DIAGNOSIS
Dengue Fever

CHIEF COMPLAINTS
Fever - 5 days
Headache - 3 days
Malaise - 6 days

HISTORY OF PRESENTING ILLNESS Patient was apparently normal 5 days ago when he developed high grade fever associated with chills .
No history of cough/cold
No history of throat pain
No history of burning micturition
c/o myalgia and multiple joint pain
came with outside report showing widal test negative

PAST HISTORY
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: Good. Sleep: Adequate. Bowel and Bladder: Regular. No substance abuse.
GENERAL EXAMINATION 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 -80/min BP-120/80mmHg RR - 16cpm
TEMPERATURE -98.6F

TREATMENT

INJ RANTAC 50MG IV Q8H
INJ EMESET 4MG IV Q8H
SYP SUCRAFIL 10 ML Q8H
T.CALPOL 500MG SOS