

HISTORY OF PRESENTING ILLNESS

PATIENT CAME WITH H/O FEVER SINCE 6 DAYS ,ASSOCIATED WITH CHILLS  
PATIENT ALSO COMPLAINS OF NAUSEA  
GIVES H/O MALAENA-1EPISODE -TODAY  
NO OTHER COMPLAINTS

PAST HISTORY: NOT SIGNIFICANT

FAMILY HISTORY: NOT SIGNIFICANT

PERSONAL HISTORY

SLEEP- NORMAL

APPETITE- NORMAL

BOWEL AND BLADDER HABITS-REGULAR

SYSTEMIC EXAMINATION

PATIENT CONSCIOUS, CO OPERATIVE, WELL ORIENTED TO TIME PLACE AND PERSON,  
NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY AND EDEMA

PULSE-78BPM

RR-16/MIN

SPO2-98%

BP -130/80MMHG

CVS: S1 S2 HEARD, NO MURMURS

RS: VBS +, NO ADDED SOUNDS

PA: SOFT, NO TENDERNESS

CNS: HMF NORMAL, NO FND

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**15-07-2015 :** Haemoglobin : 16.4g/dl, Leukocyte Count Total : 3800/cumm, Mchc : 33.8g/dl, Mch : 29.2pg, Mcv : 86.4fl, Packed Cell Volume : 48.6%, Platelet Count : 51000/cumm, Red Blood Cell Count : 5.62million/cumm, Neutrophils : 54%, Lymphocytes : 30%, Eosinophils : 06%, Monocytes : 10%, Basophils : 00%, **Other Cells Method : Manual** NIL, Serum Urea : 18mg/dl, Serum Creatinine : 0.98mg/dl, Serum Uric Acid : 4.6mg/dl, Serum Sodium : 137mEq/L, Serum Potassium : 4.89mEq/L, Serum Chloride : 95.7mEq/L, Serum Total Bilirubin : 0.65mg/dl, Serum Ast (Sgot) : 93IU/L, Serum Alt (Sgpt) : 76IU/L, **Abo Grouping & Typing** TEST RESULT A1 Rh(D) POSITIVE,

**16-07-2015 :** Haemoglobin : 16.2g/dl, Platelet Count : 42000/cumm, Packed Cell Volume : 48.1%, **Malarial Parasite Fluorescent (Mp Ft)** presence of parasites NEGATIVE,

**17-07-2015 :** Haemoglobin : 15.6g/dl, Platelet Count : 58000/cumm, Packed Cell Volume : 46.8%,

TREATMENT

IVF NS/DNS-125ML/HOUR

T.DOLO 650MG 1-1-1

INJ. PAN 40MG

T.RANTAC 150MG 1-0-1

T.ATARAX 1-0-1

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