(Patient Summary Report)

Patient Name: Rahul Sharma
Age: 32
Gender: Male
Patient ID: PT-45827
Date of Visit: 11 Dec 2025
Consultant: Dr. Meera Kapoor (MBBS, MD – General Medicine)

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1. Chief Complaints

- Fever for 3 days
- Headache
- Mild throat irritation
- Generalized weakness

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2. History of Present Illness

The patient reports a gradual onset of fever over the past three days, with temperatures ranging between 100–101°F. He also experiences intermittent headaches and mild throat irritation. No history of vomiting, chest pain, diarrhea, or respiratory distress.

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3. Past Medical History

- No known chronic illnesses
- No history of diabetes or hypertension
- No known drug allergies
- Non-smoker, occasional alcohol consumption

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4. Physical Examination

Parameter	Value
Temperature	101.2°F
Pulse Rate	92 bpm
Blood Pressure	118/76 mmHg
Respiratory Rate	18 breaths/min
Oxygen Saturation (SpO_2)	97%

General appearance: Mildly weak but conscious and oriented.
Chest: Clear breath sounds, no wheezing or crackles.
Throat: Mild redness, no pus deposits.

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5. Investigations Requested

- Complete Blood Count (CBC)
- C-Reactive Protein (CRP)
- Rapid Antigen Test for Viral Infection
- Throat Swab Culture (if symptoms persist)

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6. Diagnosis

Probable Viral Upper Respiratory Infection (Viral Fever)

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7. Treatment Plan

- Paracetamol 650 mg — *1 tablet every 8 hours as needed for fever*
- Cetirizine 10 mg — *1 tablet at night for throat irritation*
- Oral Rehydration and increased fluid intake
- Steam inhalation twice a day
- Avoid cold foods/drinks
- Rest for 2–3 days

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8. Follow-Up

Patient advised to return if:

- Fever persists beyond 72 hours
- Breathing difficulty occurs
- Symptoms worsen
  Next follow-up scheduled in **3 days**.

Doctor's Signature:

Dr. Meera Kapoor
Reg No: MP-10234