HISTORY OF PRESENTING ILLNESS

Patient comes with history of fever with chills, high grade, associated with headache and myalgia. No h/o cough, breathlessness, burning micturition. No h/o abdominal pain.

He gives a h/o 2 episodes of vomiting, which contained food particles.

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 130/80 mm Hg RR 16 cycles/min TEMPERATURE 99 F

HAEMOGLOBIN: 14.5g/dl [14_18g/dl]

PACKED CELL VOLUME: 43.6% [40_54%]

PLATELET COUNT: 146000/cumm [150000_500000/cumm]

HAEMOGLOBIN: 14.5g/dl [14_18g/dl] PACKED CELL VOLUME: 42.8% [40_54%]

PLATELET COUNT: 140000/cumm [150000 500000/cumm]

27-10-2014

HAEMOGLOBIN: 15.1g/dl [14_18g/dl] PACKED CELL VOLUME: 44.9% [40_54%]

PLATELET COUNT: 132000/cumm [150000 500000/cumm]

28-10-2014

HAEMOGLOBIN: 14.8g/dl [14_18g/dl] PACKED CELL VOLUME: 43.8% [40_54%]

PLATELET COUNT: 138000/cumm [150000_500000/cumm]

TREATMENT

Tab. Dolo 650 mg

Inj. Magpep 40 mg IV OD

Inj . Mocef 2 gm IV BD

Tab. Magpep 40 mg 1-0-0