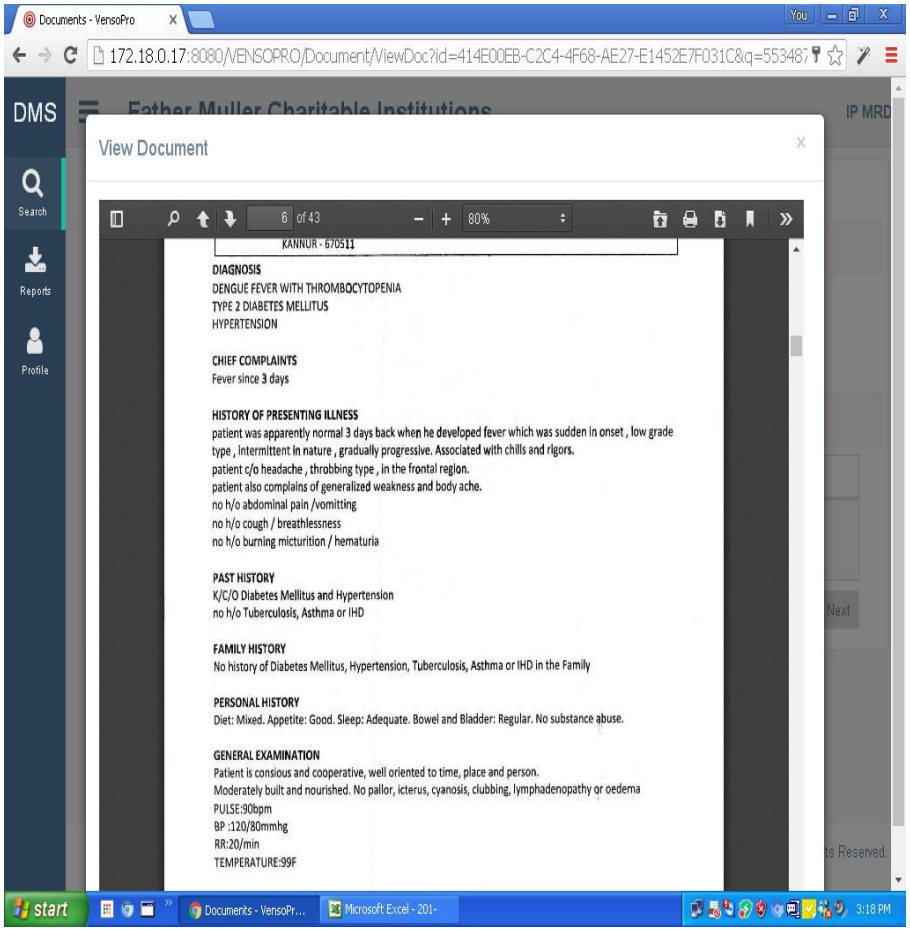
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KANNUR - 670511
DIAGNOSIS
DENGUE FEVER WITH THROMBOCYTOPENIA
TYPE 2 DIABETES MELLITUS
HYPERTENSION
CHIEF COMPLAINTS
Fever since 3 days
HISTORY OF PRESENTING ILLNESS
patient was apparently normal 3 days back when he developed fever which was sudden in onset , low grade type , intermittent in nature , gradually progressive. Associated with chills and rigors.
patient c/o headache , throbbing type , in the frontal region.
patient also complains of generalized weakness and body ache.
no h/o abdominal pain /vomitting
no h/o cough / breathlessness
no h/o burning micturition / hematuria
PAST HISTORY
K/C/O Diabetes Mellitus and Hypertension
no h/o 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:90bpm
BP :120/80mmhg
RR:20/min
TEMPERATURE:99F
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