

CHIEF COMPLAINTS

FEVER WITH CHILLS SINCE - 2 WEEKS

HISTORY OF PRESENTING ILLNESS

PATIENT WAS APPARENTLY NORMAL 2 WEEKS AGO WHEN HE DEVELOPED FEVER ASSOCIATED WITH CHILLS AND RIGORS, HIGH GRADE, INTERMITTENT IN NATURE. ASSOCIATED GENERALISED BODYACHE. PATIENT .

REDISH DISCOLOURATION OF URINE - 2 WEEKS

NO H/O BREATHLESSNESS

NO H/O VOMITING, ABDOMINAL PAIN OR LOOSE STOOLS.

PAST HISTORY - NO H/O DM/HTN/ TB/ ASTHMA/ IHD.

FAMILY HISTORY- NO H/O DM/ HTN/ TB/ ASTHMA/ IHD IN FAMILY.

PERSONAL HISTORY- DIET-MIXED; APPETITE-GOOD; SLEEP-ADEQUATE; BOWEL & BLADDER-REGULAR

GENERAL PHYSICAL EXAMINATION

PATIENT WAS CONSCIOUS, CO-OPERATIVE, WELL ORIENTED TO TIME PLACE AND PERSON. MODERATELY BUILT & NOURISHED.

ICTERUS+, CONJUNCTIVAL CONGESTION +, EPISTAXIS +

NO PALLOR, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA.

BP : 110/70 MMHG

PULSE : 78 BPM

TEMP : 101 F

RR : 18 /MIN

TREATMENT

IVF DNS/NS

INJ MOCEF 1GM IV BD

T PAN 40 MG 1-0-0

T DOLO 650MG 1-1-1

BOTROVOT NID 3-3-3

NASOVION NAAL DROPS 3rd TID

TRANSFUSED 4 UNITS OF PLATELET CONCENTRATE