Comprehensive SOAP Note

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Course: NURS7446 Fall 2014
Date: 9/24/2014 Patient: HB12993
Location: All Med for Women Preceptor: Yaple,Judy

Guidelines For Comprehensive SOAP Note

Subjective Data:

CC: "Clumpy white vaginal discharge"

HPI: Patient stated she has noticed a thick white clumpy vaginal discharge for the past 6 days. She stated she took Monistat OTC and it had gotten better for about 2 days but symptoms have returned. Patient states she does not have associated odor with the discharge but does have some vaginal itching.

PMH: Patient has an allergy to Bactrim. She stated she developed a rash when she took this medication in the past. She was prescribed Bactrim for a UTI in 2013.
Current medications include Ortho-tricyclen Lo i PO Qday. It is commonly prescribed as a low estrogen BCP and has an indication for dysmenorrhea. It contains estradiol 0.18mg/25mcg tabs x 7; then 0.215 mg/25mcg tabs x 7; then 0.25mg/25mcg tabs x 7; then inert tabs x 7. Tri-Sprintec, the generic, is available for $9 for a monthly pack on Walmart's generic drug program as well as on Target's generic drug program. The patient was prescribed this medication 2 years ago to help regulate her menstrual cycles. Ortho-tricylen is a low dose estrogen She started menstrating at age 13 but patient stated that she was irregular and for the first year, her periods were 6 months apart. Her periods became more regular but stated prior to being prescribed BTC, her periods would last 7 days, and she described them as painful and heavy. Patient stated that since starting Ortho-tricyclen Lo, her periods have been regular lasting an average of 5 days, with no break through bleeding.
IMMUNIZATIONS: Last tetanus was in 2012. Patient states she received all her childhood immunizations including the varecella vaccination. 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: Dysmenorrhe and UTI x 3. She was last treated for UTI in 2012.

PAST SURGERIES: Wisdom teeth extraction 2011, Appendectomy 2009

FAMILY HISTORY: Mother, age 51, has multiple sclerosis and a history of endometriosis which she had a hysterectomy in 1994. Father, age 55, has high cholesterol. Patient has one sibling, brother age 25, with no known medical problems. Patient denies any known family history of cancer, diabetes, heart or lung disease.

SOCIAL HISTORY: HB is single and has never been married. Does not have any children and denies any pregnancies. She has completed 4 years of college and is currently working full time as a paralegal. HB describes her over all health as "good" and "very active". She exercises regularly. HB stated she has never smoked and she but occasionally consumes ETOH. HB states she always wears her seatbelt when traveling. Her religious preference is Methodist 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 HB is well appearing, physically fit, denies fever, chills, or fatigue. She easily carries out all her ADL's and denies no weight changes.
2). Eyes- Patient last eye exam with Opthamologist was less than 3 months ago. She wears corrective lenses. 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.
4). Cardiovascular - Patient gets regualr exercise, about 4 times weekly. Denies any chest pain, murmurs, palpitations, dyspnea, or activity intolerance. Denies any edema, or varicose veins.
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 fat. Denies any intake of vitamin supplements.
7). Genitourinary - Denies any dysuria, hematuria, polyria, incontinence, or flank pain. States she has a monogomous boyfirend whom she is sexually active with at this time. Admits to having unprotected sex. Denies any history of STD's. Has never been pregnant. Her first and last pap was in April 2014 and it was reported as "normal" . Denies any history of ovarian cysts. States her menstrual cycles have been regular for the past 2 years lasting 5 days, light cramping associated. Patient does report a thick white clumpy discharge x 5 days.
8). Musculoskelatal - Patient exercises 4 times weekly. 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 occasional seasonal allergies She states she will have a "flare up 1-2 times a year" which requires additional treatment with antibiotics.

Objective Data:

PHYSICAL EXAMINATION
Vital signs: T - 97.9, P-88, R - 18, B/P 116/72 HT - 66" WT 122 BMI - 19.7
HB is a 21 year old, healthy appearing 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.
BREASTS: No breast masses, tenderness, asymmetry, nipple discharge or axillary lymphadenopathy.
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.
GENITOURINARY: Normally developed genitalia with no external lesions or eruptions. Vagina and cervix show no lesions but positive for a white , thick cheesy discharge. Negative for odor. Wet prep/KOH done showing numerous white cells with presence of clue cells. Bimanual exam perfomed noting no tenderness , normal uterus size. Adnexae nontender, no masses 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. Mixed vaginosis 616.10
Pelvic exam that included wet prep/KOH revealed numerous white cells consistant with yeast. It also revealed clue cells wich is clinically significant for the diagnosis of bacterial vaginosis. Thick white discharge suggested vaginosis as reported and noted on examinations suggest vaginosis.
2. Unprotected sex V69.2
Patient BCP only protected her from pregnancy but not from STD's. Sex can also increase her risk of vaginosis because it changes the vaginal pH. Patient admits to having unprotected sex. Patient was offered STD screening but did not feel it was necessary and refused.

Plan:

The following plan was discussed and agreed on with the patient.
1. Flagyl 500mgPO BID x 7 days.
2. Diflucan 150 mg PO once, repeat dose in 4 days.
3. Pelvic Rest - delay sexual relations untils sympoms resolve.
4. Use of condoms - protect agianst STD's and decrese occurance of BV
5. Patient instructed to avoid any alcohol while taking Flagyl.

Intervention:

Patient instructed to RTC if symptoms persist and does not resolve with medication regime. If symtoms recur within 2 months, will need to repeat pelvic exam and culture.

Evaluation: