SOAP NOTE

Outpatient Clinic Visit — Follow-Up

Patient: JB Age: 40 y/o Sex: Female Date: 03/05/2026 Provider: [Attending Physician]

Visit Type: Follow-up — Lab result review & ongoing fatigue workup

S — SUBJECTIVE

Interval History:

JB returns 1 week after her initial visit for review of laboratory results ordered at that time. She reports that her fatigue has not improved since her last visit and remains present throughout the day. She continues to feel unrefreshed upon waking despite 9–10 hours in bed. She notes mild diffuse muscle aching that she did not specifically mention at the prior visit, which she now recalls has been present for several weeks. She denies palpitations, cold intolerance, or constipation. She has not started any new medications or supplements. No new symptoms of fever, night sweats, chest pain, or shortness of breath. She has continued Sertraline 100 mg daily without any perceived change in mood or energy.

Pertinent ROS Update:

- **Constitutional:** Continued fatigue and low energy. Denies fever, chills, or night sweats. No further weight change.
- **Musculoskeletal:** New report of diffuse mild myalgia, present for several weeks.
- **Thyroid:** Denies cold intolerance, hair thinning, constipation, or dry skin.
- **Cardiovascular:** Denies palpitations, chest pain, or lower extremity edema.
- **Psychiatric:** Denies depressed mood, anhedonia, or anxiety. Reports mood is at baseline.
- **Sleep:** Unrefreshing sleep persists. Husband confirms continued loud snoring.

Past Medical History:

GERD, Depression (in remission).

Medications:

Ranitidine 150 mg PO QHS, Sertraline 100 mg PO daily, Calcium 600 mg PO BID.

O — OBJECTIVE

Vital Signs:

T 98.1°F | HR 72 reg | RR 14 | BP 138/84 mmHg | Wt 195 lbs | BMI ~30 kg/m²

General:

JB appears tired but is in no acute distress. Affect is appropriate.

Physical Examination (Focused):

- **Skin:** Mildly dry texture noted on forearms bilaterally. No pallor, jaundice, or rashes.
- **Neck:** Mild, diffuse, non-tender thyroid enlargement palpated. No discrete nodules. No bruit.
- **Cardiovascular:** RRR. 2/6 systolic ejection murmur at LLSB — unchanged from prior visit. No S3 or S4.

• **Neurologic:** Delayed relaxation phase of deep tendon reflexes (DTRs) at bilateral ankle jerks — noted on repeat testing.

• **Extremities:** Trace pedal edema bilaterally. 2+ pulses.

Laboratory Results (from 02/26/2026):

• **TSH:** 9.8 mIU/L (Reference: 0.4–4.0 mIU/L) — **ELEVATED**

• **Free T4:** 0.6 ng/dL (Reference: 0.8–1.8 ng/dL) — **LOW**

• **CBC:** Hgb 11.8 g/dL (mild normocytic anemia); WBC and platelets within normal limits.

• **Serum Potassium (K+):** 4.1 mEq/L — within normal limits.

• **Blood Cultures ×2:** No growth at 5 days — negative.

A — ASSESSMENT

Problem: Progressive fatigue × 3 months, now with lab-confirmed primary hypothyroidism and mild normocytic anemia.

Assessment & Clinical Reasoning:

• **Primary Hypothyroidism (confirmed):** Elevated TSH (9.8) and low Free T4 confirm overt primary hypothyroidism. This explains the fatigue, weight gain, myalgia, dry skin, and mildly enlarged thyroid. Delayed DTR relaxation further supports the diagnosis. Levothyroxine therapy to be initiated.

• **Mild Normocytic Anemia:** Hgb 11.8 g/dL with normocytic indices is likely related to hypothyroidism itself, which can suppress erythropoiesis. Iron-deficiency from menstrual losses remains a co-contributor; iron studies (serum iron, TIBC, ferritin) to be ordered to differentiate.

• **Hypokalemia:** Ruled out — K+ 4.1 mEq/L is normal.

• **Subacute Bacterial Endocarditis:** Ruled out — blood cultures ×2 with no growth at 5 days.

• **Obstructive Sleep Apnea:** Remains on the differential given persistent unrefreshing sleep and snoring. To be revisited after hypothyroidism treatment is established, as OSA may improve with thyroid hormone normalization.

• **Hypertension:** BP 138/84 — elevated on two visits. May be related to hypothyroidism. Will monitor after initiation of levothyroxine before determining if independent treatment is needed.

P — PLAN

• **#1 — Initiate Levothyroxine 50 mcg PO daily** (low starting dose given age and cardiac murmur; to be uptitrated based on repeat TSH). Patient counseled to take on an empty stomach 30–60 minutes before food, away from calcium supplements and Ranitidine.

• **#2 — Order iron studies** (serum iron, TIBC, ferritin) to determine if iron-deficiency anemia co-exists with hypothyroid-related anemia.

• **#3 — Recheck TSH and Free T4 in 6 weeks** to assess response to levothyroxine and guide dose adjustment.

• **#4 — Monitor blood pressure** at next visit. Hold antihypertensive initiation for now; re-evaluate once thyroid levels normalize.

• **#5 — Sleep study referral deferred** pending response to levothyroxine therapy over the next 6–8 weeks. Will revisit if fatigue and snoring persist after thyroid hormone optimization.

• **#6 — Patient education provided:** Explained diagnosis of hypothyroidism, expected timeline for symptom improvement (4–6 weeks), importance of medication adherence, and drug-supplement interaction with calcium. Patient verbalized understanding and agreed to plan.

• **#7 — Follow-up in 6 weeks** for TSH recheck and symptom reassessment. Patient instructed to call if she experiences palpitations, chest pain, or significant worsening of symptoms.

Electronically signed by: [Attending Physician, MD] Date: 03/05/2026