CHIEF COMPLAINTS

fever since 5 days

headache, bodyache and malaise since 5 days

HISTORY OF PRESENTING ILLNESS Patient was apparently normal 5 days ago when he developed fever ,high grade associated with chills and rigors,no night sweats

No history of diurnal variation

No history of cough/breathelessness

No history of rashes

No history of bleeding tendencies

No history of decreased urine output/burning micturition

No history of altered sensorium

Also complaints of headache, bodyache and malaise since 5 days

## PAST HISTORY

No history of similar complaints in the past

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 conscious and cooperative, well oriented to time, place and person. Moderately built and nourished. No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema PULSE -80/min BP-120/80mmHg RR - 16cpm TEMPERATURE -98.6F

15-02-2015: Haemoglobin: 16.4g/dl,

Packed Cell Volume: 49.3%,

Erythrocyte Sedimentation Rate : 02mm/1st hour, Packed Cell Volume : 48.3%, Platelet

Count : 56000/cumm, Serum Urea : 30mg/dl, Serum Creatinine : 0.94mg/dl, Dengue

16-02-2015: Haemoglobin: 16.3g/dl, Platelet Count: 140000/cumm, Packed Cell Volume

17-02-2015: Haemoglobin: 13.5g/dl, Packed Cell Volume: 40.7%, Platelet Count: 12000/cumm, Haemoglobin: 16.5g/dl, Packed Cell Volume: 49.3%, Platelet Count: 10000/cumm, Abo Grouping & Typing TEST RESULT A1 Rh(D) POSITIVE, Whole Blood

TREATMENT
T.DOLO 650MG 1-1-1
T.PAN 40MG 1-0-0
T.OPTINEURON 0-1-0
IVF NS at 75ml/hr
T.CALPOL 500MG 1-1-1
SYP SUCRAFIL 2TSP TID
INJ DECADRON 8MG 06H