COMPLAINTS
FEVER-2 WEEKS

HISTORY OF PRESENTING ILLNESS
THE PATIENT WAS APPARENTLY NORMAL 2 WEEKS BACK WHEN HE DEVELOPED FEVER , HIGH GRADE, CONTINUOUS.
NO H/O BURNING MICTURATION.
NO H/O COUGH
PATIENT WAS EMPIRICALLY TREATED AS MALARIA IN AN OUTSIDE HOSPITAL

PERSONAL HISTORY
SLEEP - NORMAL
APPETITE - NORMAL
DIET - MIXED
BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION
PR- 88bpm
BP-120/90 mmHg
TEMP - 98.6F
RR-18 CYCLES / MIN
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED TO TIME, PLACE AND PERSON
MODERATELY BUILT AND NOURISHED
PALLOR,ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

LAB INVESTIGATION

20-05-2015 : Haemoglobin : 12.7g/dl, Leukocyte Count Total : 6400/cumm, Mchc : 32.3g/dl, Mch : 28.4pg, Mcv : 87.8fl, Packed Cell Volume : 39.4%, Platelet Count : 252000/cumm, Red Blood Cell Count : 4.49million/cumm, Neutrophils : 39%, Lymphocytes : 60%, Eosinophils : 01%, Monocytes :

22-05-2015 : Platelet Count : 142000/cumm,

23-05-2015 : Platelet Count : 114000/cumm, **Dengue Rapid (Ns1, Igm, Igg)** NS1 ANTIGEN POSITIVE, IgM ANTIBODY : NEGATIVE, IgG ANTIBODY : NEGATIVE, COMMENTS : This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA.,

TREATMENT
TAB.DOLO 650MG 1-1-1
TAB.MALARID DS 0-1-0
TAB.PAN 40MG 1-0-0(B/F)