

#### CHIEF COMPLAINTS

Fever since 1 week

Generalised weakness since 1 week

Headache since 1 week

#### HISTORY OF PRESENTING ILLNESS :

Patient was apparently normal 1 week back when she developed fever which was insidious in onset, intermittent, gradually progressive, high grade associated with chills and rigors

she also complains of headache, body ache and generalised weakness with easy fatigability

No complaints of bleeding manifestations

No complaints of pain abdomen, vomiting, loose stools

No complaints of cough with expectoration

No complaints of burning micturition

#### 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: reduced. Sleep: Adequate. Bowel : regular and Bladder: Regular.

no h/o alcohol consumption, no smoking history .

#### GENERAL EXAMINATION

Patient is moderately built and nourished.

No pallor, icterus, cyanosis, clubbing, lymphadenopathy or oedema

PULSE:64bpm

BP:120/80mmhg

RR:18cycles/min

TEMPERATURE:98.6f

**10-06-2015 :** Haemoglobin : 13.4g/dl, Packed Cell Volume : 40.1%, Platelet Count : 109000/cumm, Serum Total Protein : 5.88g/dl, Serum Albumin : 3.42g/dl, Serum Globulin : 2.5g/dl. Serum Total Bilirubin : 0.30mg/dl, Serum ALT : 20mg/dl,

**11-06-2015 :** Haemoglobin : 13.7g/dl, Packed Cell Volume : 40.9%, Platelet Count : 127000/cumm,

ECG showed : features of left bundle branch block.

#### TREATMENT:

IVF NS/DNS @ 75ml/hr

T.Calpol 500mg 1-1-1

T.Pan 40mg 1-0-0

T.Optineuron 0-1-0

T.Cetirizine 10mg 0-0-1