NR 509 SOAP Note Template week 2

advanced health assessment (Chamberlain University)

SOAP Note Template

S: Subjective
Information the patient or patient representative told you

Initials: T.J.							Age: 28	Gender: female
Height	Weight	BP	HR	RR	Temp	SPO2	Pain Rating **-denies pain**	Allergies (and reaction)
170 cm	89 kg	140/ 81	89	20	98.5	97%		edication: Penicillin-rash Food: none Environment: cats, dust

History of Present Illness (HPI)

Chief Complaint (CC)	Breathing problems, short of breath, inhaler not working
Onset	Started two days ago
Location	Chest-tightness no pain
Duration	Episodes every 4 hours of shortness of breath, reports wheezing
Characteristics	Wheezing, shortness of breath-worse laying down and with exertion, chest tightness, denies chest pain
Aggravating *Factors*	Laying down and increased movement
R*elieving Factors*	Inhaler, warm shower
Treatment	Proventil inhaler (2-3 puffs) every 4 hours

CC is a BRIEF statement identifying why the patient is here - in the patient's own words - for instance "headache", NOT "bad headache for 3 days". Sometimes a patient has more than one complaint. For example: If the patient presents with cough and sore throat, identify which is the CC and which may be an associated symptom

Current Medications: *Include dosage, frequency, length of time used and reason for use; also include OTC or homeopathic products.*

Medication *(Rx, OTC, or Homeopathic)*	**Dosage**	**Frequency**	**Length of Time Used**	**Reason for Use**
Proventil	90 mcg	2 puffs every 4 hours	Intermittently since childhood	asthma
Tylenol	500 mg gel tab	One tab as needed for headaches	intermittent	As needed for headaches
Ibuprofen	200 mg	3 tabs 3 times a day	intermittent	As needed for menstrual cramps
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Past Medical History (PMHx) – *Includes but not limited to immunization status (note date of last tetanus for all adults), past major illnesses, hospitalizations, and surgeries. Depending on the CC, more info may be needed.*

Illnesses
-asthma-diagnosed age 2.5- saw Dr. Dewitt until 2 years ago- does not have asthma action plan in place-has never used anything besides inhaler except when hospitalized as a child
-diabetes-diagnosed age 24-patient stopped taking metformin on own due to side effects-does not check home blood glucose level or follow diabetic diet-states she does not want to hassle with medication or checking blood sugars

Surgeries-none

Hospitalizations
-was hospitalized several times as child for asthma- last time was when she was in high school- treated with nebulizer and oral steroids
-denies any other hospitalizations

Immunizations-
-patient reports up to date on childhood immunizations
-last tetanus one year ago

Social History (Soc Hx) - *Includes but not limited to occupation and major hobbies, family status, tobacco and alcohol use, and any other pertinent data. Include health promotion such as use seat bel-ts all the time or working smoke detectors in the house.*

-Employment- supervisor at Mid-American Copy & Ship- has worked at same company since high school- works 32 hours a week
-Education-currently pursuing bachelor's degree- accounting-taking 2 classes currently
-Living situation- lives with mom and sister- states family is everything
-Community support- mom, brother, sister, friends, and church family
-Spiritual-patient is member of First Baptist- patient reports being actively involved at her church and spends a lot of time with her church family
-Hobbies- reading, watching TV-documentaries, and enjoys talks at her church
-tobacco use- denies past or present use- denies exposure to secondhand smoke
-alcohol use- reports drinking alcohol one to two times a week-denies having more than 3 alcoholic beverages at a sitting.
-drug use-patient denies present drug use. Reports smoking marijuana in the past-last use approximately 7 years ago
-safety- patient reports using seat belts, patient reports smoke alarms in home-believes they are all working

Family History (Fam Hx) - *Includes but not limited to illnesses with possible genetic predisposition, contagious or chronic illnesses. Reason for death of any deceased first degree relatives should be included. Include parents, grandparents, siblings, and children. Include grandchildren if*

pertinent.

