Comprehensive SOAP Note

Student: Sheri Harrison

Course: NURS7446 Fall 2014

Date: 9/10/2014 Patient: RC31681

Location: All Med for Women Preceptor: Yaple,Judy

Guidelines For Comprehensive SOAP Note

Subjective Data:

CC: "Would like blood pregnancy test."

HPI: Patient stated she has been off of BCP for 2 years and has a "irregular period". Her last menstrual cycle was 7/1/2014. She has taken two urine pregnancy tests at home and they were both "negative". Patient stated that her menstrual period was irregular prior to being put on BCP at age 25. She took them up until age 31. She stated for about 6 months following the discontinuation of her BCP, her periods were regular, light cramping, and lasted 5-7 days. Denies any mennorhea or dysmenorrhea. For the past 15-18 months, patient stated she has been very irregular, and going greater than 45-60 days without a period. Her last PAP was in June 2014 and it was reported to her as "normal".

PMH: Patient has NKDA
Current medications include Ambien 10mg PRN at bedtime; Bystolic 10mg PO Qday; Valtrex 500mg PRN; Clonadine 0.2mg Qday; Dovan 320mg PO Qday; Aldactone 50mg PO Qday; Lasix 20mg PO Qday.
RC is a 33 year old African American, who is in fair health.

IMMUNIZATIONS: Last tetanus was in 2009. Patient had chickenpox and measles as a child. She is not a candidate for the pneumonia vaccination and has not recieved the flu shot this season. The clinic is unable to offer the flu vaccination at this time but patient was offered to come back when it was available.

PAST MEDICAL HISTORY: hypertension -being managed by her primary care physician. Her Clonidine has just been increased by her PCP in the past week from 0.1 mg to 0.2mg. Patient unsure how how her blood pressure when this adjustment was made. Patient denies any previous hospitalizations.

PAST SURGERIES: Right carpal tunnel 2005, Bilateral great toe surgery 2007; Breast reduction 2005; Tonsilectomy 1990.

FAMILY HISTORY: Mother has diabetes, and hypertension. Father died of CVA at age 65. AA denies any other family history.

SOCIAL HISTORY: RC is single and has never been married. Does not have any children. She has completed 2 years of college and is working full time in retail. RC describes her over all health as "ok" and "sedentary". RC stated she has never smoked and she but occasionally consumes ETOH. AA 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 no financial concerns and is insured with individual private health insurance through BCBS of Alabama.

REVIEW OF SYSTEMS
1). Overall RC is well appearing, moderatley obese, denies fever, chills, or fatigue. She is still able to carry out her ADL's and attend work as scheduled. No weight changes.
2). Eyes- Patient last eye exam with Opthamologist was less than 6 months ago. She does not wear corrective lenses but wears glasses when she drives. 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 a few times a week. Denies any lesions. She visits her dentist every 6 months for routine cleaning. Her last appointment was in June 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. Postive for HTN. Diagnosed at age 28. At this time it is poorly controlled but her PCP increased her Clonidine a few days ago for better control as listed above. Patient also says she is compliant with a low salt diet.
5.) Respiratory - Denies any 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. No recent change in bowel habbits. Patient states she eats a diet low in salt. Denies any intake of vitamin supplements.
7). Genitourinary - Denies any dysuria, hematuria, polyria, incontinence, discharge or flank pain. States she has a monogomous fiancé whom she is sexually active with at this time. Denies any history of STD's. Has never been pregnant. She does complain of ammenorrhea as stated in the chief complaint. Her last pap was in June 2014 and it was reported as "normal" . Patient denies ever having abnormal pap smears. Denies any history of ovarian cysts
8). Musculoskelatal - Patient denies exercises. Patient uses her seatbet regularly. Denies any joint or 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 at least 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, los of memory, or headaches.
11). Psychiatric - Denies any depression, anxiety, nervousness, insomnia, suicidal thoughts, or mental history.
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.
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 seasonal allergies since she was a child. She states she will have a "flare up 1-2 times a year" which requires additional treatment with steroids and antibiotic. Patient says she only uses antihistamines and stays away from decongestants because of her hypertension.

Objective Data:

PHYSICAL EXAMINATION
Vital signs: T - 98.7, P-64, R - 18, B/P 142/100 (manual) HT - 66" WT 270lbs BMI - 43.57
RC is a 53 year old, healthy appearing, obese 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.
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.
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.
HEMATOLOGIC - No brusing, fatigue, no bleeding. Neck and head lymph nodes are not palpable.

Assessment/Analysis:

1. Secondary ammenorrhea 626.0
Patient has been greater than 6 months with irregular periods. Last menstrual cycle was over 2 months ago. Will rule out pregnancy with Beta HCG. Check thyroid levels to include TSH. Other labs to consider to help guide the reason for secondary ammenorrhea is PRL, free testosterone, and estradiol. Patient has no history of polycystic ovarian syndrome but obesity and ammenorrhea are characteristics. May need to consider an ovarian US.
2. Hypertension, uncontrolled 401.9 - Patient stated she has only been on increased dose of Clonidine for 2 days as recentlyt prescribed by her PCP. She had not taken her Aldactone this morning because she had not eaten yet.
3. Obesity 278.0- Patient's BMI is 43.57. If PCOS is the cause of the ammenorrhea, weight-loss diet will help restore menstrual cycle.

Plan:

The following plan was discussed and agreed on with the patient.
1. Labs: Beta HCG, TSH, PRL, Free testosterone, estradiol, FSH. Depending on results, treatment will be decided. Patient requested not to be treated with oral contraceptives because she is wanted to become pregnant in the near future. If labs are abnormal, will consider ovarian US to see if ovaries are enlarged with cysts. May need a referral to ob/gyn or endocrinologist
2. Patient instructed to take Aldactone and recheck pressure. Follow up with PCP if pressure continues to run high.
3. Instructed patient that once labs are received she will be followed up with a phone call on further ins ructions.
4. Dietary managment and behavior modification for weight control.

Intervention:

Patient received information on high blood pressure and how it related to stroke. A phone call was made to the patient a couple hours ater patient left the clinic to follow up on blood pressure and patient stated her blood pressure was 136/84.
Dietary information on a low fat, low sodium diet was provided to the patient.
Instructed patient to return to the clinic if symptoms worsen. Follow-up will be decided once lab results are returned.

Evaluation: