**SOAP Note Template**

**Encounter date**: 10/30/2023

**Patient Initials:** J.S. **Gender:** M **Age:** 45 **Race:** Caucasian **Ethnicity:** Non-Hispanic

**Reason for Seeking Health Care:** Mr. J.S. presents with a chief complaint of recurrent abdominal pain and digestive issues.

**HPI:**

Mr. J.S. is a 45-year-old male who has been experiencing recurrent abdominal pain and digestive issues for the past six months. He describes the pain as a dull, cramp-like sensation located in the lower abdomen, which is aggravated by eating, especially fatty foods. He reports associated symptoms such as bloating, belching, and occasional diarrhea. These symptoms have been affecting his daily life and causing significant discomfort. He has tried over-the-counter antacids with minimal relief but has not sought medical attention until now. The pain is intermittent but tends to worsen after meals and can last for several hours.

**Allergies(Drug/Food/Latex/Environmental/Herbal):** No known allergies.

**Current perception of Health**: Fair

**Past Medical History:**

* Major/Chronic Illnesses: Mr. J.S. has a history of hypertension, which is well-controlled with medication.
* Trauma/Injury: No recent history of trauma or injury.
* Hospitalizations: He had a brief hospitalization three years ago for pneumonia, which was treated successfully.

**Past Surgical History:** Mr. J.S. had an appendectomy during childhood and had his tonsils removed in his early twenties.

**Medications:**

* Lisinopril 10 mg daily for hypertension.
* Over-the-counter antacids as needed for indigestion.

**Family History**: Mr. J.S. has a family history of cardiovascular disease, with both his parents having a history of hypertension and his father experiencing a heart attack in his late 50s.

**Social history**:

**Lives:** Single-family House with stairs **Marital Status:** Single

**Employment Status:** Employed **Current/Previous occupation type:** Software Engineer

**Exposure to: Smoke:** No **ETOH (Alcohol):** Occasional social drinker **Recreational Drug Use:** No

**Sexual orientation**: Heterosexual **Sexual Activity**: Active **Contraception Use:** Barrier methods (condoms)

**Family Composition:** Lives alone

**Health Maintenance:**

**Screening Tests:**

* Mammogram: Not applicable (Male)
* PSA (Prostate-Specific Antigen): Not applicable (Male)
* Colonoscopy: Not yet, not due for screening
* Pap Smear: Not applicable (Male)

**Exposures**: No significant exposures reported

**Immunization HX:** Up-to-date on routine vaccinations, including flu shot and tetanus booster.

**Review of Systems:**

General: The patient presents with a general sense of well-being. No fever, chills, or unintentional weight loss is reported. There are no signs of acute distress, and the patient's energy levels are within the expected range for their age and lifestyle.

HEENT (Head, Eyes, Ears, Nose, Throat): The head is normocephalic and atraumatic. The patient reports no recent headaches or head injuries. There is no evidence of visual disturbances or blurred vision. The ears, nose, and throat are free from discharge, pain, or discomfort. No recent issues with hearing loss, tinnitus, or sinus congestion are reported.

Neck: No complaints of neck pain or stiffness. No enlarged lymph nodes or masses are palpable. Full range of motion is observed without discomfort.

Lungs: The patient denies any cough, shortness of breath, or chest pain. No wheezing or crackles are auscultated during lung examination, suggesting normal respiratory function.

Cardiovascular: No complaints of chest pain, palpitations, or shortness of breath. There is no history of heart disease in the family. Blood pressure is well-controlled with medication, as mentioned in the previous note.

Breast: The patient does not report any breast lumps, pain, or nipple discharge. There is no personal or family history of breast cancer.

GI (Gastrointestinal): The patient reports abdominal discomfort related to the chief complaint. No recent changes in bowel habits, such as diarrhea or constipation, are noted. There are no signs of gastrointestinal bleeding or melena.

Male/Female Genital: For males, there are no issues with the testicles, scrotum, or penile abnormalities. No history of erectile dysfunction or sexual dysfunction. For females, no specific concerns regarding vaginal health, menstrual abnormalities, or vaginal discharge are mentioned. The patient is using barrier contraception for safe sex practices.

