

CHIEF COMPLAINTS

H/O LOOSE STOOLS- 1 DAY

HISTORY OF PRESENTING ILLNESS

patient who was normal 1 day back when she developed loose stools 1 day back, 3 episodes, no blood/mucus in stools, associated with epigastric pain and nausea
no h/o fever

PAST HISTORY

no similar complaints in the past
not a k/c/o dm,htn

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 or oedema,clubbing ,lymphadenopathy absent
vitals

PULSE 80/min

BP 100/60 mm HG

RR 20/min

TEMPERATURE 98.6

TREATMENT

Inj.Emeset 4mg iv
Inj. Pan 40mg IV bd
T.Ciplox 500mg bd
Cap.Bacelac tid