COMPLAINTS
Fever x 3 days
Vomiting since today

HISTORY OF PRESENTING ILLNESS
Patient came with complaints of fever since 2 days.fever was insidious in onset and gradually progressive.it was high grade and was associated with chills.he also complains of body ache.no h/o abdominal pain
no h/o nausea/vomiting
no h/o headache
no h/o cough with expectoration
no h/o chest pain
no h/o breathlessness
no h/o palpitations
patient went to a local hospital where he was diagnosed to have dengue fever.he was referred here for further evaluation and management.

PAST HISTORY
no h/o diabetes mellitus,hypertension,tuberculosis,bronchial asthma

FAMILY HISTORY
nothing significant

PERSONAL HISTORY
sleep - normal appetite - decreased diet - mixed bowel and bladder - regular,

GENERAL EXAMINATION
patient was conscious, cooperative, well oriented with time, place and person.
moderately built and nourished
pallor,icterus, cyanosis, clubbing, lymphadenopathy, edema absent
PR-80 bpm BP- 110/80mmHg TEMP - 98.6F RR-16 CYCLES / MIN

09-07-2015 : Haemoglobin : 15.7g/dl, Platelet Count : 97000/cumm, Packed Cell Volume : 46.3%,

10-07-2015 : Neutrophils : 33%, Lymphocytes : 50%, Eosinophils : 01%, Monocytes : 08%, Basophils : 00%, **Other Cells** Method : Manual Reactive lymphocytes - 08%, Leukocyte Count Total : 3700/cumm, Haemoglobin : 15.4g/dl, Platelet Count : 80000/cumm, Packed Cell Volume : 44.8%,

TREATMENT
IV FLUIDS DNS @ 75ML/HR
TAB DOLO 650MG 1-1-1
INJ RANTAC 150MG 1-0-1
INJ EMESET 4MG 1-1-1