HISTORY OF PRESENTING ILLNESS

patient was apparently normal 3 days back till he developed fever and headache since 3 days - insidious in onset ; gradually progressive , not associated with chills and rigors ; headache bifrontal in nature , no h/o vomiting , loose stools or cough , no h/o burning micturition , decreased urine output ; no h.o bleeding manifestations .

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 80/min

BP 120/80mmHg

RR 15min

TEMPERATURE 100 deg F

13-02-2015 : Haemoglobin : 11.6g/dl, Packed Cell Volume : 36.9%, Platelet Count : 116000/cumm, Haemoglobin : 12.4g/dl, Packed Cell Volume : 38.7%, Platelet Count : 110000/cumm,

14-02-2015 : Haemoglobin : 12.7g/dl, Packed Cell Volume : 40.0%, Platelet Count : 123000/cumm,

15-02-2015 : Haemoglobin : 12.7g/dl, Packed Cell Volume : 39.1%, Platelet Count : 103000/cumm,

16-02-2015 : Platelet Count : 99000/cumm,

TREATMENT

IVF DNS AT 75ML/HR

T.DOLO 650MG 1-1-1

T.PAN 40 1-0-0

CAP .BECELAC 2-2-2