DIAGNOSIS
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DENGUE FEVER

CHIEF COMPLAINTS
Fever since 4 days
Bodyache since 4 days
Headache since 4 days
Generalised weakness since 4 days
Vomiting since 4 day

HISTORY OF PRESENTING ILLNESS
The patient was apparently normal 4 days back when she developed fever,insiduous in onset,gradually progressive.
It was of high degree and associated with chills .No diurnal variation and relieved on medication.
Patient also complains of associated bodyache , which was generalised in nature .
She also complains of headache associated with fever ,bifrontal and throbbing type of pain,It relieved on medication .
The patient gives h/o vomiting of 2-3 episodes .The vomitus contained food particles.It was non blood stained and non bile stained .
No h/o decreased urine output ,no h/o cough with expectoration
No h/o abdominal pain or loose stools
No h/o burning micturition

PAST HISTORY
No history of 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: decreased
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.
pallor absent , no icterus, cyanosis, clubbing, lymphadenopathy or oedema

PULSE 70 bpm BP-120/70 mm hg RR-16 cpm TEMPERATURE -afebrile

TREATMENT
IV Fluids NS/DNS at 75 ml/hr
T pan d 40 mg 1-0-0
T beplex forte 0-1-0
T calpol 500 mg 1-1-1
Inj emeset 4 mg iv sos