GU (Genitourinary): No urinary frequency, urgency, or dysuria. No hematuria or flank pain. The patient denies any history of kidney stones or urinary tract infections.

Neuro: No history of seizures, syncope, or altered mental status. The patient is alert and oriented. There are no focal neurological deficits or signs of neuropathy.

Musculoskeletal: No joint pain, stiffness, or swelling is reported. No history of arthritis or musculoskeletal injuries. The patient has good mobility and can perform daily activities without difficulty.

Activity & Exercise: The patient maintains an active lifestyle, engaging in regular physical exercise to stay healthy. No complaints of exercise-related injuries or limitations are mentioned.

Psychosocial: Mental health appears stable. No symptoms of anxiety, depression, or other psychiatric concerns are reported. The patient maintains a support system and copes well with life stressors.

Derm: No rashes, itching, or skin abnormalities are reported. The skin is intact without any suspicious lesions or moles. The patient practices sun safety measures.

Nutrition: The patient has a balanced diet and is mindful of their nutritional intake. No specific dietary restrictions or concerns are raised. The patient stays hydrated and follows a well-rounded meal plan.

Sleep/Rest: The patient reports getting adequate sleep, with no complaints of insomnia or excessive daytime sleepiness. Sleep patterns appear regular.

LMP (Last Menstrual Period): Not applicable (Male).

STI Hx (Sexually Transmitted Infections History): The patient reports no known history of sexually transmitted infections. Consistent safe sex practices are followed, as evidenced by barrier contraception use.

**Physical Exam**

**BP:** 124/80 mm Hg **TPR (Temperature, Pulse, Respiratory rate): Temp:** 98.6°F, **HR:** 72 bpm, **RR:** 16 breaths/min **Ht:** 5 feet 10 inches, **Wt:** 175 lbs **BMI (percentile):** BMI of 25.1, falls within the healthy weight range

General: The patient presents as well-nourished, in no acute distress, and with appropriate grooming and hygiene. There are no signs of pallor, cyanosis, or jaundice. The overall appearance is consistent with the patient's reported age and stated general health status.

HEENT:

* Head: The head is normocephalic and atraumatic, with no tenderness or palpable abnormalities.
* Eyes: Pupils are equal, round, and reactive to light. Extraocular movements are intact, and there are no signs of nystagmus or ptosis.
* Ears: Both ears are symmetrical and without discharge, erythema, or pain.
* Nose: The nasal mucosa is pink and moist. There are no signs of epistaxis or congestion.
* Throat: The oropharynx is clear, and the tonsils are not enlarged. No exudate or masses are observed.

Neck: The neck is supple with full range of motion. No masses, lymphadenopathy, or jugular vein distension are noted. There is no tenderness or pain upon palpation.

Pulmonary: Respirations are unlabored, with normal breath sounds on auscultation. No wheezing or crackles are heard, indicating normal lung function.

Cardiovascular: Heart sounds are regular, with no murmurs, gallops, or rubs. Capillary refill time is less than 2 seconds. No edema or peripheral cyanosis is observed in the extremities. The patient has a well-controlled blood pressure of 124/80 mm Hg, consistent with previous records.

Breast: The patient reports no breast lumps, and on examination, there are no palpable masses or tenderness in the breast tissue.

GI (Gastrointestinal): Abdominal examination reveals mild tenderness in the lower quadrants, which is consistent with the patient's reported abdominal discomfort. No masses, organomegaly, or signs of peritoneal irritation are noted. Bowel sounds are normal, and there are no signs of gastrointestinal bleeding or hernias.

Male/Female Genital: For males, the testicles and scrotum appear normal without abnormalities. No signs of penile lesions or abnormalities. For females, no specific vaginal concerns are reported, and examination is not indicated.

GU (Genitourinary): No costovertebral angle tenderness, suggesting no renal involvement. No palpable bladder distension. The patient reports no urinary symptoms.

Neuro: The patient is alert and oriented to person, place, and time. Cranial nerves appear intact, and no focal neurological deficits are observed.

