CHIEF COMPLAINTS
Fever-3 days

HISTORY OF PRESENTING ILLNESS
The patient was apparently normal; 3 days back,then she developed fever which was high grade,continuous and decreses only after taking medications,fever was not associated with chills and rigors
No history of rash/bleeding
No history of cough/cold/coryza/headache
Patient is taking well orally.No bowel and bladder disturbance.

GENERAL PHYSICAL EXAMINATION
No Pallor, Icterus, Cyanosis, Clubbing, Lymphadenopathy, Oedema
BP:100/60mmofHg
Pulse: 96/min
Temp:100F
RR:22/min

LAB INVESTIGATION

14-06-2015 : Peripheral Smear Report No H/3715/15, **Impression** : Normocytic normochromic blood picture with leucopenia., Erythrocyte Sedimentation Rate : 09mm/1st hour, Haemoglobin : 12.3g/dl, Leukocyte Count Total : 3700/cumm, Mchc : 32.3g/dl, Mch : 27.9pg, Mcv : 86.2fl, Packed Cell Volume : 38.2%, Platelet Count : 140000/cumm, Rdw : 12.7%, Red Blood Cell Count : 4.43million/cumm, Neutrophils : 70%, Lymphocytes : 19%, Eosinophils : 01%, Monocytes : 10%, Basophils : 00%, Serum Urea : 30mg/dl, Serum Creatinine : 0.47mg/dl, Serum Ast (Sgot) : 34IU/L, Serum Alt (Sgpt) : 15IU/L, Serum Sodium : 137mEq/L, Serum Potassium : 4.35mEq/L, Serum Chloride : 101.7mEq/L, Serum Crp : 0.99mg/l,

15-06-2015 : Leukocyte Count Total : 2700/cumm, Packed Cell Volume : 40.2%, Platelet Count : 132000/cumm,

16-06-2015 : Packed Cell Volume : 43.3%, Platelet Count : 108000/cumm,

TREATMENT
T.Dolo 500 mg 0.5-0.5-0.5