CHIEF COMPLAINTS
FEVER- 4 DAYS

HISTORY OF PRESENTING ILLNESS
Patient came with c/o fever since 4 days, intermittent ,low grade, not asssociated with chills and rigors
h/o cough with mucoid expectoration since 4 days
no h/o vomiting/ nausea/ headache
no h/o cough/expectoration/abdominal pain/diarrhoea/fever/sore throat/burning micturition

PAST HISTORY
not a k/c/o dm, htn,ptb,ba

FAMILY HISTORY
No history of Diabetes Mellitus, Hypertension, Tuberculosis, Asthma or IHD in the Family

PERSONAL HISTORY
Diet: Mixed.
Appetite: normal
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,no icterus, cyanosis or oedema,clubbing ,lymphadenopathy absent
vitals
PULSE 80/min
BP 140/90 mm HG
RR 20/min
TEMPERATURE 98.6

LAB INVESTIGATION

09-06-2015 : Platelet Count : 67000/cumm,
10-06-2015 : Platelet Count : 86000/cumm,
11-06-2015 : Platelet Count : 98000/cumm,
12-06-2015 : Platelet Count : 112000/cumm,

TREATMENT
T.Dolo 650 mg
T.Neurobion
Syp.Ascoril 5ml tid
T.Rantac 150mg
Combimist nebulization
Steam inhalation