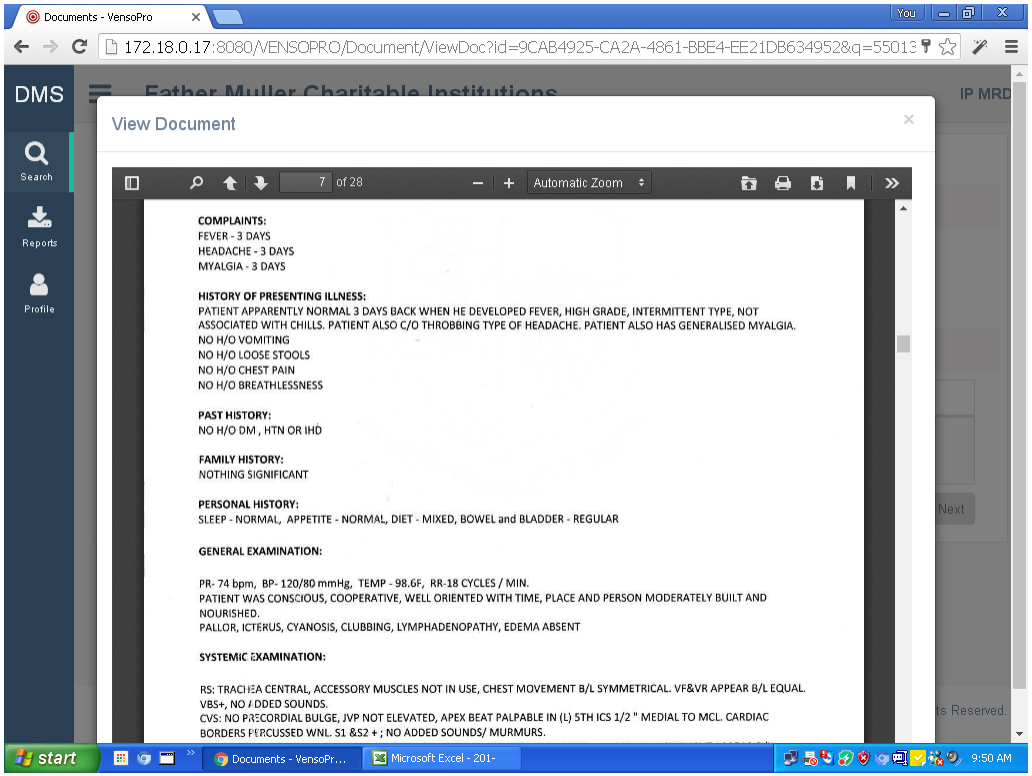
Documents - VensoPro
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Automatic Zoom
COMPLAINTS:
FEVER - 3 DAYS
HEADACHE - 3 DAYS
MYALGIA - 3 DAYS
HISTORY OF PRESENTING ILLNESS:
PATIENT APPARENTLY NORMAL 3 DAYS BACK WHEN HE DEVELOPED FEVER, HIGH GRADE, INTERMITTENT TYPE, NOT ASSOCIATED WITH CHILLS. PATIENT ALSO C/O THROBBING TYPE OF HEADACHE. PATIENT ALSO HAS GENERALISED MYALGIA.
NO H/O VOMITING
NO H/O LOOSE STOOLS
NO H/O CHEST PAIN
NO H/O BREATHLESSNESS
PAST HISTORY:
NO H/O DM , HTN OR IHD
FAMILY HISTORY:
NOTHING SIGNIFICANT
PERSONAL HISTORY:
SLEEP - NORMAL, APPETITE - NORMAL, DIET - MIXED, BOWEL and BLADDER - REGULAR
GENERAL EXAMINATION:
PR- 74 bpm, BP- 120/80 mmHg, TEMP - 98.6F, RR-18 CYCLES / MIN.
PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WITH TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED.
PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT
SYSTEMIC EXAMINATION:
RS: TRACHEA CENTRAL, ACCESSORY MUSCLES NOT IN USE, CHEST MOVEMENT B/L SYMMETRICAL. VF&VR APPEAR B/L EQUAL.
VBS+, NO ADDED SOUNDS.
CVS: NO PRECORDIAL BULGE, JVP NOT ELEVATED, APEX BEAT PALPABLE IN (L) 5TH ICS 1/2 " MEDIAL TO MCL. CARDIAC BORDERS PERCUSSED WNL. S1 &S2 + ; NO ADDED SOUNDS/ MURMURS.
Next
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