SOAP Note
Patient Name: Robert Thompson
DOB: 04/15/1949 (62 years old)
MRN: 12345678
Date of Visit: October 7, 2011
Provider: Dr. John Smith, MD
Location: Internal Medicine Clinic

Subjective
Chief Complaint:
"Doing alright, but I feel more tired than usual."
History of Present Illness (HPI):
Mr. Robert Thompson, a 62-year-old male with a history of heart failure with reduced ejection fraction (HFrEF, EF 30%), coronary artery disease (CAD) with prior MI, atrial fibrillation on chronic anticoagulation, hypertension, type 2 diabetes, and CKD stage 3, presents for his annual follow-up.
He reports feeling more fatigued over the past month, especially with mild activities like walking to the mailbox. He denies worsening dyspnea, orthopnea, or paroxysmal nocturnal dyspnea (PND) but notes that he has reduced his physical activity due to tiredness. He has been adherent to medications and diet, but he acknowledges he sometimes skips his midday diuretic if he is out running errands.
There are no episodes of chest pain, dizziness, palpitations, syncope, or significant edema. His weight has remained stable, and there is no significant change in urinary output.
Diabetes remains stable—he denies polyuria, polydipsia, or recent hypoglycemia.
Review of Systems (ROS):
- **General**: Mild increase in fatigue, no recent weight changes
- **Cardiac**: No new chest pain, no palpitations, no syncope
- **Pulmonary**: No dyspnea at rest, no cough
- **GI**: No nausea, vomiting, or abdominal pain
- **GU**: No hematuria or dysuria
- **Neuro**: No focal deficits, but reports increased tiredness

Objective
Vital Signs
- Blood Pressure: 138/84 mmHg
- **Heart Rate**: 76 bpm, irregularly irregular
- Respiratory Rate: 16 breaths/min
- Oxygen Saturation: 97% on room air
- **Weight**: 200 lbs (no significant changes)

General
- Well-appearing, no acute distress

Cardiovascular
- Irregularly irregular rhythm
- No JVD
- No significant edema

Pulmonary
- Clear breath sounds bilaterally, no crackles or wheezing

Extremities
- No significant edema

Neurologic
- Alert and oriented, no focal deficits

Recent Lab Results (from Sept 30, 2011)
- **BNP**: 315 pg/mL (slightly increased from 290 a year ago)
- Creatinine: 2.0 mg/dL (slight worsening, prior 1.9)
- **BUN**: 38 mg/dL

- **K+**: 4.7 mmol/L
- **Na+**: 135 mmol/L
- **Hgb A1c**: 8.5% (slightly improved, prior 8.7%)
- **INR**: 2.2 (therapeutic)

Imaging:

- Echocardiogram (done last month, Sept 10, 2011): EF remains at 30%, no significant valvular disease

Assessment & Plan

Primary Diagnosis:

1. Heart Failure with Reduced Ejection Fraction (HFrEF), stable but with mild worsening fatigue
   - Slight increase in fatigue but no signs of volume overload
   - BNP slightly increased (315 pg/mL vs. 290 last year)
   - Creatinine slightly worsened (2.0 mg/dL vs. 1.9 last year)
   - Recent echocardiogram shows stable EF at 30%
   - Plan:
     - Continue furosemide 40 mg daily (emphasize strict adherence)
     - Continue **lisinopril 5 mg daily** (monitor renal function)
     - Continue metoprolol succinate 50 mg daily
     - Monitor symptoms closely, follow up sooner if fatigue worsens
     - Repeat BNP in 3 months
     - Consider referral for **cardiac rehab**
2. Atrial Fibrillation, stable on warfarin
   - No reported palpitations, dizziness, or syncope
   - INR in target range (2.2)
   - **Plan:** Continue **warfarin 5 mg daily**, repeat INR in 2 weeks
3. Hypertension, stable
   - BP controlled at 138/84 mmHg
   - Plan: Continue lisinopril 5 mg daily
4. Chronic Kidney Disease (CKD) Stage 3, stable but slight worsening of creatinine
   - Creatinine increased slightly (2.0 vs. 1.9 last year)
   - **Plan:** Continue monitoring renal function, avoid nephrotoxic medications
5. Type 2 Diabetes Mellitus, mild improvement in control but still suboptimal
   - A1c improved (now 8.5%)
   - No recent hypoglycemia
   - Plan:
     - Continue insulin glargine 20 units at bedtime
     - Continue insulin aspart sliding scale
     - Reinforce dietary advice
6. Hyperlipidemia, stable
   - Plan: Continue atorvastatin 40 mg nightly

Patient Instructions & Follow-Up

✔ Continue all prescribed medications as discussed
✔ Strict adherence to diuretic therapy
✔ Daily weight monitoring for signs of fluid retention
✔ Follow-up:

- INR check in 2 weeks
- Repeat BNP in 3 months
- Annual visit in 6 months unless symptoms worsen
- Consider referral for cardiac rehab next visit

Patient voices understanding of plan and has no urgent concerns today.

Signed,
Dr. John Smith, MD
October 7, 2011