CHIEF COMPLAINTS
Fever since 3 days
Body ache since 3 days
Headache since 3 days
Cough since 3 days

HISTORY OF PRESENTING ILLNESS
The patient was apparently normal 3 days back when she developed fever,insiduous in onset,gradually progressive.
It was of high degree and associated with chills .No diurnal variation and relieved on medication.
Patient also complains of cough with minimal expectoration
Patient also complains of associated body ache , which was generalised in nature .
She also complains of headache associated with fever ,bifrontal and throbbing type of pain,It relieved on medication .
No h/o fever with chills.no h/o vomiting or nausea
No h/o decreased urine output ,no h/o cough with expectoration
No h/o abdominal pain or loose stools

PAST HISTORY
h/o chikungunya 8 years back
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: Adequate.
Bowel and Bladder: Regular. No substance abuse.

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 72 bpm BP-110/70 mm hg RR-17 cpm TEMPERATURE -afebrile

16-06-2015 : Haemoglobin : 10.1g/dl, Neutrophils : 61%, Lymphocytes : 36%, Eosinophils : 02%, Monocytes : 01%, Basophils : 00%, **Other Cells** Method : Manual -, Leukocyte Count Total : 2200/cumm, Platelet Count : 160000/cumm, **Malarial Parasite Fluoroscent (Mp Ft)** presence of
17-06-2015 : Haemoglobin : 11.0g/dl, Packed Cell Volume : 34.6%, Platelet Count : 125000/cumm, **Peripheral Smear Report No** H/3775/15, **Impression** : Mild microcytic hypochromic anemia with neutropenia.,

TREATMENT
Cap Doxy xl 100 mg 1-0-1
Syp Ascoryl 2tstp-2tsp-2tsp
C Doxt sz 1-0-1
T Pan 40 mg 1-0-0
Inj Emeset 4 mg iv sos
T Dolo 500 mg sos