HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 1 day ago when she developed fever, sudden in onset, progressive, associated with chills and rigors, no diurnal or seasonal variation. h/o vomiting since 1 day, containing food particles, non blood stained, non bilious, non foul smelling. Also complains of generalised weakness, bodyache since 1 day.
No h/o abdominal pain, loose stools, burning micturition.

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 conscious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE -90bpm BP-12/80mmHg RR - 16cpm TEMPERATURE -98.6F

HAEMOGLOBIN	: 10.5g/dl [12_15g/dl]
[illegible]	: [illegible] [4_5.5million/cumm]
PACKED CELL VOLUME	: 33.0% [36_47%]
PLATELET COUNT	: 184000/cumm [150000_500000/cumm]
MCV	

20-11-2014

HAEMOGLOBIN	: 11.1g/dl [12_15g/dl]
PACKED CELL VOLUME	: 33.0% [36_47%]
PLATELET COUNT	: 124000/cumm [150000_500000/cumm]

21-11-2014

HAEMOGLOBIN	: 10.9g/dl [12_15g/dl]
PACKED CELL VOLUME	: 32.5% [36_47%]
PLATELET COUNT	: 108000/cumm [150000_500000/cumm]

22-11-2014

HAEMOGLOBIN	: 11.6g/dl [12_15g/dl]
PACKED CELL VOLUME	: 34.9% [36_47%]
PLATELET COUNT	: 107000/cumm [150000_500000/cumm]

ECG:normal ECHO: not done

REFERRAL
nil

TREATMENT
T. Calpol 500mg SOS
T. Supradyne OD
IV fluids DNS/NS
Inj. Pantop 40mg IV OD
T. Rantac 150mg BD
T. Cyclopam TID
Syp. Digene gel 2 tsp