HISTORY OF PRESENTING ILLNESS
Patient gives h/o fever since 2 days. High grade. Present throughout day. Associated with chills.
Patient also c/o headache since 2 days. bilateral temporal region.
Patient c/o nausea since few hours.
No h/o burning micturition
No h/o pain abdomen
No h/o vomiting

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- 80bpm
BP-130/80mmhg
RR- 17 cycles/min
TEMPERATURE-100F

PACKED CELL VOLUME	:	38.1% [36_47%]

HAEMOGLOBIN	:	12.7g/dl [12_15g/dl]
PACKED CELL VOLUME	:	38.1% [36_47%]
PLATELET COUNT	:	124000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	12.6g/dl [12_15g/dl]
PACKED CELL VOLUME	:	37.8% [36_47%]
PLATELET COUNT	:	103000/cumm [150000_500000/cumm]

TREATMENT
INF NS/DNS @ 100ML/HR
INJ. EMESET 4 MG IV Q8H
INJ. PAN 40 MG 1-0-0
T. DOLO 650 MG 1-1-1
T. PAN 40 MG 1-0-0