COMPLAINTS: FEVER - 3 DAYS BODY ACHE - 3 DAYS

HISTORY OF PRESENTING ILLNESS:
PATIENT WAS APPARENTLY NORMAL 3 DAYS BACK WHEN HE DEVELOPED FEVER, HIGH GRADE, INTERMITTENT IT WAS
ASSOCIATED WITH CHILLS.
HE ALSO C/O GENERALISED BODY ACHE AND HEADACHE.
NO H/O VOMITING
NO H/O LOOSE STOOLS
NO H/O ANY URINARY SYMPTOMS

PAST HISTORY:

K/C/O HTN ON TAB. AMLODAC 5 MG 1-0-0, PAST H/O ALCOHOL CONSUMPTION PRESENT NO H/O DM. IHD

FAMILY HISTORY: NOTHING SIGNIFICANT

PERSONAL HISTORY: SLEEP - NORMAL, APPETITE - NORMAL, DIET - MIXED, BOWEL and BLADDER - REGULAR

GENERAL EXAMINATION:

PR- 80 bpm, BP- 120/70 mmHg, TEMP - 98.6F, RR-18 CYCLES / MIN. PATIENT WAS CONSCIOUS, COOPERATIVE, WELL ORIENTED WITH TIME, PLACE AND PERSON MODERATELY BUILT AND NOURISHED PALLOR, ICTERUS, CYANOSIS, CLUBBING, LYMPHADENOPATHY, EDEMA ABSENT

16-05-2015 : Haemoglobin : 13.9g/dl, Leukocyte Count Total : 3700/cumm, Mchc : 34.2g/dl, Mch : 29.2pg, Mcv : 85.4fl, Packed Cell Volume : 40.6%, Platelet Count : 83000/cumm, Red Blood

2.3units, Haemoglobin: 14.6g/dl, Packed Cell Volume: 43.7%. Platelet Count: 77000/cumm 17-05-2015: Haemoglobin: 14.9g/dl, Packed Cell Volume: 44.5%, Platelet Count: 60000/cumm,

18-05-2015 : Haemoglobin : 15.6g/dl, Packed Cell Volume : 46.4%, Platelet Count :

51000/cumm, Serum Urea: 18mg/dl, Serum Creatinine: 1.31mg/dl, Serum Sodium: 139mEq/L,

Serum Potassium: 3.95mEq/L, Serum Chloride: 96.9mEq/L,

19-05-2015: Haemoglobin: 14.3g/dl, Platelet Count: 40000/cumm, Packed Cell Volume: 42.0%,

CHEST XRAY: NORMAL

TREATMENT:
TAB. DOLO 650 MG SOS
TAB. TIM 100 MG 1-1-1
TAB. OPTINEURON 0-1-0
TAB. PAN 40 MG 1-0-0
TAB. AMLONG 5 MG 1-0-0
INJ. EMESET 4 MG IV STAT