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KASAPAGU

DIAGNOSIS
DENGUE FEVER WITH THROMBOCYPENIA

CHIEF COMPLAINTS
Fever since 3 days
Vomiting since 4 days

HISTORY OF PRESENTING ILLNESS
patient was apparently normal 3 days back when he developed fever which was sudden in onset , high grade type .
intermittent in nature , gradually progressive. Associated with chills,fever was present throughout the day,he gives a h/o
vomiting 4-5 episodes/day.
no h/o bleeding tendencies
no h/o abdominal pain
no h/o cough / breathlessness
no h/o burning micturition / hematuria

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 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

SYSTEMIC EXAMINATION
RS: Trachea central, accessory muscles not in use, chest movements are bilaterally symmetrical, VF and VR appear bilaterally equal, VS +. No added sounds
CVS: No precordial bulge, JVP not elevated, apex beat palpable in left 5th ICS 1/2 inch medial to MCL. Cardiac borders percussed WNL. S1 and S2 heard. No murmurs
P/A: Soft, non tender, no guarding, no distension, No palpable mass / organomegaly. Bowel sounds heard.

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