Musculoskeletal: The patient has full range of motion in all major joints without pain, swelling, or deformities. Muscle strength is normal in both upper and lower extremities. There are no signs of joint inflammation or muscle weakness.

Derm: The skin is intact with no rashes, itching, or suspicious lesions. The patient practices sun safety measures, and there are no signs of excessive sun exposure.

Psychosocial: The patient exhibits stable mental health with no apparent symptoms of anxiety, depression, or other psychiatric concerns. There are no immediate psychosocial stressors reported.

Miscellaneous:

* The patient has a well-balanced diet and maintains an active lifestyle.
* The patient is up-to-date on routine vaccinations and follows safe sex practices with the use of barrier contraception.
* No issues with sleep patterns or disturbances are reported.

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| Significant Data/Contributing Dx/Labs/Misc.   1. Abdominal Tenderness: The presence of mild tenderness in the lower abdominal quadrants during the physical examination contributes to the diagnosis and workup of the patient's recurrent abdominal pain and digestive symptoms, which may indicate gastrointestinal issues such as gastritis, peptic ulcer disease, or irritable bowel syndrome. 2. Blood Pressure (BP): The patient's well-controlled blood pressure of 124/80 mm Hg is significant, as hypertension is a chronic condition requiring ongoing management with Lisinopril. Maintaining optimal blood pressure control is crucial for reducing the risk of cardiovascular events and ensuring the patient's overall health. 3. BMI (Body Mass Index): The patient's BMI of 25.1 falls within the healthy weight range. This information is essential for assessing the patient's nutritional status and overall health. A healthy BMI is associated with a lower risk of chronic health conditions. 4. Medications: The patient's current use of Lisinopril for hypertension and over-the-counter antacids for indigestion is significant in understanding the patient's medication regimen and potential interactions. 5. Lifestyle Factors: The patient's reported active lifestyle and balanced diet, as well as the absence of tobacco or recreational drug use, are important for assessing the patient's overall health and well-being. These factors contribute to a positive health profile. 6. Family History: The family history of cardiovascular disease, including hypertension and a father who experienced a heart attack, is significant in assessing the patient's risk factors and may influence the treatment and prevention plan. 7. Barrier Contraception: The patient's use of barrier contraception (condoms) is relevant to their sexual history and safety practices, ensuring protection against sexually transmitted infections (STIs) and unwanted pregnancies. 8. Abdominal Examination: The physical examination findings of abdominal tenderness and associated symptoms are vital for contributing to the differential diagnosis and assessment of the patient's gastrointestinal concerns. 9. Previous Hospitalization: The patient's history of hospitalization for pneumonia three years ago is relevant, as it provides information about the patient's past medical experiences and possible predispositions to certain health conditions. 10. Psychosocial Well-being: The patient's stable mental health and ability to cope with stressors are important considerations for their overall well-being and may influence their response to treatment and follow-up care. |

**Plan:**

**Differential Diagnoses:**

1. **Gastroesophageal Reflux Disease (GERD):** The patient's recurrent abdominal pain, aggravated by fatty foods and associated symptoms like belching and occasional diarrhea, could be indicative of GERD, a condition where stomach acid flows back into the esophagus, causing irritation and discomfort (Antunes & Curtis, 2019).
2. **Irritable Bowel Syndrome (IBS):** The patient's abdominal pain and digestive issues may be attributed to IBS, a functional gastrointestinal disorder characterized by abdominal discomfort, bloating, and changes in bowel habits (National Institute of Diabetes and Digestive and Kidney Diseases, 2019).
3. **Peptic Ulcer Disease**: Peptic ulcers, which are open sores in the lining of the stomach or duodenum, may present with abdominal pain, especially after eating, and can be associated with symptoms like belching (Malik et al., 2023). This should be considered given the patient's symptoms.

