HISTORY OF PRESENTING ILLNESS
PATIENT CAME WITH H/O FEVER SINCE 6 DAYS ,ASSOCIATED WITH CHILLS
PATIENT ALSO COMPLAINS OF NAUSEA
GIVES H/O MALAENA-1EPISODE -TODAY
NO OTHER COMPLAINTS

PAST HISTORY: NOT SIGNIFICANT

FAMILY HISTORY: NOT 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-78BPM
RR-16/MIN
SPO2-98%
BP -130/80MMHG
CVS: S1 S2 HEARD, NO MURMURS
RS: VBS +, NO ADDED SOUNDS
PA: SOFT, NO TENDERNESS
CNS: HMF NORMAL, NO FND

15-07-2015 : Haemoglobin : 16.4g/dl, Leukocyte Count Total : 3800/cumm, Mchc : 33.8g/dl, Mch : 29.2pg, Mcv : 86.4fl, Packed Cell Volume : 48.6%, Platelet Count : 51000/cumm, Red Blood Cell Count : 5.62million/cumm, Neutrophils : 54%, Lymphocytes : 30%, Eosinophils : 06%, Monocytes : 10%, Basophils : 00%, **Other Cells** Method : Manual NIL, Serum Urea : 18mg/dl, Serum Creatinine : 0.98mg/dl, Serum Uric Acid : 4.6mg/dl, Serum Sodium : 137mEq/L, Serum Potassium : 4.89mEq/L, Serum Chloride : 95.7mEq/L, Serum Total Bilirubin : 0.65mg/dl, Serum Ast (Sgot) : 93IU/L, Serum Alt (Sgpt) : 76IU/L, **Abo Grouping & Typing** TEST RESULT A1 Rh(D) POSITIVE,

16-07-2015 : Haemoglobin : 16.2g/dl, Platelet Count : 42000/cumm, Packed Cell Volume : 48.1%, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites NEGATIVE,

17-07-2015 : Haemoglobin : 15.6g/dl, Platelet Count : 58000/cumm, Packed Cell Volume : 46.8%,

TREATMENT
IVF NS/DNS-125ML/HOUR
T.DOLO 650MG 1-1-1
INJ. PAN 40MG
T.RANTAC 150MG 1-0-1
T.ATARAX 1-0-1

COURSE