HISTORY OF PRESENTING ILLNESS
Patient complains of fever since 5 days, acute in onset , gradually progressivehigh grade, associated with chills. Patient also complains of b/l throbbing headache. No h/o pain abdomen. No c/o loose stools. No c/o cough/ breathlessness. No c/o vomiting.

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 consious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE -88 bpm
BP -130/80 m Hg
RR -16 breaths per minute
TEMPERATURE -99 F

21-11-2014

HAEMOGLOBIN	: 15.4g/dl [14_18g/dl]
PACKED CELL VOLUME	: 45.6% [40_54%]
PLATELET COUNT	: 96000/cumm [150000_500000/cumm]

22-11-2014

HAEMOGLOBIN	: 15.1g/dl [14_18g/dl]
PACKED CELL VOLUME	: 44.6% [40_54%]
PLATELET COUNT	: 84000/cumm [150000_500000/cumm]

23-11-2014

HAEMOGLOBIN	: 15.1g/dl [14_18g/dl]
PACKED CELL VOLUME	: 44.9% [40_54%]
PLATELET COUNT	: 99000/cumm [150000_500000/cumm]

REFERRAL
nil

TREATMENT
IVF NS/DNS @ 75 ML/HR

T.Dolo 650 mg tid
T.Magpep 40 mg OD
Inj.Emeset 4 mg IV STAT and TID
Inj.Vegacef 1 gm IV BD