

HISTORY OF PRESENTING ILLNESS

Patient was apparently normal 2 days ago when he developed fever associated with chills.No h/o burning micturation,pain abdomen.

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 -78 bpm BP120/80mmhg- RR - 16cpm TEMPERATURE -98.6F

INVESTIGATION

04-03-2015 : Haemoglobin : 15.4g/dl,

05-03-2015 : Platelet Count : 96000/cumm, Dengue Rapid (Ns1, Igm, Igg) **NS1 ANTIGEN POSITIVE, IgM ANTIBODY : POSITIVE, IgG ANTIBODY : NEGATIVE, COMMENTS** : This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA.,

06-03-2015 : Platelet Count : 126000/cumm,

05-03-2015 : Usg Abdomen IMPRESSION: - NO SONOLOGICAL ABNORMALITY DETECTED.

04-03-2015 : Xray Chest Pa NORMAL CHEST RADIOGRAPH

ECG:wnl

REFERRAL -none

TREATMENT

04-03-2015 ACILOC RD .. (TAB), CALPOL .. (TAB),

05-03-2015 ACILOC RD .. (TAB),

