

CHIEF COMPLAINTS

Fever since 4 days
Headache and bodyache since 1 day

HISTORY OF PRESENTING ILLNESS

patient was apparently normal 4 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 headache, throbbing type, present over the frontal region.

patient also complains of generalized weakness.

no h/o abdominal pain /vomitting

no h/o cough / breathlessness

no h/o burning micturition / hematuria

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:90bpm

BP :120/80mmhg

RR:20/min

TEMPERATURE:99F

14-06-2015 : Haemoglobin : 11.3g/dl, Platelet Count : 69000/cumm, Packed Cell Volume : 34.4%, Plasma Glucose Fasting : 83mg/dl, Serum Urea : 14mg/dl, Serum Creatinine : 0.70mg/dl, Serum Sodium : 139mEq/L, Serum Potassium : 4.02mEq/L, Serum Chloride : 103.8mEq/L, Serum Total Protein : 5.86g/dl, Serum Albumin : 2.96g/dl, Serum Globulin : 2.9g/dl, Serum Total Bilirubin : 0.42mg/dl, Serum Conjugated Bilirubin : 0.26mg/dl, Serum Unconjugated-Bilirubin : 0.16mg/dl, Serum Ast (Sgot) : 312IU/L, Serum Alt (Sgpt) : 115IU/L, Serum Alkaline Phosphatase : 112IU/L, Serum A/G Ratio : 1.0units,
15-06-2015 : Haemoglobin : 10.9g/dl, Packed Cell Volume : 33.6%, Platelet Count : 105000/cumm,

TREATMENT

T.Calpqi 500mg 1-1-1

Inj Pan 40mg IV stat and (b/f) 1-0-0

Inj Emeset 4mg IV Q 8h

IVF NS @ 100ml/hr