Sample Type / Medical Specialty: General Medicine

Sample Name: Gen Med SOAP - 7
Description: One-month followup for unintentional weight loss, depression, paranoia, dementia, and osteoarthritis of knees. Doing well.

(Medical Transcription Sample Report)

CHIEF COMPLAINT: One-month followup.

HISTORY OF PRESENT ILLNESS: The patient is an 88-year-old Caucasian female. She comes here today with a friend. The patient has no complaints. She states she has been feeling well. Her knees are not hurting her at all anymore and she is not needing Bextra any longer. I think the last steroid injection that she had with Dr. XYZ really did help. The patient denies any shortness of breath or cough. Has no nausea, vomiting, abdominal pain. No diarrhea or constipation. She states her appetite is good. She clears her plate at noon. She has had no fevers, chills, or sweats. The friend with her states she is doing very well. Seems to eat excellently at noontime, despite this, the patient continues to lose weight. When I asked her what she eats for breakfast and for supper, she states she really does not eat anything. Her only meal that she eats at the nursing home is the noon meal and then I just do not think she is eating much the rest of the time. She states she is really not hungry the rest of the time except at lunchtime. She denies any fevers, chills, or sweats. We did do some lab work at the last office visit and CBC was essentially normal. Comprehensive metabolic was essentially normal as was of the BUN of 32 and creatinine of 1.3. This is fairly stable for her. Liver enzymes were normal. TSH was normal. Free albumin was normal at 23. She is on different antidepressants and that may be causing some difficulties with unintentional weight loss.

MEDICATIONS: Currently are Aricept 10 mg a day, Prevacid 30 mg a day, Lexapro 10 mg a day, Norvasc 2.5 mg a day, Milk of Magnesia 30 cc daily, and Amanda 10 mg b.i.d.

ALLERGIES: No known drug allergies.

PAST MEDICAL HISTORY: Reviewed from 05/10/2004 and unchanged other than the addition of paranoia, which is much improved on her current medications.

SOCIAL HISTORY: The patient is widow. She is a nonsmoker, nondrinker. She lives at Kansas Christian Home independently, but actually does get a lot of help with medications, having a driver to bring her here, and going to the noon meal.

REVIEW OF SYSTEMS: As above in HPI.

PHYSICAL EXAM:
General: This is a well-developed, pleasant Caucasian female, who appears thinner especially in her face. States are clothes are fitting more loosely.
Vital Signs: Weight: 123, down 5 pounds from last month and down 11 pounds from May 2004. Blood pressure: 128/62. Pulse: 60. Respirations: 20. Temperature: 96.8.
Neck: Supple. Carotids are silent.
Chest: Clear to auscultation.
Cardiovascular: Regular rate and rhythm.
Abdomen: Soft and nontender, nondistended with positive bowel sounds. No organomegaly or masses are appreciated.
Extremities: Free of edema.

ASSESSMENT:
1. Unintentional weight loss. I think this is more a problem of just not