[redacted]
[redacted]
SOAP NOTE [redacted]

Episodic Visit

Your Name: [redacted]

Source and Reliability: Self; reliable, well-spoken historian.

SUBJECTIVE

Chief Complaint (CC): Patient presents to clinic with complaints of 6/10 abdominal pain. Patient c/o pain "down low in her belly". Patient has c/o bloating and pain which gets worse upon eating. Pain is explained as a dull cramping. Patient c/o lack of bowel movements for past 5 days however, she has also stated that she has had diarrhea recently. Patient reports current Bowel movements as normal, not runny or hard. Patient also reports decreased appetite stating "eating is unappealing.

History of Present Illness (HPI): Patient reports diarrhea once recently with constant abdominal pain for about 5 days. Pain is now a 6 on the 0-10 pain scale. Denies constipation, nausea/vomiting, denies mucus/blood in stool. Patient describes pain as constant but the severity tends to fluctuate. Did not feel her symptoms warranted a medical appointment which is why she waited, denies chest pain. Her daughter insisted that patient get checked out.

Past Medical History (**PMH):** Patient with history of hypertension diagnosed at 54 y/o. Reports seeing her PCP [redacted] with normal test results. Patient does not check BP at home however, at the PCP appointment she believes that at her BP was 125/80. Gravida 3, para 2 (stillborn C-section).

Past Surgical History (PSH): Reports a surgical history of cholecystectomy and one C-section (stillborn child); hospitalized for both surgeries.

Medications: Accupril 10 mg PO daily

Allergies: Latex (contact dermatitis)

Immunizations: Patient reports being up-to-date on all immunizations however, does not remember the date of her last T-Dap. She has yet to receive the flu vaccine this season however, reports getting her Covid vaccine.

Family Hx:
Mother: Deceased age 88→ Hx HTN, DM2; pneumonia and consecutive stroke in hospital
Father: Deceased age 82→Passed away in his sleep; Hx HTN, HLD, obesity
Maternal Grandfather: Passed from heart attack; Hx of CAD
Maternal Grandmother: Hx DM2 and CAD, unsure of age and how she died.
Paternal Grandmother: Passed from Cancer, Hx HTN
Paternal Grandfather: No known Hx, passed away in sleep in his 90's
Brother, 80 y/o: HLD, HTN, prostate Cancer
Brother, 81 y/o: HTN
Son, 48 y/o: Healthy
Daughter, 46 y/o: Healthy

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Social Hx: Patient was married for 50 years and is now widowed. Her husband passed away [redacted]. She currently lives with her daughter and her family where she does help with household chores. Reports being active and exercising daily.

Tobacco: Denies Cigarette smoke and/or tobacco use, denies secondhand smoke exposure

Alcohol: Reports one glass of white wine weekly

Drugs: Denies use of illicit drugs

Review of Systems (ROS): Pertinent to CC

OBJECTIVE

Physical Exam:

General: [redacted] is seated upright on the exam table and is alert and oriented. She is showing some signs of discomfort. Appears well nourished, well developed, dressed appropriately and with good hygiene. Face and head normocephalic and symmetrical. She answers questions appropriately and maintains good eye contact during exam.

Neuro: Negative for dizziness, heart palpitations, dizziness, and chest pain.

VS: Weight: 120 lbs Height: 5' 2"
BP: 110/70

HR: 92

RR:16

Temp: 37.0

SpO2: 99%

UA: Clear, dark yellow, malodorous, negative for nitrates, WBC's, RBC's, Ketones, PH 6.5, SG 1.017: NORMAL

ASSESSMENT/IMPRESSION:

General: Negative for night sweats, fever, fatigue, headaches, chills, nausea and weight loss.

HEENT: flushed appearance of skin, head/skull symmetrical. Nasal mucosa and mouth moist and pink

Skin: Warm, dry and negative for tenting. Face Flush.

Respiratory: Denies SOB, dyspnea, chest pain. Breath sounds are clear in all areas and free from adventitious sounds.

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Cardiovascular: Heart sounds auscultated with both bell and diaphragm of stethoscope. S1 and S2 audible with no extra heart sounds. No lower extremity edema. No bruit or friction rub over liver or spleen. Auscultated iliac, renal and femoral arteries bilaterally with absence of bruits. Lower legs negative for edema.

Gastrointestinal: Normoactive bowel sounds in all 4 quadrants. No guarding, masses or tenderness in RLQ, RUQ, LUQ. Abdomen appears flat and symmetrical. Two scars noted: 1 in RUQ and one midline in suprapubic region. Spleen tympanic and not palpable. Liver is 7 cm and palpable midclavicular line intercostal margin. Digital rectal exam with no fissures, ulcerations, and strong sphincter tone. Patient feels as though eating makes her abdominal pain and bloating worse. Negative foe CVA tenderness. Tenderness reported in LLQ with palpable firm oblong mass of 2 by 4 cm observed with some guarding and distention. Palpated aortic width is 3 cm or less.

Diagnosis:

Constipation

Differential Diagnoses:

1) Hernia
2) Ovarian Cyst
3) Lipoma
4) Ovarian cancer

Problem List:

- Flu shot inactive for season
- Poor PO intake including fluid and fiber
- Abdominal mass LLQ with tenderness
- Acute abdominal pain
- Constipation/change in bowel habits
- Decreased appetite

PLAN:

- Increase PO intake of fluid and fiber in diet
- Encourage laxative/stool softener including Senna, Colace, Miralax
- Encourage small meals due to decreased appeal for food and high fat foods to increase caloric intake if tolerated
- CBC with diff, Renal, CMP, Liver panel, lipid panel, HbA1c, hormone levels d/t family history and current state of health
- Encourage BP taken at home including log to update PCP as needed
- KUB to assess stool burden
- Suggest EGD to assess hernia
- Colonoscopy, Cancer screening

- Encourage flu shot
- Recommend Tylenol for pain, assess for results, also recommend heat or cold for pain as well if patient refuses PO pain medications
- US of lower abdomen to assess for masses
- Consult GI to assess state of bowel health
- Encourage continuation of exercise as tolerated to maximize bowel health/bowel movements
- Consult OB to assess hormonal levels and need for further testing