HISTORY OF PRESENTING ILLNESS
Patient c/o fever since 3 days, high grade associated with chills and rigors.
H/o loose stools since 1 day, watery, 3-4 episodes per day
No h/o vomiting
No h/o abdominal pain
No h/o burning micturition

PAST HISTORY
Patient is a native of germany came to india 3 months back.
No h/o malaria in the past
No h/o malaria prophylaxis
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:80bpm
BP:110/70mmhg
RR:18/min
TEMPERATURE:98.6F

HAEMOGLOBIN	:	10.9g/dl [12_15g/dl]
PACKED CELL VOLUME	:	33.4% [36_47%]
PLATELET COUNT	:	178000/cumm [150000_500000/cumm]
06-11-2014		
HAEMOGLOBIN	:	10.7g/dl [12_15g/dl]
PACKED CELL VOLUME	:	33.1% [36_47%]
PLATELET COUNT	:	181000/cumm [150000_500000/cumm]
07-11-2014		
HAEMOGLOBIN	:	10.7g/dl [12_15g/dl]
PACKED CELL VOLUME	:	33.0% [36_47%]
PLATELET COUNT	:	185000/cumm [150000_500000/cumm]

TREATMENT
T.DOLO 650MG 1-1-1
T.RANTAC 150MG 1-0-1
IVF DNS@100ML/HR
T.CYCLOPAM 1 SOS
INJ.EMESET 4MG IV SOS
T.ORNILOX 1-0-1
C.BECELAC 1-1-1