Mother- alive- high blood pressure and high cholesterol- diagnosed a few years ago- denies any other medical history
Father- deceased- (cause of death MVA age 58)- Type 2 diabetes, hypertension, high cholesterol-states he was diagnosed in his 30s-denies any other medical history
Paternal grandfather-deceased in his 60s - colon cancer (cause of death), high cholesterol, high blood pressure, type 2 diabetes
Paternal grandmother-alive age 82- high cholesterol and high blood pressure -denies other health problems
Maternal grandfather-deceased at age 80- heart attack (cause of death), high blood pressure and high cholesterol
Maternal grandmother-deceased age 73- stroke (cause of death), high blood pressure and high cholesterol-denies any other health history
Sister- asthma-reports rare asthma exacerbations
Brother-no diagnosed medical problems-states he is kind of bigger

Review of Systems (ROS): *Address all body systems that may help rule in or out a differential diagnosis Check the box next to each positive symptom and provide additional details.*

Constitutional If patient denies all symptoms for this system, check here: ☐	**Skin** If patient denies all symptoms for this system, check here: ☐	**HEENT** If patient denies all symptoms for this system, check here: ☐		
☒Fatigue reports not sleeping well for past 2 nights ☐Weakness denies ☐Fever/Chills denies ☐Weight Gain -not pertinent ☐Weight Loss- not pertinent ☒Trouble Sleeping laying flat on back causes	☐Itching -not pertinent ☐Rashes -not pertinent ☐Nail Changes denies any blue tinge under finger nail ☐Skin Color Changes -not pertinent ☐Other: Click or tap here to enter text.	☐Diplopia -not pertinent ☐Eye Pain -not pertinent ☐Eye redness -not pertinent ☐Vision changes -not pertinent ☐Photophobia -not pertinent ☐Eye discharge -not pertinent	☐Earache -not pertinent ☐Tinnitus -not pertinent ☐Epistaxis -not pertinent ☐Vertigo denies ☐Hearing Changes -not pertinent	☐Hoarseness -not pertinent ☐Oral Ulcers -not pertinent ☐Sore Throat denies ☐Congestion denies ☐Rhinorrhea denies ☐Other: Click or tap here to enter text.

shortness of breath ☐Night Sweats denies ☐Other: Click or tap here to enter text.				

Respiratory If patient denies all symptoms for this system, check here: ☐	**Neuro** If patient denies all symptoms for this system, check here: ☐	**Cardiac and Peripheral Vascular** If patient denies all symptoms for this system, check here: ☐	
☒Cough Click or tap here to enter text. ☐Hemoptysis denies ☒Dyspnea Click or tap here to enter text. ☒Wheezing Click or tap here to enter text. ☐Pain on Inspiration denies ☐Sputum Production -denies ☐Other: Click or tap here to enter text.	☐Syncope or Lightheadedness denies ☐Headache denies ☐Numbness denies ☐Tingling denies ☐Sensation Changes -not pertinent ☐Speech Deficits -not pertinent ☐Other: Click or tap here to enter text.	☐Chest pain denies ☒SOB Click or tap here to enter text. ☒Exercise Intolerance Click or tap here to enter text. ☒Orthopnea Click or tap here to enter text. ☐Edema denies ☐Murmurs -not pertinent	☐Palpitations denies ☐Faintness denies ☐Claudications -not pertinent ☐PND -not pertinent ☐Other: Click or tap here to enter text.

MSK If patient denies all symptoms for this system, check here: ☐	**GI** If patient denies all symptoms for this system, check here: ☐	**GU** If patient denies all symptoms for this system, check here: ☐	**PSYCH** If patient denies all symptoms for this system, check here: ☐
☐Pain denies ☐Stiffness -not pertinent ☐Crepitus -not pertinent ☐Swelling -not pertinent ☐Limited ROM ☐Redness -not pertinent	☐Nausea/Vomiting -not pertinent ☐Dysphasia -not pertinent ☐Diarrhea Click or tap here to enter text. ☒Appetite Change increased ☐Heartburn not assessed ☐Blood in Stool -not pertinent	☐Urgency -not pertinent ☐Dysuria -not pertinent ☐Burning -not pertinent ☐Hematuria -not pertinent ☐Polyuria -not pertinent ☐Nocturia -not pertinent ☐Incontinence -not pertinent	☐Stress denies ☐Anxiety denies ☐Depression -not pertinent ☐Suicidal/Homicidal Ideation --not pertinent ☐Memory Deficits -not pertinent

☐Misalignment -not pertinent ☐Other: Click or tap here to enter text.	☐Abdominal Pain -not pertinent ☐Excessive Flatus -not pertinent ☐Food Intolerance -not pertinent ☐Rectal Bleeding -not pertinent ☐Other:	☐Other: Click or tap here to enter text.	☐Mood Changes -not pertinent ☐Trouble Concentrating -not pertinent ☐Other: Click or tap here to enter text.

