CHIEF COMPLAINTS
FEVER X 5 DAYS
HEADACHE X 5 DAYS
VOMITING X 4 DAYS

HISTORY OF PRESENTING ILLNESS
PATIENT WAS APPARENTLY NORMAL 5 DAYS AGO WHEN HE DEVELOPED FEVER, SUDDEN ONSET, NON PROGRESSIVE, HIGH GRADE, ASSOCIATED WITH CHILLS. HE COMPLAINED OF HEADACHE ALONG WITH THE ONSET OF FEVER, BILATERAL FRONTAL, THROBBING TYPE. HE GAVE A HISTORY OF VOMITING 4 DAYS AGO, 4 EPISODES PER DAY SUDDEN ONSET, PRECEDED BY NAUSEA, MUCOID, NON BLOOD/ BILE STAINED. HE VISITED A LOCAL HOSPITAL AND WAS FOUND TO BE POSITIVE FOR DENGUE NS1. HE CAME HERE FOR FURTHER MANAGEMENT.
NO HISTORY OF BLEEDING MANIFESTATIONS, BONY PAINS, BODYACHE.
NO HISTORY OF CORYZA, COUGH WITH EXPECTORATION, BLOOD IN SPUTUM.
NO HISTORY OF BURNING/ PAINFUL MICTURITION, DECREASED URINE OUTPUT.
NO HISTORY OF BOWEL DISTURBANCES.

PAST HISTORY
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 88/ MIN
BP 120/80 MMHG
RR 18/ MIN
TEMPERATURE 98.6 DEGREE F

HAEMOGLOBIN	: 16.8g/dl [14_18g/dl]
PACKED CELL VOLUME	: 50.8% [40_54%]
PLATELET COUNT	: 32000/cumm [150000_500000/cumm]

PACKED CELL VOLUME	: 50.0% [40_54%]
PLATELET COUNT	: 42000/cumm [150000_500000/cumm]

28-12-2014

PACKED CELL VOLUME	: 48.4% [40_54%]
PLATELET COUNT	: 57000/cumm [150000_500000/cumm]

29-12-2014

PACKED CELL VOLUME	: 48.6% [40_54%]
PLATELET COUNT	: 114000/cumm [150000_500000/cumm]

REFERRAL
NIL

TREATMENT
IV FLUIDS
T. DOLO 650 MG 1 SOS
INJ EMESET 4 MG IV SOS