

**CHIEF COMPLAINTS**

FEVER-4 DAYS

**HISTORY OF PRESENTING ILLNESS**

Patient came with c/o fever since 4 days, intermittent ,high grade,not associated with chills and rigors  
h/o urinary urgency and hesitancy  
no h/o vomiting/nausea/ headache  
no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

**PAST HISTORY**

k/c/o DM since 6 years on T.Metformin  
k/c/o HTN/IHD sinc3 6 years on medication  
not a k/c/o ptb,ba

**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: decreased urine putput and constipation  
no substance abuse

**GENERAL EXAMINATION**

Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.

vitals

PULSE 80/min

BP 190/100mm HG

RR 20/min

TEMPERATURE 101

**LAB INVESTIGATION**

08-06-2015 : Haemoglobin : 11.2g/dl, Leukocyte Count Total : 4700/cumm, Mchc : 29.5g/dl, Mch : 24.8pg, Mcv : 84.1fl, Packed Cell Volume : 38.1%, Platelet Count : 135000/cumm, Red Blood Cell Count : 4.53million/cumm, Neutrophils : 81%,

**TREATMENT**

T.Dolo 650 mg 1-1-1

T.Supradyn 0-1-0

T.Rantac 150mg 1-0-1

T.Telsar 40mg1-0-0

T.Cilacar 10mg 0-0-1/2

T.Novastat CV 10mg 0-0-1

T.Clinidipine 10mg 0-0-1

T.Metformin 500mg1/2-0-1/2