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.fever was present throughout the day.he gives a
no h/o bleeding tendencies
no h/o abdominal pain
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:54bpm
BP :120/80mmhg
RR:20/min
TEMPERATURE:99F

LAB INVESTIGATION

11-06-2015 : Haemoglobin : 14.0g/dl, Leukocyte Count Total : 2100/cumm, Mchc : 31.8g/dl, Mch : 25.7pg, Mcv : 80.8fl, Packed Cell Volume : 44.0%, Platelet Count : 19000/cumm, Red Blood Cell

13-06-2015 : Haemoglobin : 13.4g/dl, Packed Cell Volume : 41.4%, Platelet Count : 16000/cumm, Serum Ast (Sgot) : 233IU/L, Serum Alt (Sgpt) : 113IU/L, Serum Tsh : 1.78uIU/ml,

14-06-2015 : Haemoglobin : 13.2g/dl, Packed Cell Volume : 40.8%, Platelet Count : 20000/cumm, Platelet Count : 27000/cumm, Packed Cell Volume : 41.5%,

15-06-2015 : Haemoglobin : 12.7g/dl, Packed Cell Volume : 39.5%, Platelet Count : 46000/cumm,

16-06-2015 : Haemoglobin : 13.0g/dl,

TREATMENT
TAB DOLO 650MG SOS
TAB OPTINUERON OD
INJ EMESET 4MG SOS