HISTORY OF PRESENTING ILLNESS
PATIENT WAS APPARENTLY NORMAL 4 DAYS AGO WHEN HE DEVELOPED FEVER ASSOCIATED WITH CHILLS AND RIGORS.
high GRADE, INTERMITTENT IN NATURE.
ASSOCIATED GENERALISED BODYACHE.
NO H/O BREATHLESSNESS
NO H/ PAIN ABDOMEN OR LOOSE STOOLS,VOMITING.
NO H/O ANY URINARY SYMPTOMS.
NO H/O RASHES OR BLEEDING MANIFESTATIONS

PAST HISTORY - NO H/0 DM/HTN/ TB/ ASTHMA/ IHD.

FAMILY HISTORY- NO H/O DM/ HTN/ TB/ ASTHMA/ IHD IN FAMILY.

PERSONAL HISTORY- DIET-MIXED; APPETITE-GOOD; SLEEP-ADEQUATE; BOWEL & BLADDER-REGULAR

GENERAL PHYSICAL EXAMINATION:
PATIENT WAS CONSCIOUS, CO-OPERATIVE, WELL ORIENTED TO TIME PLACE AND PERSON. MODERATELY BUILT & NOURISHED.
NO PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA.

BP : 120/80 MMHG
PULSE : 78 BPM
TEMP : 101 F
RR : 18 /MIN

LAB INVESTIGATION
11-02-2015 : Packed Cell Volume : 49.2%, Platelet Count : 141000/cumm,

Cells : 1-2, Crystals : Negative, Casts : Nil, Others : Nil,
12-02-2015 : Haemoglobin : 15.5g/dl, Packed Cell Volume : 46.0%, Platelet Count : 130000/cumm,
13-02-2015 : Haemoglobin : 16.2g/dl, Packed Cell Volume : 48.7%, Platelet Count : 120000/cumm,

REFERAL
NIL

TREATMENT
IVF DNS/NS
T CALPOL 500 MG TID