COMPLAINTS
Fever with chills, joint pain and generalized weakness for 1 week

PAST HISTORY
no h/o dm,htn,tb

FAMILY HISTORY
nothing significant

PERSONAL HISTORY
sleep - normal appetite - decreased diet - mixed bowel and bladder - regular,

GENERAL EXAMINATION
patient was conscious, cooperative, well oriented with time, place and person.
moderately built and nourished
pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent
PR-80 bpm BP- 110/70mmHg TEMP - 100 F RR-16 CYCLES / MIN

LAB INVESTIGATION

09-06-2015 : Haemoglobin : 9.9g/dl,
33.3g/dl, Mch : 28.2pg, Mcv : 84.7fl, Packed Cell Volume : 29.6%, Platelet Count : 111000/cumm, Red Blood Cell Count : 3.5million/cumm, Neutrophils : 79%,
POSITIVE,
10-06-2015 : Haemoglobin : 10.6g/dl, Packed Cell Volume : 32.0%, Platelet Count : 66000/cumm,
11-06-2015 : Haemoglobin : 10.9g/dl, Packed Cell Volume : 32.3%, Platelet Count : 29000/cumm, Serum Urea : 10mg/dl, Serum Creatinine : 0.56mg/dl,
12-06-2015 : Haemoglobin : 9.9g/dl, Packed Cell Volume : 30.3%, Platelet Count : 27000/cumm, Haemoglobin : 9.9g/dl, Packed Cell Volume : 30.5%, Platelet Count : 45000/cumm,
14-06-2015 : Platelet Count : 80000/cumm,
15-06-2015 : Haemoglobin : 9.6g/dl, Packed Cell Volume : 29.4%, Platelet Count : 124000/cumm,

TREATMENT
T.Dolo 650mg 1-1-1
T.Supradyn 0-1-0

T.Rantac 150mg 1-0-1
IV fluids DNS/NS at 100ml/hr