GYN If patient denies all symptoms for this system, check here: ☐	**Hematology/Lymphatics** If patient denies all symptoms for this system, check here: ☐	**Endocrine** If patient denies all symptoms for this system, check here: ☐
☐Rash -not pertinent ☐Discharge -not pertinent ☐Itching -not pertinent ☐Irregular Menses -not pertinent ☐Dysmenorrhea -not pertinent ☐Foul Odor -not pertinent ☐Amenorrhea -not pertinent ☐LMP: Not addressed ☐Contraception not currently sexually active or on contraception ☐Other:Click or tap here to enter text.	☐Anemia -not pertinent ☐ Easy bruising/bleeding -not pertinent ☐ Past Transfusions -not pertinent ☐ Enlarged/Tender lymph node(s) not addressed ☐ Blood or lymph disorder -not pertinent ☐ Other Click or tap here to enter text.	☐ Abnormal growth -not pertinent ☒ Increased appetite Click or tap here to enter text. ☐ Increased thirst -not pertinent ☐ Thyroid disorder -not pertinent ☐ Heat/cold intolerance denies fever and sweats ☐ Excessive sweating denies ☒ Diabetes uncontrolled type 2 ☐ Other Click or tap here to enter text.

O: Objective

Information gathered during the physical examination by inspection, palpation, auscultation, and percussion. If unable to assess a body system, write "Unable to assess". Document pertinent positive and negative assessment findings. Pertinent positive are the "abnormal" findings and pertinent "negative" are the expected normal findings. Separate the assessment findings accordingly and be detailed.

Body System	Positive Findings	Negative Findings
General	*Weight 89 kg*	*Well groomed*
Skin	*None noted*	Visual exam (-) open wounds (-) lesions
HEENT	*not assessed* -not pertinent	*Not assessed* -not pertinent
Respiratory	*Expiratory wheezing posterior right lower lobe, expiratory wheezing posterior lower left lobe*	*Respiratory rate-20, SPO2 97%, FVC 3.91, FVC_1 3.15 Chest appearance symmetrical; chest expansion symmetrical; tactile fremitus symmetrical with expected vibration; all areas resonant, no areas of dullness; breath sounds present in all areas, negative for adventitious sounds in all areas anteriorly, in posterior right upper lobe, and in posterior left upper lobe, negative for bronchophony*
Neuro	*None noted-limited assessment-not pertinent*	*Patient facial expressions symmetrical, patient responds to questions and verbal cues appropriately*
Cardiovascular	*blood pressure 140/81*	*Heart rate 89*
Musculoskeletal	*Not assessed* -not pertinent	*Not assessed* -not pertinent
Gastrointestinal	*Not assessed* -not pertinent Click or tap here to enter text.	*Not assessed* -not pertinent
Genitourinary	*Not assessed* -not perti	ertinent

Problem List		
1. dyspnea	6. elevated blood pressure	11. Click or tap here to enter text.
2. wheezing	7. Click or tap here to enter text.	12. Click or tap here to enter text.
	8. Click or tap here to enter text.	13. Click or tap here to enter text.
4. uncontrolled type 2 diabetes	9. Click or tap here to enter text.	14. Click or tap here to enter text.
5. obesity	10. Click or tap here to enter text.	15. Click or tap here to enter text.

A: Assessment

Medical Diagnoses. Provide 3 differential diagnoses (DDx) which may provide an etiology for the CC. The first diagnosis (presumptive diagnosis) is the diagnosis with the highest priority. Provide the ICD-10 code and pertinent findings to support each diagnosis.

