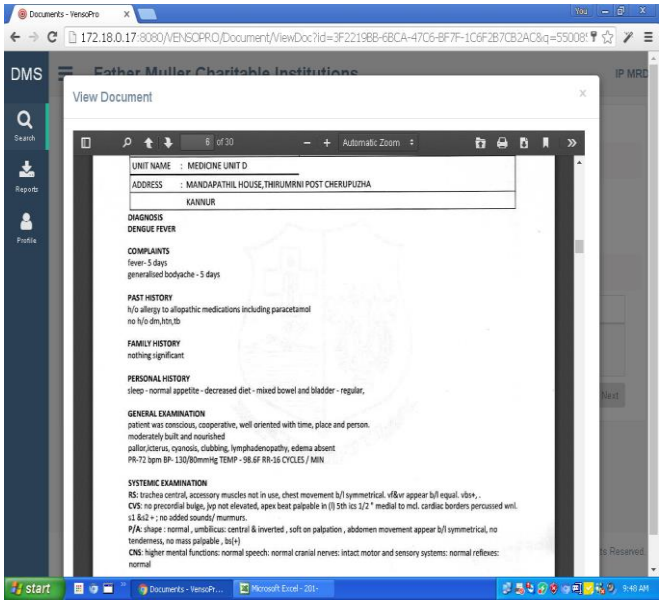
Documents - VensoPro
172.18.0.17:8080/VENSOPRO/Document/ViewDoc?id=3F2219BB-6BCA-47C6-BF7F-1C6F2B7CB2AC&q=55008
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Automatic Zoom
UNIT NAME : MEDICINE UNIT D
ADDRESS : MANDAPATHIL HOUSE,THIRUMRNI POST CHERUPUZHA
KANNUR
DIAGNOSIS
DENGUE FEVER
COMPLAINTS
fever- 5 days
generalised bodyache - 5 days
PAST HISTORY
h/o allergy to allopathic medications including paracetamol
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-72 bpm BP- 130/80mmHg TEMP - 98.6F RR-16 CYCLES / MIN
SYSTEMIC EXAMINATION
RS: trachea central, accessory muscles not in use, chest movement b/l symmetrical. vf&vr appear b/l equal. vbs+, .
CVS: no precordial bulge, jvp not elevated, apex beat palpable in (l 5th ics 1/2 " medial to mcl. cardiac borders percussed wnl.
s1 &s2 + ; no added sounds/ murmurs.
P/A: shape : normal , umbilicus: central & inverted , soft on palpation , abdomen movement appear b/l symmetrical, no
tenderness, no mass palpable , bs(+)
CNS: higher mental functions: normal speech: normal cranial nerves: intact motor and sensory systems: normal reflexes:
normal
Next
start
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Microsoft Excel - 201-
9:48 AM