SOAP Note
Patient Name: Robert Thompson
MRN: 12345678
Provider: Dr. John Smith, MD
Location: Internal Medicine Clinic

Subjective
Chief Complaint:
“I’ve been feeling better, but I still get a little short of breath when walking.”
History of Present Illness (HPI):
Mr. Robert Thompson is a 61-year-old male with heart failure (HFrEF), CAD with prior MI, atrial fibrillation on anticoagulation, hypertension, type 2 diabetes, and CKD stage 3, presenting for routine follow-up after his hospital discharge for acute decompensated heart failure on June 18, 2010.
Since discharge, he reports mild persistent dyspnea on exertion, but denies worsening orthopnea or paroxysmal nocturnal dyspnea (PND). He has been weighing himself daily and notes a 2-3 lb weight fluctuation but no significant gain. He adheres to his low-sodium diet and fluid restriction, though he acknowledges that it's been challenging.
He **denies chest pain, palpitations, dizziness, or syncope**. He remains compliant with his medications but occasionally forgets his **midday furosemide dose** when he is out of the house. He **denies leg swelling, cough, or fever**. No signs of **excessive bleeding or bruising** on warfarin.
Diabetes symptoms are stable; he **denies polyuria or polydipsia**. No recent episodes of hypoglycemia.

Objective
Vital Signs
- Blood Pressure: 144/88 mmHg
- **Heart Rate**: 82 bpm (irregularly irregular)
- Respiratory Rate: 16 breaths/min
- Oxygen Saturation: 96% on room air
- **Weight**: 202 lbs (down 5 lbs since discharge)

General
- Well-appearing, no acute distress

Cardiovascular
- Irregularly irregular rhythm, no murmurs, no rubs
- No JVD
- Trace pitting edema bilaterally (improved from hospitalization)

Pulmonary
- Clear breath sounds **bilaterally**, no crackles or wheezing

Extremities
- No cyanosis, clubbing, or significant edema

Neurologic
- No focal deficits

Recent Lab Results
- **BNP**: 320 pg/mL (down from 980 during admission)
- **Creatinine**: 1.8 mg/dL (improved from 2.1 during hospitalization)
- **BUN**: 35 mg/dL
- **K+**: 4.6 mmol/L
- **Na+**: 137 mmol/L
- **Hgb A1c**: 8.9% (previously 9.2%)
- **INR**: 2.3 (therapeutic)

Assessment & Plan
Primary Diagnosis:

1. Heart Failure with Reduced Ejection Fraction (HFrEF), stable post-hospitalization
   - Symptoms improving, mild residual exertional dyspnea
   - BNP improved, weight stable
   - Plan:
     - Continue **furosemide 40 mg daily** (encourage adherence)
     - Continue **lisinopril 5 mg daily** (monitor renal function)
     - Continue metoprolol succinate 50 mg daily
     - Reinforce sodium restriction (<2g/day) and fluid restriction (1.5-2L/day)
2. Atrial Fibrillation, stable on chronic anticoagulation
   - No syncope, dizziness, palpitations
   - INR stable at 2.3
   - **Plan**: Continue **warfarin 5 mg daily**; repeat INR in one week
3. Hypertension, mildly elevated today
   - BP 144/88 mmHg, but lower than at discharge
   - Plan:
     - Continue lisinopril 5 mg daily
     - Encourage strict sodium restriction
     - Reassess in 4 weeks
4. Chronic Kidney Disease (CKD) Stage 3, stable
   - Creatinine stable at 1.8 mg/dL
   - **Plan**: Continue routine monitoring, avoid NSAIDs
5. Type 2 Diabetes Mellitus, improving but still suboptimal control
   - A1c improved from 9.2% → 8.9%
   - Plan:
     - Continue insulin glargine 20 units at bedtime
     - Continue insulin aspart sliding scale
     - Dietary counseling with nutritionist
6. Hyperlipidemia, stable
   - Continue atorvastatin 40 mg nightly

Patient Instructions & Follow-Up
- Continue all prescribed medications as discussed
- **Daily weight monitoring**: Call if weight increases by **>3 lbs in a day**
- Strict low-sodium diet
- Follow-up INR check in one week
- Return to clinic in four weeks for routine follow-up

Patient understands and agrees with the plan. No urgent concerns today.

Signed,
Dr. John Smith, MD