CHIEF COMPLAINTS
FEVER- 4 DAYS
VOMITING-2 DAYS
HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 4 days, intermittent ,high grade, asssociated with chills and rigors
h/o vomiting present,multiple episodes
no mh/o nausea and headache
no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

PAST HISTORY
not a k/c/o htn,ptb,ba,dm

FAMILY HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

PERSONAL HISTORY
Diet: Mixed.
Appetite: normal
Sleep: Adequate.
Bowel and Bladder: regular
GENERAL EXAMINATION
Patient is conscious and cooperative, well oriented to time, place and person. Moderately built and nourished.
no pallor,no icterus, cyanosis or oedema,clubbing ,lymphadenopathy absent

vitals
PULSE 80/min
BP 130/80 mm HG
RR 20/min
TEMPERATURE 101

LAB INVESTIGATION

14-06-2015 : Haemoglobin : 9.3g/dl, Leukocyte Count Total : 2200/cumm, Mchc : 31.1g/dl, Mch : 23.1pg, Mcv : 74.3fl, Packed Cell Volume : 30.0%, Platelet Count : 60000/cumm, Red Blood Cell Count : 4.04million/cumm, Neutrophils : 41%, Lymphocytes : 50%, Eosinophils : 03%, Monocytes : 06%, Basophils : 00%, **Other Cells** Method : Manual -, **Peripheral Smear Report No** H/3701/15, **Impression** : Mild pancytopenia., Plasma Glucose Random : 83mg/dl, Serum Creatinine : 0.64mg/dl, Serum Total Bilirubin : 0.16mg/dl, Serum Ast (Sgot) : 68IU/L, Serum Alt (Sgpt) : 36IU/L,

15-06-2015 : Haemoglobin : 9.9g/dl, Packed Cell Volume : 31.4%, Platelet Count : 62000/cumm,

16-06-2015 : Haemoglobin : 9.7g/dl, Platelet Count : 66000/cumm, Packed Cell Volume : 30.6%,

17-06-2015 : Haemoglobin : 9.9g/dl, Packed Cell Volume : 31.3%, Platelet Count : 132000/cumm,

TREATMENT
IVF NS @ 75ml/hr
T.Dolo 650 mg
T.Supradyn