cumm, Packed Cell Volume : 49.0%, Platelet Count : 101000/cumm,

16-06-2015 : Haemoglobin : 15.0g/dl, Packed Cell Volume : 46.2%, Platelet Count : 159000/cumm,

TREATMENT
T.DOLO 650MG 1-1-1
IV FLUIDS NS/DNS AT 75ML/HOUR
INJ.PERINORM 1 AMP BD
STEAM INHALATION WITH KARVOL PLUS
T.EBART
INJ.AUGMENTIN 625MG 1-1-1