Comprehensive SOAP Note

Student: Sheri Harrison

Course: NURS7446 Fall 2014
Date: 10/8/2014 Patient: VG112838
Location: All Med for Women Preceptor: Yaple,Judy

Guidelines For Comprehensive SOAP Note

Subjective Data:

VG is a 75 year old female caucasion lady presenting to the office today "looking for a primary care physician". Her primary care physician passed away about a year ago and she has not found someone else to manage her care. The patient is the informant. She has been married for the past 50 years to her husband. They are both retired. She describes her usual health as "pretty good", she said she feels she should exercise a little bit more. She used to work out at the YMCA doing water aerobics a few years ago and she enjoyed that. She occasionally takes walks in the early morning with her pet dog and husband. She has 2 sons, one who lives locally and he visits often. Her other son lives 8 hours away and she sees him a couple times a year. She has 5 grand children, ages 12-17.

PMH:
CURRENT MEDICATIONS: Tylenol 1000mg PRN arthritis pain; Ibuprofin 400mg PRN arthritis pain; Lovastatin 40mg PO Q pm, OTC Calcium chews daily. She prefers Tyelnol over Iburprofin and takes at least one dose per day.
ALLERGIES: PCN and Codeine.
Patient stated she was told as a child that she was allergic to PCN but wasn't sure what type of reaction she had with it. Codeine makes the patent severly nauseated, but denies any rash, hives, or anaphylactic reaction when taking Codeine. PAST MEDICAL HISTORY: arthritis, hyperlipidemia, and diet controled type II diabetis, uterine fibroids (which she is now status post hysterectomy since 1984) and seasonal allergies. She was diagnosed with arthrits 20 years ago when she noticed pain in her elbow. Since then she has arthritis in her mostly in her knees and hands. It is worse in the morning or if it is raining, but improves throughout the day and she denies any interference inher ADL's. Patient was diagnosed with hyperlipidemia in her 50's but was able to adjust her diet and it improved. A few years ago she was told she needed to be on some medication. She has been on lovastatin since then.
IMMUNIZATIONS: She has had pnuemonia vaccination in 2009; She gets her flu shot annually but has not had one this season; She is unsure of Tdap booster and has not had the Zoster vaccine. Prior Hospitalizations include
PREVIOUS SCREENING TESTS: She states she gets annual mammograms, last one was 12 months ago and is due. She has never been told they were abnormal. She states she performs self breast checks at least once a month if not more often and denies any abnormal findings. Her last bone density test was 3 years ago and was told it was normal. She had a colonoscopy 3 years ago and it was normal.
PREVIOUS HOSPITALIZATIONS: Patient denies any recent hospitalizations in the recent several years. She stated she was hospitalized about 5 years ago for dehydration related to a GI virus.
SURGERIES: hemorroid surgery 1995; hysterectomy 1984
FH: Father was deceased at age 82 from cardiac arrest. His history included hypertension and COPD, and ETOH abuse. Mother was deceased at age 90 from a "fall" related incident. Patient denies any medical history with her mom. Patient has a sister who recently passed away at age 79 from a stroke Patient denies any family history of asthmas, glaucoma, cancer, TB, DM, kidney disease, hemophilia or psychiatric diseases.
SH: Parent is married x 50 years. She is retired x10 from after working in the probate office in the Selma Court house for over 20 years. VG stated she used to smoke 1 pack of cigarettes daily for 20 years but has been a non smoker for about 20 years. She drinks 3-4 glasses of

wine a week. VG stated she always wears her seatbelt when traveling. Her religious preference is Baptist and denies any religious interference or spirtual needs related to her health. She has some financial concerns but states she and her husband prepared well for retirement and are able to take care of their needs but they do live on fixed income and are insured through Medicare.
ROS: REVIEW OF SYSTEMS
1). Overall VG IS well appearing and looks here age. Denies fever, chills, or fatigue. She is still able to carry out her ADL's independently. No weight changes.
2). Eyes- Patient last eye exam with Opthamologist was less than 12 months ago. She does not wear corrective lenses but wears glasses when she reads. Denies any double or blurred vision, or redness,
3). Ears, nose, mouth, and throat - Denies any hearing loss or exposure to loud noises. Does not wear hearing aids. Denies any vertigo, pain, or presence of infection to ears. Patient denies any loss of smell, discharge, epstaxis. Patient brushes her teeth twice daily and flosses occasionally. Denies any lesions. She visits her dentist every 6 months for routine cleaning. Her last appointment was in September 2014.
4). Cardiovascular - Patient denies any exercise pattern currently. Denies any chest pain, murmurs, palpitations, dyspnea, or activity intolerance. Denies any edema, or varicose veins.
5.) Respiratory - Denies any present exposure to tobacco smoke, No SOB, wheezing, hemoptysis, or cough.
6). Gastrointestinal - Denies any melana, abdominal pain, nausea, vomiting, or diarrhea. She decribes her bowel habbits as regular in nature admitting to having a bowel movement daily. Has occasionally constipation relieved with OTC fleece ememas. No recent change in bowel habbits. Patient states she eats a diet high in calcium, low fat, low cholesterol.
7). Genitourinary - Denies any dysuria, hematuria, polyria, incontinence, or discharge. Patient states she usually gets up about once a night to void. 2 live pregnancies, 1 miscarriage, post hysterectomy in 1982 due to fibroids. She denies any sexual activity in the past several years because she and her spouse no longer have a desire and is positive for vaginal dryness.
8). Musculoskelatal - Patient exercises include daily morning walks with husband and pet. Patient uses her seatbet regularly. Postive for occasional joint and back pain or stiffness. Has full ROM.
9). Integumentary - Patient admits to using sunscreen with sun exposure and inspects her skin condition regularly. Denies any rash, itching, hair loss, nail deformity, or lesions. Patient states she self-examines her breasts greater than once monthly. Patient denies any findings of lumps or bumps in her breast exams.
10). Denies any muscle weakness, symcope, stroke, seizures, paresthesias, involuntary movements or tremors, loss of memory, or headaches.
11). Psychiatric - Denies any anxiety, nervousness, insomnia, suicidal thoughts, or mental history. Patient admits to some depression x 1 year which occured after the loss of her sister. She says some days she doesn't have much interest in leaving the house. She denies any thoughts of suicide. Identified her husband and children as a strong support system that helps her cope during the rough times.
12). Endocrine - Denies any thyroid, cold or heat intolerance, diabetes, polydipsia, polyphagia, polyuria,changes in skin, hair or nail texture. Denies any unexplained weight change. Has never been on Hormonal replacement therapy.
13). Hematoloic/lymphatic - Denies any brusing, unusual bleeding, fatique, history of anemia, blood transfusions, swollen and/or tender glands. Her last HCT is unavailable.
14). Patient is postive for occasional seasonal allergies. Patient states she will take OTC Benadryl occasionally for this.

