[redacted]

NUR 670 ([redacted]) Preceptor: [redacted] NP

FOCUSED SOAP NOTE #6

[redacted] 4 yo female

Subjective

CC: Pt complains of sore throat, runny nose, and cough x 3 days.

HPI: Mom reports that she has been complaining of a sore throat for 3 days. She has not been eating much because it hurts when she swallows. She has been drinking cold fluids ok. She also has a dry cough, runny nose, post nasal drip for 2 days. They have been giving her Tylenol otc for pain but nothing else otc. She said it helps a little with her throat pain. Drinking cold fluids helps a lot temporarily. No one else in the house is sick. No one in the home smokes. She denies fevers.

Review of Systems

General: She has a decrease in appetite but denies fever, lethargy.

Skin: Denies rash, urticaria.

Head: Denies headache, dizziness, or syncope.

Neck: Denies lumps, swollen glands.

EENT: Reports sore throat but denies hoarseness. Denies itchy, watery eyes. Denies ear pain. Reports runny nose and post nasal drip.

CV: Denies chest pain, history of heart murmurs. Denies edema.

Resp: Reports dry cough but denies shortness of [redacted]eath, wheezing.

GI: Denies loose stools, abdominal bloating and nausea. Denies dysphagia, vomiting, or blood in stool.

Past Medical History

Last WCC: [redacted]

Medical Illness: none

Surgical history: none

Injuries: none

Hospitalizations: none

Transfusions: none

Psych history: none

Childhood disease: none

Immunizations: *all childhood imms. up to date. Got flu shot [redacted]

Allergies: NKDA, no food allergies.

Meds: none

Personal/Social & Family History

Lives at home with her mother, father and younger sister

Financial: has [redacted] which covers all her medical care.

Not exposed to second hand smoke, no guns in home.

Family History

Mother: asthma

Father: Gerd, hyperlipidemia

PGM-HTN

PGF-HTN

MGM-hyperlipidemia

MGF-asthma, CAD

Objective

Vitals

BP: 90/68

P: 78

T: 100.6 (tympanic)

R: 18

WT: 30lbs

HT: 34 inches

BMI: 18.2

Exam

General: Well developed, well -nourished young female who is alert, oriented, cooperative and in no acute distress.

Skin: pink, warm and dry with no evidence of any rashes.

Head: normocephalic, atraumatic

Ears/nose/ Mouth/Throat: TMs grey with normal light reflex bilaterally. Nasal mucosa erythema and edema bilaterally with some clear discharge. Dentition in good repair, buccal mucosa pink without lesions. Posterior oropharynx beefy red with exudates.

Neck: small enlarged anterior cervical nodes.

Resp: Auscultate resonance throughout. No wheezing, rales or rhonchi. [redacted]eath sounds are clear bilaterally.

Cardio: Regular rate and rhythm, no murmurs, heaves or thrills. S1 & S2 intact.

Abdomen: soft, nontender, no distention, normal bowel sounds, tympany on percussion, no heptosplenomegaly.

Assessment/Diagnosis

1) Strep Pharyngitis 034.0

Plan

Rapid strep in office positive for strep. Start pt on Zithromax 100mg/5ml 1 ¼ tsp day 1, then ¾ tsp days 2-5 # 5ml NR. Pt can continue Tylenol prn for pain.

Patient education

Mom to throw toothbrush away after 24 hours on medication. . No sharing cups, utensils, no kissing. Rest as much as possible. She can go back to school in 24 hours if no fever.

Special instructions: If symptoms worsen or change, fever develops, etc., call office for visit.

Follow up: Only if six's persist or worsen.

Differential Diagnosis

- Upper respiratory infection
- Eustachian tube dysfunction
- Serous otitis
- Otitis media
- Pneumonia