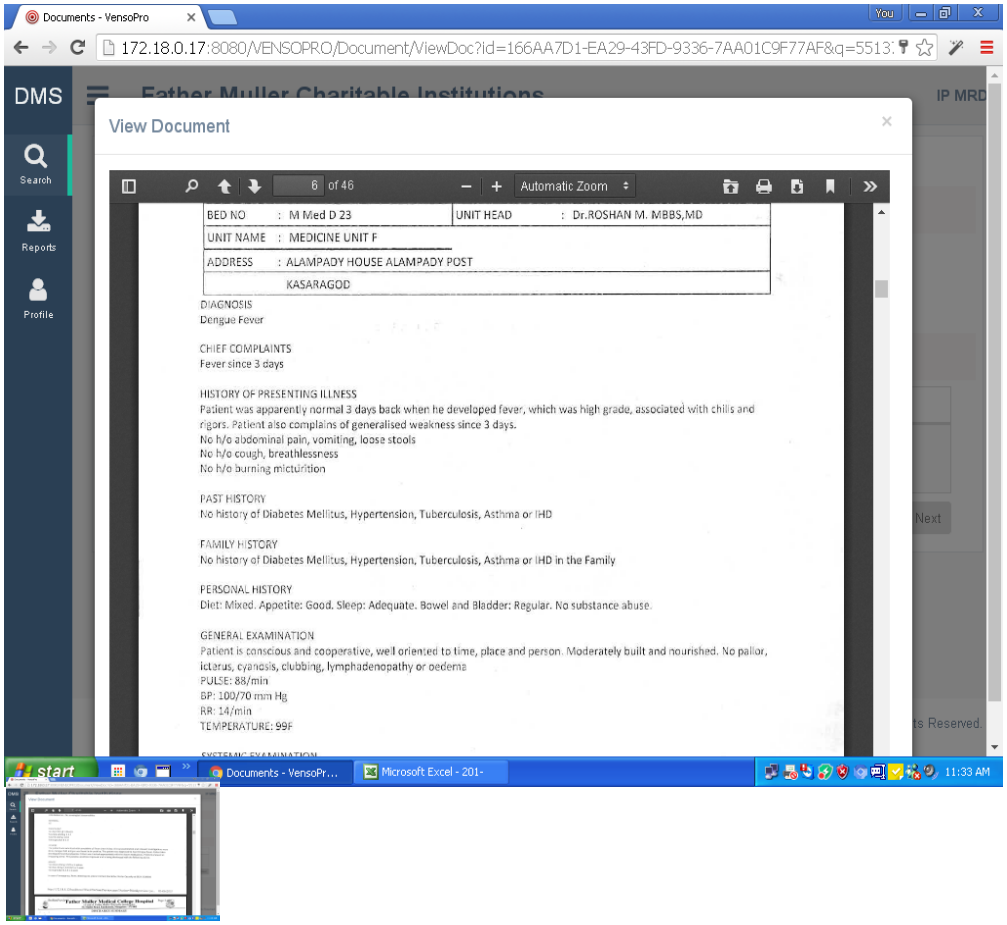
Documents - VensoPro
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View Document
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Automatic Zoom
BED NO : M Med D 23
UNIT HEAD : Dr.ROSHAN M. MBBS,MD
UNIT NAME : MEDICINE UNIT F
ADDRESS : ALAMPADY HOUSE ALAMPADY POST
KASARAGOD
DIAGNOSIS
Dengue Fever
CHIEF COMPLAINTS
Fever since 3 days
HISTORY OF PRESENTING ILLNESS
Patient was apparently normal 3 days back when he developed fever, which was high grade, associated with chills and rigors. Patient also complains of generalised weakness since 3 days.
No h/o abdominal pain, vomiting, loose stools
No h/o cough, breathlessness
No h/o burning micturition
PAST HISTORY
No history of Diabetes Mellitus, 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 conscious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema
PULSE: 88/min
BP: 100/70 mm Hg
RR: 14/min
TEMPERATURE: 99F
Next
start
Documents - VensoPr...
Microsoft Excel - 201-
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