CHIEF COMPLAINTS
FEVER SINCE 4 DAYS
COUGH SINCE 3 DAYS
ABDOMINAL DISCOMFORT SINCE 2 DAYS
LOOSE STOOLS SINCE 2 DAYS

HISTORY OF PRESENTING ILLNESS
PATIENT GIVES H/O FEVER SINCE 3 DAYS,PRESENT THROUHOUT THE DAY,HIGH GRADE,ASSOCIATED WITH CHILLS .
PATIENT ALSO C/O COUGH SINCE 3 DAYS,NOT ASSOCIATED WITH SPUTUM PRODUCTION.,NO DIURINAL OR POSITIONAL VARIATION.
THE PATIENT ALSO C/O ABDOMINAL DISCOMFORT AND 3-4 PISODES OF LOOSE STOOLS SINCE 2 DAYS.IT HAS SUBSIDED NOW.
NO HISTORY OF HEADACHE
NO HISTORY OF NAUSEA AND VOMITING
NO HISTORY OF BURNING MICTURITION
NO HISTORY OF GIDDINESS
NO HISTORY OF CHESTPAIN AND PALPITATION
NO HISTORY OF COUGH WITH EXPECTORATION
NO HSITORY OF BREATHLESSNESS

PAST HISTORY
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 CONSIOUS 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 130/80MMHG
RR 18/MIN
TEMPERATURE AFEBRILE

TREATMENT
IVF DNS @ 100ML/HR
INJ SOLUMEDROL 40MG IV OD
T.DOLO 650MG 1-1-1
T.RABIMOR 20MG B/F
SYP LINCTUS CODEINE 2TSP BD