CHIEF COMPLAINTS:
FEVER SINCE 3 DAYS

HISTORY OF PRESENTING ILLNESS:
PATIENT CAME WITH COMPLAINTS OF FEVER SINCE 3 DAYS ,INTERMITTENT,ASSOCIATED WITH CHILLS,NO SPECIFIC PATTERN,ASSOCIATED WITH HEADACHE AND BACK ACHE.NO H/O COUGH,EXPECTORATION,VOMITING,LOOSE STOOLS,HAEMATURIA,SEIZURES,RASHES,ABDOMINAL PAIN.

PAST HISTORY:
TOOK 2DAYS OF ANTI MALARIALS FOR THE CURENT FEBRILE ILLNESS.NO HISTORY OF DM,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 CONSCIOUS 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- 140/70MMHG RR - 20CPM TEMPERATURE -98.6F

TREATMENT:
IVF NS/DNS @100ML/HR
T.PAN 40MG OD
T.CALPOL 500MG TID
INJ.EMESET 4MG IV SOS
C.BECELAC 2-2-2
T.CYCLOPAM SOS
THROMBOPHOBE OINTMENT