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6 of 45 Automatic Zoom

KANNUR - 670511

**DIAGNOSIS**  
DENGUE FEVER WITH THROMBOCYTOPENIA

**CHIEF COMPLAINTS**  
Fever since 2 days

**HISTORY OF PRESENTING ILLNESS**  
patient was apparently normal 2 days back when he developed fever which was sudden in onset, low grade type, intermittent in nature, gradually progressive. Associated with chills and rigors.  
patient also complains of generalized weakness:  
no h/o abdominal pain /vomitting  
no h/o cough / breathlessness  
no h/o burning micturition / hematuria

**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 consious and cooperative, well oriented to time, place and person.  
Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema  
PULSE:90bpm  
BP :120/80mmhg  
RR:20/min  
TEMPERATURE:99F

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