SOAP NOTE

Outpatient Clinic Visit

Patient: JB Age: 40 y/o Sex: Female Date: 02/26/2026 Provider: [Attending Physician]

S — SUBJECTIVE

Chief Complaint:
Progressive fatigue for 3 months.

History of Present Illness (HPI):
JB is a 40-year-old woman who presents with a 3-month history of increasing fatigue. She first noted fatigue when working extended hours to meet a work deadline; however, she has since returned to her normal 8-hour workday for the past 2 months without any improvement in energy levels. She describes the fatigue as 'feeling limp.' It is present throughout the day and worsens with significant exertion, such as walking more than 3–4 blocks or climbing more than one flight of stairs. Sleeping up to 10 hours per night (compared to her baseline of 8 hours) has provided no relief. She is concerned that something is seriously wrong, as family and friends have begun commenting on her appearance. She has been unable to engage in her usual exercise routine.

Pertinent Review of Systems (ROS):

- **Constitutional:** Denies fever, chills, or night sweats. Reports weight gain of ~6–7 lbs over the past few months, attributed by patient to inactivity.
- **HEENT:** Denies alopecia.
- **Cardiovascular:** Denies chest pain.
- **Pulmonary:** Denies shortness of breath at rest or with exertion.
- **GI:** Denies abdominal pain, nausea, vomiting, diarrhea, or change in stool character.
- **Dermatologic:** Denies rashes or skin changes.
- **Psychiatric:** Denies depressed mood, sadness, or anhedonia. No recurrence of prior depression symptoms.
- **Sleep:** Goes to bed at 10 PM; wakes at 6 AM on weekdays and 8 AM on weekends feeling unrefreshed. Husband reports loud snoring (longstanding).
- **Gynecologic:** Menses regular in timing; heavy flow for 1–2 days, then lighter for 2–3 days — pattern unchanged from prior to fatigue onset. LMP: approximately 1 week ago.

Past Medical History:
GERD, Depression (in remission).

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

Allergies:
Not documented / NKDA.

Social History:
Employed full-time. Married. Denies tobacco, alcohol, or illicit drug use.

O — OBJECTIVE

Vital Signs:

T 97.9°F | HR 80 reg | RR 12 | BP 140/86 mmHg | Ht 67 in | Wt 195 lbs | BMI ~30 kg/m²

General:

JB appears well and is in no acute distress.

Physical Examination:

- **Skin:** No pallor, jaundice, or rashes.
- **Neck:** No thyromegaly or thyroid nodules palpated.
- **Lymph Nodes:** No cervical, axillary, or inguinal lymphadenopathy.
- **Chest:** Clear to auscultation and percussion bilaterally. No wheezes, rales, or rhonchi.
- **Cardiovascular:** Regular rate and rhythm (RRR). 2/6 systolic ejection murmur heard best at the left lower sternal border (LLSB), radiating to the apex. No S3 or S4. No JVD.
- **Abdomen:** Normal active bowel sounds. No hepatosplenomegaly by palpation or percussion. No abdominal tenderness.
- **Extremities:** No edema. 2+ posterior tibialis and dorsalis pedis pulses bilaterally.
- **Neurologic:** Not formally documented; patient is alert and oriented.

A — ASSESSMENT

Problem: Progressive fatigue × 3 months, with weight gain and elevated blood pressure — no obvious inciting event.

Differential Diagnosis & Clinical Reasoning:

- **Hypothyroidism (most likely):** Weight gain, fatigue, and elevated BP in a middle-aged woman are classic. Thyroid nodules were absent on exam, but TSH is needed to confirm or exclude.
- **Anemia:** Heavy menstrual flow raises concern for iron-deficiency anemia. Skin was not pale, but this does not rule it out; CBC warranted.
- **Hypokalemia:** Not currently on diuretics, but should be checked given symptom profile and BP findings.
- **Obstructive Sleep Apnea (OSA):** Longstanding loud snoring, unrefreshing sleep, weight gain, and elevated BMI are risk factors. However, chronicity of snoring predates the fatigue onset, making this less likely as a new cause — though a sleep study may be warranted if initial workup is unremarkable.
- **Subacute Bacterial Endocarditis (SBE):** Known murmur increases theoretical risk; however, no fever, chills, night sweats, or change in murmur character make this unlikely. Blood cultures to be considered.
- **Recurrence of Depression:** Patient denies depressed mood, anhedonia, or sadness. No new psychological symptoms; considered unlikely at this time.
- **Pregnancy:** LMP approximately 1 week ago, making active pregnancy unlikely.

P — PLAN

• **#1 — Check TSH** to evaluate for hypothyroidism.

• **#2 — Check CBC with differential** to rule out anemia (iron-deficiency given menstrual history).

• **#3 — Check serum potassium (K+)** to rule out hypokalemia.

• **#4 — Sleep study** to be ordered if labs #1–#3 return unremarkable, given history of snoring and unrefreshing sleep.

• **#5 — Blood cultures ×2** to be considered to rule out subacute bacterial endocarditis given known cardiac murmur.

• **#6 — Follow-up visit in 1 week** to discuss lab results and determine next steps in workup. Patient instructed to return sooner or go to the ED if she develops fever, chest pain, or worsening symptoms.

Electronically signed by: [Attending Physician, MD] Date: 02/26/2026