HISTORY OF PRESENTING ILLNESS

Patient ewas apparently normal 4 days back when she deveoped fever which was insidious in onset, moderate grade. fever was associated with chills and rigor
Patient also c/o headache and bodyache since the past 4 days.
No h/o cough, cold
No h/o burning micturition
No h/o pain abdomen

PAST HISTORY

Patient was admitted in another hospital and treated for dengue
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD

FAMILY HISTORY

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

PERSONAL HISTORY

Diet: Mixed. Appetite: Good. Sleep: Adequate. Bowel and Bladder: Regular. No substance abuse.

GENERAL EXAMINATION

Patient is consious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE- 80bpm
BP- 130/80 mmhg
RR- 17 cycles/min
TEMPERATURE- 98.6F

HAEMOGLOBIN	: 12.5g/dl [12_15g/dl]
presence of parasites	: Negative
PACKED CELL VOLUME	: 37.8% [36_47%]
PLATELET COUNT	: 117000/cumm [150000_500000/cumm]

23-11-2014

HAEMOGLOBIN	: 11.8g/dl [12_15g/dl]
PACKED CELL VOLUME	: 36.1% [36_47%]
PLATELET COUNT	: 92000/cumm [150000_500000/cumm]

24-11-2014

HAEMOGLOBIN	: 11.5g/dl [12_15g/dl]
PACKED CELL VOLUME	: 34.5% [36_47%]
PLATELET COUNT	: 86000/cumm [150000_500000/cumm]

25-11-2014

HAEMOGLOBIN	: 13.0g/dl [12_15g/dl]
PACKED CELL VOLUME	: 38.3% [36_47%]
PLATELET COUNT	: 122000/cumm [150000_500000/cumm]

REFERRAL

nil

TREATMENT

CAP. MALZIX 0-1-0
T. PANTOLEX 40 MG 1-0-0
T. DOLO 650 MG SOS
IVF. NS/DNS @ 100 ML/HR
INJ. EMESET 4 MG IV SOS
T. ATARAX 10 MG TID