CHIEF COMPLAINTS
fever since 5 days
headache,bodyache and malaise since 5 days

HISTORY OF PRESENTING ILLNESS Patient was apparently normal 5 days ago when he developed fever ,high grade associated with chills and rigors,no night sweats
No history of diurnal variation
No history of cough/breathelessness
No history of rashes
No history of bleeding tendencies
No history of decreased urine output/burning micturition
No history of altered sensorium
Also complaints of headache,bodyache and malaise since 5 days

PAST HISTORY
No history of similar complaints in the past
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 - 16cpm TEMPERATURE -98.6F

15-02-2015 : Haemoglobin : 16.4g/dl,

Packed Cell Volume : 49.3%,
Haemoglobin : 16.1g/dl,
Erythrocyte Sedimentation Rate : 02mm/1st hour, Packed Cell Volume : 48.3%, Platelet Count : 56000/cumm, Serum Urea : 30mg/dl, Serum Creatinine : 0.94mg/dl, **Dengue**

16-02-2015 : Haemoglobin : 16.3g/dl, Platelet Count : 140000/cumm, Packed Cell Volume : 48.3%,

17-02-2015 : Haemoglobin : 13.5g/dl, Packed Cell Volume : 40.7%, Platelet Count : 12000/cumm, Haemoglobin : 16.5g/dl, Packed Cell Volume : 49.3%, Platelet Count : 10000/cumm, **Abo Grouping & Typing** TEST RESULT A1 Rh(D) POSITIVE , Whole Blood

TREATMENT
T.DOLO 650MG 1-1-1
T.PAN 40MG 1-0-0
T.OPTINEURON 0-1-0
IVF NS at 75ml/hr
T.CALPOL 500MG 1-1-1
SYP SUCRAFIL 2TSP TID
INJ DECADRON 8MG Q6H