CHIEF COMPLAINTS
Fever since 1 day
Giddiness since 1 day

HISTORY OF PRESENTING ILLNESS
Patient comes with complaints of fever since 1 day, insidious in onset, gradually progressive, low grade, not associated with chills. Fever was present throughout the day.
Patient also gives history of giddiness. It was associated with 1 episode of vomiting . Vomitus contained food particles, non blood stained.
No h/o burning micturition
No h/o loose stools
No h/o cough, coryza
No h/o chest pain, breathlessness

PAST HISTORY
K/C/O Type 2 Diabetes Mellitus since 2 years, on Tab Glycomet
K/C/O Hypertension since 2 years, not on any medication
No history of 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 conscious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE: 72/min
BP: 150/80mm Hg
RR: 16/min
TEMPERATURE: 99F

15-05-2015 : Haemoglobin : 12.9g/dl, Leukocyte Count Total : 2700/cumm, Mchc : 33.5g/dl, Mch : 28.0pg, Mcv : 83.6fl, Packed Cell Volume : 38.4%, Platelet Count : 123000/cumm, Red Blood Cell Count : 4.59million/cumm, Neutrophils : 65%, Lymphocytes : 33%, Eosinophils : 00%, Monocytes : 02%, Basophils : 00%, **Other Cells** Method : Manual Nil, Erythrocyte Sedimentation Rate : 23mm/1st hour, **Prothrombin Time** CONTROL 11.5, TEST : 12.2, INR : 1.01, **Malarial Parasite Fluoroscent (Mp Ft)** presence of parasites Negative, Plasma Glucose Random : 209mg/dl, Whole Blood Glycated Hb (Hba1c) : 8.7%, Serum Urea : 34mg/dl, Serum Creatinine : 0.72mg/dl, Serum Uric Acid : 4.22mg/dl, Serum Sodium : 128mEq/L, Serum Potassium : 3.58mEq/L, Serum Chloride : 90.3mEq/L, Serum Total Protein : 7.03g/dl, Serum Albumin : 4.57g/dl, Serum Globulin : 2.5g/dl, Serum Total Bilirubin : 0.49mg/dl, Serum Conjugated Bilirubin : 0.20mg/dl, Serum Unconjugated-Bilirubin : 0.29mg/dl, Serum Ast (Sgot) : 34IU/L, Serum Alt (Sgpt) : 42IU/L, Serum Alkaline Phosphatase : 93IU/L, Serum A/G Ratio : 1.9units, Serum Tsh : 1.03uIU/ml, **Dengue Rapid (Ns1, Igm, Igg)** NS1 ANTIGEN POSITIVE, IgM ANTIBODY : NEGATIVE, IgG ANTIBODY : NEGATIVE, COMMENTS : This is only a screening test. Detectable antibody levels may be low in early infection. Please confirm by ELISA.,

16-05-2015 : Haemoglobin : 13.5g/dl, Neutrophils : 58%, Lymphocytes : 29%, Eosinophils : 01%, Monocytes : 12%, Basophils : 00%, **Other Cells** Method : Manual Nil, Leukocyte Count Total : 2600/cumm, Platelet Count : 115000/cumm, Haemoglobin : 12.9g/dl, Packed Cell Volume : 38.3%, Platelet Count : 109000/cumm,

17-05-2015 : Haemoglobin : 13.9g/dl, Packed Cell Volume : 41.4%, Platelet Count : 112000/cumm,

18-05-2015 : Haemoglobin : 14.1g/dl, Platelet Count : 95000/cumm, Packed Cell Volume : 40.6%,

19-05-2015 : Haemoglobin : 14.4g/dl, Packed Cell Volume : 41.2%, Platelet Count : 90000/cumm,

20-05-2015 : Haemoglobin : 12.0g/dl, Packed Cell Volume : 35.8%, Platelet Count : 73000/cumm,

Chest Xray (15/05/15): Normal chest radiograph
USG Abdomen (15/05/15): No sonological abnormality

22-05-2015 : Haemoglobin : 13.3g/dl, Platelet Count : 189000/cumm, Packed Cell Volume : 40.1%,

TREATMENT :
TAB DOLO 650 MG 1-1-1
INJ SOLUMEDROL 40 MG IV OD

TAB METFORMIN 1-0-0
INJ EMESET 4 MG IV TID
INJ PAN 40 MG IV OD
INJ OPTINEURON 1 AMP IV OD
TAB NICARDIA 10 MG 0-0-1
NORMAL SALINE 75