Objective Data:

Vital signs: T - 98.4, P-64, R - 18, B/P 134/71 HT - 69" WT 177lbs BMI - 26.1
VG is a pleasant 75 year old, looks her stated age, female in no acute distress. Alert and oriented x 3.
EYES: PERRLA, EOMI No redness, edema, or drainage noted.

EARS, NOSE, THROAT: TM's clear, OP clear with no redness, no exudate or lesions present. Nose symmetric. Nasal turbinates clear with no drainage. No sinus tenderness or lymphoadenopathy present.
CARDIOVASCULAR: Regular rate and rhythm, S1S2 present with no murmurs appreciated. No lower extremity edema. No variocose veins noted. Some spider veins noted to bilateral ankles and upper calves bilaterally.
RESPIRATORY: Chest symmetric and clear to auscultation anteriorly and posteriorly.
GASTROINTESTINAL: Abdomen soft, non-distended, non-tender, bowel sounds present x 4 quandrants. No masses or rebound pain noted.
BREASTS: No breast masses, tenderness, asymmetry, nipple discharge or axillary lymphadenopathy.
RECTAL: no fissure, hemorrhoids, fistula or lesions in perianal area; sphincter tone good. Stool brown, guaiac neg.
MUSCULOSKELETAL: Stength 5/5, normal tone, gait steady, and full range of motion.
INTEGUMENT- No rashes. No lesions.
NEUROLOGIC - Cranial nerves 2-12 grossly intact.
PSYCHIATRIC - Normal affect, pleasant mood, alert and oriented x 3.

Assessment/Analysis:

LEVEL OF VISIT: 99214
Health Maintenance:
1. Annual health exam V70.0
2. Influenza vaccine V04.81 0
3. Tdap Booster V06.1-
4. Zoster vaccine V05.8 -
5. Mammogram screening V76.12 - She needs one yearly until age 75.
Actue Self-limited problems
1. depression, 311 - She has been having some depressed greater than 2 weeks with some lack of interest in leaving her house. She also stated she was no longer interested in sexual activitiy.
(Will check TSH, Vit B-12, LFT, CBC, CMP to rule out any other causes that mimic depression)
Vaginal dryness 625.8
Chronic health problems
1. arthrits 716.5
(Checking Calcium and Vit D levels; will order bone density scan since it has been greater than the recommended 2 years. Patient's age, sex, and postmenapausal are positie risk factors)
2. hyperlipidemia, stable 272.4
(Will advise patient to RTC for fasting lips to check levels and adequacy of current dose of lovastatin.
3. Dibeties type 2, diet controlled
(Will check fasting BS when patient comes in for fasting lipid profile. We will also check A1c to check the average blood sugars.

Patient does have risk factors for CAD: post menapausal, hyperlipidemia, family history of CAD, history of smoking. Will order an EKG for now since patient denied any symptoms.

Plan:

The following plan was discussed and agreed on with the patient.
1. Labs: UA, Vit D, Calcium level, TSH, FSH, LH, CBC, CMP, Fasting BS, A1c, UA, Fasting Lipid profile.

2. Sertraline 25mg PO Daily - This is a SSRI described for the first line treatment of elderly depression. Will initially start out on 25mg daily and increase to treatment range of 50-200. Brand name is Zoloft. The cost of the generic is 25mg (30each) is 97.95 whereas 50mg (30each) is $16.00. 100mg (30 each) is $18.75. Its MOA is that selectively inhibits serotonin reuptake.
3. Vit E suppositiory as needed for vaginal dryness. - women more than 9 years post menopause should not be started on hormone therapy or estrogen therapy for CAD prevention or low estrogen symptoms such as vaginal dryness. Vit E suppositiories can be used as a lubricant and costs vary, but average 9 dollars a pack. 24 to a pack, 30 IU Vit E in each suppository.
4. Mammogran, screening. Will do today in office
5. Vaccines: Influenza, Zoster, and Tdap Booster.
5. Follow up in 4 weeks to see about titrating dose of Setriline.

Intervention:

Educated the patient that she will not immediatley see the benefit of starting setriline until 2-4 weeks after starting medication. But depression is a treatable illness and is not a natural part of aging.
Patient is to continue her daily walks and maybe increase activity. Instructed pateint to thinking about retaking water aerobics for the benefit of exercise on depression, cholesterol, and diabetes. It will also help keep her bones strong and reduce injury with falls. Patient is to continue a diet in low fat, low cholesterol.

Evaluation:

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