

Documents - VenoPro

172.18.0.17:8080/VENOPRO/Document/ViewDoc?id=EA124AD6-B411-49B7-94A2-98EB4C94AE3E&q=55075

View Document

7 of 91 80%

CHIEF COMPLAINTS
Fever since 5 days
headache since 4 days

HISTORY OF PRESENTING ILLNESS:
52year female patient: who was apparently healthy, 5 days back, presented with complaints of fever since 5 days, high grade, continuous associated with chills.
no h/o burning micturition
h/o headache since 3 days, diffuse, severe intensity, throbbing in nature associated with myalgia and joint pain.
no h/o loss of consciousness, no h/o seizures
h/o abdominal pain since 1 day severe, non radiating, no aggravating or relieving factors
no h/o vomiting or loose stools
no h/o bleeding gums, petechial rash or malena.
For the above complaints, patient had consulted a nearby doctor, following which she was diagnosed to be positive for dengue fever, and referred here for further management.

PAST HISTORY
K/c/o Diabetes Mellitus and Hypertension on treatment
No history of, 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 moderately built and nourished.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE: 100bpm
BP: 150/70mmHg

Phone : 0834-2238134, 22370000 Fax : 2434661, 2437402
Email: mulierhospital@gmail.com / mulier@muliermulier.in Website : www.muliermulier.com

start Documents - VenoPr... Microsoft Excel - 201- 10:45 AM

Documents - VenoPro

172.18.0.17:8080/VENOPRO/Document/ViewDoc?id=EA124AD6-B411-49B7-94A2-98EB4C94AE3E&q=55075

View Document

7 of 91 80%

CHIEF COMPLAINTS
Fever since 5 days
headache since 4 days

HISTORY OF PRESENTING ILLNESS:
52year female patient: who was apparently healthy, 5 days back, presented with complaints of fever since 5 days, high grade, continuous associated with chills.
no h/o burning micturition
h/o headache since 3 days, diffuse, severe intensity, throbbing in nature associated with myalgia and joint pain.
no h/o loss of consciousness, no h/o seizures
h/o abdominal pain since 1 day severe, non radiating, no aggravating or relieving factors
no h/o vomiting or loose stools
no h/o bleeding gums, petechial rash or malena.
For the above complaints, patient had consulted a nearby doctor, following which she was diagnosed to be positive for dengue fever, and referred here for further management.

PAST HISTORY
K/c/o Diabetes Mellitus and Hypertension on treatment
No history of, 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 moderately built and nourished.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE: 100bpm
BP: 150/70mmHg

Phone : 0834-2238134, 22370000 Fax : 2434661, 2437402
Email: mulierhospital@gmail.com / mulier@muliermulier.in Website : www.muliermulier.com

