CHIEF COMPLAINTS
Fever since 13 days

HISTORY OF PRESENTING ILLNESS
Pateint was apparently normal 13 days ago when he developed fever, intermittent, with evening rise of temperature. it was associated with headache - diffuse and myalgia. he was diagnosed with dengue fever at a local hospital and where he was admitted. The fever recurred 2 days after discharge.
H/O burning micturition present.
He also complains of back ache, non radiating, throbbing type
No H/O altered sensorium, vomiting, reduced urine output

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 = 78/min
BP=130/90mmHg
RR = 16/min
TEMPERATURE=afebrile

LAB INVESTIGATION

09-06-2015 : Haemoglobin : 13.3g/dl, Neutrophils : 72%, Lymphocytes : 16%, Eosinophils : 01%, Monocytes : 11%, Basophils : 00%, **Other Cells** Method : Manual NIL, Leukocyte Count Total : 15200/cumm, Erythrocyte Sedimentation Rate : 74mm/1st hour, Packed Cell Volume : 39.2%, Platelet Count : 535000/cumm, **Peripheral Smear Report No** H/3606/15, **Impression** : Normocytic

12-06-2015 : Haemoglobin : 13.2g/dl, Platelet Count : 544000/cumm, Packed Cell Volume : 40.2%,

13-06-2015 : Haemoglobin : 13.8g/dl, Platelet Count : 567000/cumm, Packed Cell Volume : 42.0%,

14-06-2015 : Haemoglobin : 13.7g/dl, Platelet Count : 555000/cumm, Packed Cell Volume : 41.1%,

TREATMENT
IV Fluids
T.Calpol 500mg 1-0-1
T.Cyra 20mg 1-0-0 B/F