CHIEF COMPLAINTS:
FEVER SINCE 2 DAYS

HISTORY OF PRESENTING ILLNESS:
PATIENT CAME WITH COMPLAINTS OF FEVER SINCE 2 DAYS ,INTERMITTENT,ASSOCIATED WITH global headache and retro orbital pain,NO SPECIFIC PATTERN,ASSOCIATED WITH BURNING MICTURATION.NO H/O HEADACHE,COUGH,EXPECTORATION,VOMITING,LOOSE STOOLS,ALTERED SENSORIUM,MYALGIA,JOINT PAIN.h/o nausea present.

PAST HISTORY:
NO HISTORY OF DM, 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 - 86/MIN BP- 130/70MMHG RR - 23CPM TEMPERATURE -98.6F

27-10-2015 : Haemoglobin : 14.1g/dl, Leukocyte Count Total : 4500/cumm, Mchc : 33.0g/dl, Mch : 27.7pg, Mcv : 83.9fl, Packed Cell Volume : 42.8%, Platelet Count : 89000/cumm, Red Blood Cell Count : 5.11million/cumm, Neutrophils : 77%,

28-10-2015 : Haemoglobin : 13.5g/dl, Packed Cell Volume : 40.3%, Platelet Count : 72000/cumm, Plasma Glucose Fasting : 86mg/dl, Serum Uric Acid : 6.3mg/dl, Serum Hdl Cholesterol : 30mg/dl, Serum Triglyceride : 100mg/dl, Serum Total Cholesterol : 160mg/dl, Serum Ldl Cholesterol : 121mg/dl, Serum Vldl : 20mg/dl, Serum Total Cholesterol-Hdl Cholesterol Ratio : 5.3units,

29-10-2015 : Haemoglobin : 13.5g/dl, Packed Cell Volume : 40.7%, Platelet Count : 73000/cumm, Neutrophils : 72%, Lymphocytes : 17%, Eosinophils : 01%, Monocytes : 10%, Basophils : 00%, Leukocyte Count Total : 2800/cumm,

TREATMENT:
ivf ns @75ml/hr
inj.emeset 4mg iv q8h
inj.rantac 50mg iv q8h
t.calpol 500mg tid
t.beplex forte 0-1-0
syp.sucrafil 2tsp tid
t.cremalax 2 hs