CHIEF COMPLAINTS
FEVER-5 DAYS
HEADACHE & BODYACHE - 5 DAYS

HISTORY OF PRESENTING ILLNESS
Patient developed fever which was insidious in onset,intermittent,moderate grade fever subsides on medication.Fever was associated with chills.Patient also complaints of headache & bodyache.
No c/o cough, burning micturition
No c/o pain abdomen,loose stools

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 -78bpm
BP 110/70 mmhg
RR-16
TEMPERATURE -Afebrile

HAEMOGLOBIN	:	15.9g/dl [14_18g/dl]
LEUKOCYTE COUNT TOTAL	:	2400/cumm [4000_11000/cumm]
PACKED CELL VOLUME	:	47.3% [40_54%]
PLATELET COUNT	:	70000/cumm [150000_500000/cumm]
HAEMOGLOBIN	:	15.4g/dl [14_18g/dl]
PACKED CELL VOLUME	:	46.0% [40_54%]
PLATELET COUNT	:	75000/cumm [150000_500000/cumm]
28-10-2014		
HAEMOGLOBIN	:	15.9g/dl [14_18g/dl]
PACKED CELL VOLUME	:	46.5% [40_54%]
PLATELET COUNT	:	66000/cumm [150000_500000/cumm]

TREATMENT
T.Dolo 650 mg 1-1-1
T.Magpep 40 mg 1-0-0
Inj.Mocef 1 gm IV
IVF NS/DNS at 125 ml/hr