CHIEF COMPLAINTS
Fever x 3 days
Headache x 3 days

HISTORY OF PRESENTING ILLNESS
The patint was apparently healthy prior to 3 days developed fever which was high grade , associated with chills and rigors, present throughout the day. History of headache since 3 days, diffuse, throbbing type, severe intensity, associated with myalgia. The patient had taken Ayurvedic medications for the following complains after which he developed loose stools.
No history of vomiting, no history of pain abdomen, burning micturition, loss of consciousness or seizures. No history of malena, bleeding gums, petecchial rash.

PAST HISTORY
Known case of Type II Diabtes Mellitus since 19 years on tab. Glucored 1/2-0-0
No history of 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- 92 bpm BP-140/70 mmHg RR-16/min TEMPERATURE-98.6ºF at the time of examination

LAB INVESTIGATION

02-06-2015 : Haemoglobin : 13.8g/dl, Leukocyte Count Total : 4000/cumm, Mchc : 33.3g/dl, Mch : 27.9pg, Mcv : 83.8fl, Packed Cell Volume : 41.3%, Platelet Count : 121000/cumm, Red Blood Cell Count : 4.93million/cumm, Neutrophils : 78%,

03-06-2015 : Haemoglobin : 13.0g/dl, Packed Cell Volume : 39.3%, Platelet Count : 118000/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., **Stool Analysis** MACROSCOPIC FINDINGS Methodology: Observation ---, CONSISTENCY : Semi solid, COLOUR : Brownish, BLOOD : Negative, MUCUS : Negative, MICROSCOPIC FINDINGS Methodology: Microscopy : ---, PUS CELLS : 2-3, R.B.C : Nil, OVA : Not seen, CYST : Not seen, FAT GLOBULES : Not seen,

04-06-2015 : Haemoglobin : 13.4g/dl, Packed Cell Volume : 40.5%, Platelet Count : 128000/cumm, Serum Urea : 27mg/dl, Serum Creatinine : 1.27mg/dl,

05-06-2015 : Haemoglobin : 13.9g/dl, Packed Cell Volume : 41.3%, Platelet Count : 113000/cumm, Serum Hdl Cholesterol : 35mg/dl, Serum Triglyceride : 126mg/dl, Serum Total Cholesterol : 135mg/dl, Serum Ldl Cholesterol : 75mg/dl, Serum Vldl : 25.2mg/dl, Serum Total Cholesterol-Hdl Cholesterol Ratio : 3.8units, Plasma Glucose Fasting : 187mg/dl,

TREATMENT
IV fluids NS at 100 ml/hr
Tab. Pan 40 mg 1-0-0
Tab. Dolo 500 mg 1 SOS
Tab. Ciplox TZ 1-0-1 (1 day)
Tab. Lorel 2 mg 1 SOS
Syp. Sucrafil 2 tbsp TID