

CHIEF COMPLAINTS

Fever since 5 days
Bodyache since 5 days
Headache since 5 days
Cough with scanty sputum since 7 days
Generalised weakness since 5 days
Vomiting since 5 day
Loose stools since 2 days

HISTORY OF PRESENTING ILLNESS

The patient was apparently normal 7 days back when she developed fever, insidious in onset, gradually progressive.

It was of high degree and associated with chills. No diurnal variation and relieved on medication.

Patient also complains of associated bodyache, which was generalised in nature.

She also complains of headache associated with fever, bifrontal and throbbing type of pain, It relieved on medication.

Patient also complains of vomiting since 7 day, 6-7 episodes. It was non-projectile. It was non-bile-stained, non-blood stained. Vomitus contained food.

Patient also complains of passing loose stools since 2 days, it was of 4-6 episodes. No h/o blood or mucous in stools.

Patient also complains of cough with expectoration since 5 days. Sputum was scanty in quantity and mucoid in consistency. The expectoration was white in color and non blood stained.

No h/o decreased urine output

No h/o abdominal pain or loose stools

No h/o burning micturition

PAST HISTORY

No history of Hypertension, Tuberculosis, Asthma or IHD

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

PERSONAL HISTORY

Diet: Mixed.

Appetite: decreased

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 96 bpm BP-110/80 mm hg RR-16 cpm TEMPERATURE -febrile

Sinus tenderness -present

TREATMENT

T Becelac 2-2-2

T Calpol 500 mg sos

Inj Emeset 4 mg q 8h

Inj Ciplox 200 ml 1-0-1

ORS

ONS

Inj Pantaprazole q 24 h

Syp Gelusil 2tsp 1-1-1

T Cyclopan 1-1-1

Steam inhalation tid