CHIEF COMPLAINTS
fever with chills since - 3 days.
body ache-3 days.
vomiting 1 day.

HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 3 days ago when she developed fever associated with chills ,low grade, intermittent in nature decreases on taking medications,associated generalised bodyache.she also gives h/o vomiting 1 episode on the day of admission,non projectile,non bilious,not blood stained.
no h/o breathlessness,cough .
no h/o abdominal pain or loose stools.
no h/o any urinary symptoms.

PAST HISTORY - no h/0 dm/htn/ tb/ asthma/ ihd.

FAMILY HISTORY- no h/o dm/ htn/ tb/ asthma/ ihd in family.

PERSONAL HISTORY- diet-mixed; appetite-good; sleep-adequate; bowel & bladder-regular

GENERAL PHYSICAL EXAMINATION.
patient was conscious, co-operative, well oriented to time place and person. moderately built & nourished.
no pallor, icterus, cyanosis, clubbing, lymphadenopathy, edema
bp : 120/80 mmhg
pulse : 78 bpm
temp : 101 f
rr : 18 /min

LAB INVESTIGATION

25-01-2015 : Haemoglobin : 12.9g/dl, Packed Cell Volume : 38.7%, Platelet Count : 152000/cumm,

24-01-2015 : Haemoglobin : 13.2g/dl, Platelet Count : 175000/cumm, Packed Cell Volume : 39.6%,

23-01-2015 : Haemoglobin : 12.7g/dl, Packed Cell Volume : 37.9%, Platelet Count : 187000/cumm,

Platelet Count : 186000/cumm,

TREATMENT
ivf dns/ns
t.calpol 500mg sos.
inj perinorm iv sos