CHIEF COMPLAINTS
Fever since 3 days

HISTORY OF PRESENTING ILLNESS
patient was apparently normal 3 days back when he developed fever which was sudden in onset , high grade type , intermittent in nature , gradually progressive. Associated with chills.
Patient also complains of headache , throbbing type , present over the frontal region.
patient also complains of generalized weakness.
no h/o abdominal pain /vomitting
no h/o cough / breathlessness
no h/o burning micturition / hematuria

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 consious and cooperative, well oriented to time, place and person.
Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE:80bpm
BP :130/80mmhg
RR:20/min
TEMPERATURE:99F

LAB INVESTIGATION

11-06-2015 : Haemoglobin : 14.2g/dl, Neutrophils : 72%, Lymphocytes : 13%, Eosinophils : 03%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual Nil, Leukocyte Count Total : 3200/cumm, Erythrocyte Sedimentation Rate : 05mm/1st hour, Packed Cell Volume : 42.7%, Platelet Count : 71000/cumm, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites

12-06-2015 : Haemoglobin : 14.1g/dl, Platelet Count : 41.8/cumm, Packed Cell Volume : 68000%, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites NEGATIVE,

13-06-2015 : Haemoglobin : 14.4g/dl, Platelet Count : 53000/cumm, Packed Cell Volume : 43.6%, Serum Ast (Sgot) : 105IU/L, Serum Alt (Sgpt) : 60IU/L,

14-06-2015 : Haemoglobin : 13.4g/dl, Packed Cell Volume : 41.0%, Platelet Count : 86000/cumm,

15-06-2015 : Haemoglobin : 14.6g/dl, Packed Cell Volume : 44.9%, Platelet Count : 150000/cumm,

TREATMENT
IVF DNS/NS @ 75ml/hr
T.dolo 650mg tid
T.Magpep 40mg 1-0-0
T.optinueron 0-1-0