Diagnosis	ICD-10 Code	Pertinent Findings
Mild intermittent asthma with (acute) exacerbation	J45.21	Cough, shortness of breath, expiratory wheezing bilateral posterior lower lobes, known exposure to irritant of cats, previously diagnosed asthma-patient reports not needing to use inhaler frequently except for last two days *Respiratory rate-20, SPO2 97%, FVC 3.91, FVC_1 3.15*
Reactive airways dysfunction	J68.3	Cough, shortness of breath, expiratory wheezing bilateral posterior lower lobes, known exposure to irritant of cats *Respiratory rate-20, SPO2 97%, FVC 3.91, FVC_1 3.15*
	J45.31	Cough, shortness of breath, expiratory wheezing bilateral

Mild persistent asthma with (acute) exacerbation		posterior lower lobes, known exposure to irritant of cats, previously diagnosed asthma-patient reports not needing to use inhaler frequently except for last two days *Respiratory rate-20, SPO2 97%, FVC 3.91, FVC_1 3.15*

P: Plan

Address all 5 parts of the comprehensive treatment plan. If you do not wish to order an intervention for any part of the treatment plan, write "None at this time" but do not leave any heading blank. No intervention is self-evident. Provide a rationale and evidence-based in-text citation for each intervention.

Diagnostics: *List tests you will order this visit*	
Test	Rationale/Citation
spirometry	Was done during assessment of patient-checks for expiratory airflow obstruction (Hollier, 2018)

SPO2	Was done during assessment of patient -should be greater than 92% (Pollart et al., 2015)
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Medications: *List medications/treatments including OTC drugs you will order and "continue meds" if pertinent.*

Drug	Dosage	Length of Treatment	Rationale/Citation
Prednisone	20 mg tablet- take two tablets by mouth daily	Five-day treatment Dispense 10 tablets with 0 refills	Incomplete response to short acting beta$_2$ agonist -add oral corticosteroid (Pollart et al., 2015) Short course glucocorticoid of prednisone 40-60 mg a day for 5-7 days. (Fanta, 2020) dosing recommendations-no taper recommended for short duration asthma treatment (Prednisone: Drug Information, 2020)
Continue Proventil	90 mcg inhale 2 puffs every 4	Use every 4 hours for 2 days and taper usage back to as needed after	Continue short acting beta$_2$ agonist (Pollart et al., 2015) regular use for first few days then taper (Fanta, 2020)
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Referral/Consults:			
Referral to allergist		To identify other asthma triggers as well as minimize asthma triggers from irritants and allergens	(Hollier, 2018)
Education:			
-Prednisone should be taken as prescribed *-Prednisone possible side effects* elevated blood glucose, mood alteration, insomnia, excess energy, increased appetite, and fluid retention -Recommend taking prednisone in morning to reduce sleep disturbance -Use Proventil inhaler regularly for the first 2 days and taper back to as needed use		-Patient should understand how to take medications for best response and understand potential side effects. -an asthma action plan allows patient to manage mild asthma exacerbations at home	Prednisone, and Proventil usage (Fanta, 2020) Asthma action plan (Pollart et al., 2015)

-Ensure patient is using inhaler correctly -Develop an asthma action plan and teach patient to monitor for signs and symptoms of asthma exacerbation and take appropriate action -discuss with patient and include in written action plan recognizing and treating warning signs of asthma –increase in asthma symptoms, awakening at night with shortness of breath or wheezing, increase in daytime shortness of breath, wheezing, and/or chest tightness -patient should seek emergency treatment if cyanosis (blue tinge to lips or nail beds), medication fails to improve symptoms, emphasize the severity of symptoms that require medical treatment vs. what can be managed at home- include this in asthma action plan -patient to call provider if symptoms worsen or don't improve -patient should call provider if experiencing adverse effects from medication	-teach patient to recognize early symptoms of asthma to better manage symptoms	(Apter, 2020)
Follow Up: *Indicate when patient should return to clinic and provide detailed symptomatology indicating if the patient should return sooner than scheduled or seek attention elsewhere.*		
Follow up in 5 days	After prednisone course is finished to ensure symptoms have resolved and ensure asthma is under control	(Fanta, 2020)
References Include at least one evidence-based peer-reviewed journal article which relates to this case. Use the correct current APA edition formatting.		

References

Apter, A. (2020). Asthma education and self management. UpToDate. http://www.uptodate.com

Fanta, C. (2020). Acute exacerbations of asthma in adults: Home and office management. UpToDate. http://www.uptodate.com

Hollier, A. (2018). Clinical Guidelines in Primary Care (3rd ed.). Advanced Practice Education Associates, Inc.

Pollart, S., Compton, R., & Elward, K. (2015). Management of acute asthma exacerbations. American Family Physician, *91*(Special Issue), 1–13. http://www.aafp.org/journals/afp.html

Prednisone: Drug information. (2020). UpToDate. http://www.uptodate.com

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