HISTORY OF PRESENTING ILLNESS
Patient was apparently normal since 5 days when he developed fever which was high grade,intermittent ,not associated with chills.Patient also gives history of headache since 3 days which was throbbing in nature and more on the peri orbital region.Patient gives history of vomiting since 2 days,non projectile,contained food particles.No history of cough ,breathlessness,loose stools,burning micturition.

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:decreased.
Sleep: decreased.
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 -76bpm
BP-110/70 mmHg
RR-16cpm
TEMPERATURE-98.6 ° F

HAEMOGLOBIN : 12.7g/dl [14_18g/dl]

PLATELET COUNT : 16000/cumm [150000_500000/cumm]

07-12-2014

PLATELET COUNT : 13500/cumm [150000_500000/cumm]

PLATELET COUNT : 14000/cumm [150000_500000/cumm]

PLATELET COUNT : 23000/cumm [150000_500000/cumm]

HAEMOGLOBIN : 12.0g/dl [14_18g/dl]

PACKED CELL VOLUME : 36.6% [40_54%]

PLATELET COUNT : 42000/cumm [150000_500000/cumm]

PLATELET COUNT : 34000/cumm [150000_500000/cumm]

HAEMOGLOBIN : 12.1g/dl [14_18g/dl]

LEUKOCYTE COUNT TOTAL : 7000/cumm [4000_11000/cumm]

PACKED CELL VOLUME : 36.6% [40_54%]

PLATELET COUNT : 42000/cumm [150000_500000/cumm]

TREATMENT
8 Pint Platelet Concentrate
Inj Emeset 4mg IV SOS
T Pantolex 40 mg OD
T Dolo 650 mg SOS
IV FLUIDS DNS/NS
T Doxy 100 mg BD
Inj Mocef 1gm IV BD
Inj Hydrocortiosone 100mg TID