**Principal Diagnoses:**

1. **Gastroesophageal Reflux Disease (GERD):** The principal diagnosis is GERD, as it aligns with the patient's chief complaint of recurrent abdominal pain that worsens after eating, particularly with fatty foods (Antunes & Curtis, 2019). GERD is a common condition that can be managed with lifestyle modifications and medication, such as proton pump inhibitors (PPIs).
2. **Hypertension:** While it is not directly related to the patient's chief complaint, hypertension is a principal diagnosis as it is a chronic condition that requires ongoing management with Lisinopril (Iqbal & Jamal, 2022; Mayo Clinic, 2022). Addressing and controlling hypertension is essential to reduce the risk of cardiovascular events and maintain overall health.

**Plan**

**Diagnosis: Gastroesophageal Reflux Disease (GERD)**

**Diagnostic Testing:** The patient will undergo an upper endoscopy to evaluate the extent of esophageal damage and confirm the diagnosis (Antunes & Curtis, 2019). An abdominal ultrasound will be conducted to rule out structural abnormalities or gallbladder issues as contributing factors to the symptoms.

**Pharmacological Treatment:** The patient will be prescribed a proton pump inhibitor (PPI), such as omeprazole, to reduce stomach acid production and alleviate GERD symptoms (Katzung et al., 2021; Whalen, 2018). Over-the-counter antacids will be continued for occasional symptom relief as needed.

**Education:** Lifestyle modifications will be emphasized, including dietary changes such as avoidance of trigger foods (fatty and spicy foods), reducing caffeine and alcohol intake, and consuming smaller, more frequent meals (Katzung et al., 2021; Whalen, 2018). The patient will be advised to elevate the head of the bed to prevent nighttime reflux (Antunes & Curtis, 2019). Discussion about the importance of maintaining a healthy weight to alleviate GERD symptoms will take place.

**Referrals:** The patient will be referred to a gastroenterologist for further evaluation if GERD symptoms persist or worsen.

**Follow-up:** A two-week follow-up appointment will be scheduled to assess the efficacy of the treatment and make necessary adjustments to the patient's GERD management plan.

**Anticipatory Guidance:** The patient will be educated about the importance of medication compliance and adherence to dietary and lifestyle changes (Antunes & Curtis, 2019). Long-term management and periodic follow-up with the healthcare provider will also be discussed.

**Diagnosis: Hypertension**

**Diagnostic Testing:** The patient will continue regular blood pressure monitoring to assess the effectiveness of Lisinopril and ensure blood pressure remains within the target range (Iqbal & Jamal, 2022; Mayo Clinic, 2022).

**Pharmacological Treatment:** The patient will continue with their current medication, Lisinopril 10 mg daily, for blood pressure control (Katzung et al., 2021; Whalen, 2018).

**Education:** Emphasis will be placed on medication adherence, stressing the importance of taking Lisinopril consistently as prescribed (Katzung et al., 2021; Whalen, 2018). The patient will receive guidance on dietary approaches, including a low-sodium diet and adherence to the DASH (Dietary Approaches to Stop Hypertension) diet. Lifestyle modifications will be discussed, highlighting the benefits of regular physical activity, weight management, and stress reduction in blood pressure control (Iqbal & Jamal, 2022; Mayo Clinic, 2022).

**Referrals:** No referrals are necessary at this time, as the patient's hypertension is well-controlled.

**Follow-up:** Routine blood pressure monitoring every 3-6 months will be recommended to ensure blood pressure remains within the target range, with medication adjustments made if necessary.

**Anticipatory Guidance:** The patient will be educated on the importance of continuous blood pressure monitoring and maintaining a healthy lifestyle to prevent cardiovascular complications associated with hypertension.

**Signature (with appropriate credentials): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cite current evidenced based guideline(s) used to guide care (Mandatory)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. For GERD: American College of Gastroenterology (ACG) at <https://gi.org/>
2. For Hypertension: American Heart Association (AHA) at <https://www.heart.org/>

**DEA#: 101010101 STU Clinic LIC# 10000000**

**Tel: (000) 555-1234 FAX: (000) 555-12222**

**Patient Name:** J.S. **Age** 45

**Date:** 10/30/2023

**RX:** Omeprazole 20 mg

**SIG:** Take 1 capsule by mouth daily, 30 minutes before breakfast.

**Dispense:** 30 capsules **Refill:** 2

**No Substitution**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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