COMPLAINTS FEVER- 5 DAYS HEADACHE- 5 DAYS BODY ACHE- 5 DAYS

HISTORY OF PRESENTING ILLNESS

THE PATIENT WAS APPARENTLY NORMAL 5 DAYS BACK WHEN HE DEVELOPED FEVER, BODY PAIN AND MALAICE.

THE FEVER WAS ASSOCIATED WITH CHILLS

PAST HISTORY NO H/O DM , HTN OR IHD

PERSONAL HISTORY
SLEEP - NORMAL
APPETITE - NORMAL
DIET - MIXED
BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION
PR-78 bpm
BP-120/90 mmHg
TEMP - 98.6F RR-18 CYCLES / MIN
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WTO TIME, PLACE AND PERSON
MODERATELY BUILT AND NOURISHED
PALLOR,ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION

03-06-2015 : Haemoglobin : 14.0g/dl, Leukocyte Count Total : 3300/cumm, Mchc : 33.8g/dl, Mch : 29.8pg, Mcv : 88.1fl, Packed Cell Volume : 41.3%, Platelet Count : 87000/cumm, Red Blood Cell Count : 4.69million/cumm, Neutrophils : 43%, Lymphocytes : 57%, Eosinophils : 00%, Monocytes :

04-06-2015: Haemoglobin: 13.6g/dl, Packed Cell Volume: 40.9%, Platelet Count: 82000/cumm, 05-06-2015: Haemoglobin: 13.1g/dl, Packed Cell Volume: 39.5%, Platelet Count: 74000/cumm, 06-06-2015: Haemoglobin: 12.4g/dl, Neutrophils: 17%, Lymphocytes: 70%, Eosinophils: 08%, Monocytes: 05%, Basophils: 00%, Other Cells Method: Manual-, Leukocyte Count Total: 6100/cumm, Packed Cell Volume: 37.7%, Platelet Count: 99000/cumm,

TREATMENT TAB.DOLO 650MG 1-0-1 TAB.RANTAC 150MG 0-0-1