COMPLAINTS:

FEVER - 6 DAYS HEADACHE -6 DAYS MYALGIA -6 DAYS

HISTORY OF PRESENTING ILLNESS:

PATIENT WAS APPARENTLY NORMAL 3 DAYS BACK WHEN HE DEVELOPED FEVER, HIGH GRADE, INTERMITTENT TYPE WHICH WAS ASSOCIATED WITH CHILLS. PATIENT ALSO C/O HEADACHE, GENERALISED, THROBBING TYPE .PATIENT ALSO C/O MYALGIA.PATIENT WAS ADMITTED IN OUTSIDE HOSPITAL KANHANGAD WITH DENGUE REACTIVE NO H/O VOMITING NO H/O LOOSE STOOLS NO H/O ABDOMINAL PAIN NO H/O LOC

PAST HISTORY

NO H/O DM , HTN

FAMILY HISTORY:

NOTHING SIGNIFICANT

NO H/O NECK STIFFNESS

PERSONAL HISTORY:

SLEEP - NORMAL, APPETITE - NORMAL, DIET - MIXED, BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION:

PR- 88 Bpm, BP-130/70 mmHg, TEMP - 100 F, RR-18 CYCLES / MIN.
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WITH TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED.
PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

Hbx - 13.7 gmx
TWBC - 5000 cell/como

bla reso Attic

Platelet Count

DLUUD KEPUK I

95,000 cells/cumm

1.5 - 4.0 Lakhs /cumm

Haemoglobin

13.7 gm%

Platelet Count

1.90 lakhs/cumm