NR509 week 3 soap note

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**Patient Information:**

*JNG,38, Male, Caucasian, United Healthcare*

**S.**

**CC** “Headache, back pain and cough”

**HPI**:

*Headache:*

*Onset: 1 week ago*

*Location: temporal area*

*Duration: on and off*

*Characteristics: throbbing and pressure feeling behind eyes*

*Aggravating Factors: reading and too much screen time*

*Relieving Factors: dark and quit room*

*Treatment: ibuprofen*

*Back pain:*

*Onset: 3 weeks ago*

*Location: Lumbar area both side of spine*

*Duration: present most of the time, worse in the morning*

*Characteristics: ache tight feeling, difficult to bend over at times, non-radiating*

*Aggravating Factors: sedentary time*

*Relieving Factors: going for a walk and stretching*

*Treatment: ibuprofen*

*Cough:*

*Onset: 3 days ago*

*Location: chest*

*Duration: on and off throughout day*

*Characteristics: dry nonproductive, self-limiting*

*Aggravating Factors: talking too much*

*Reliving Factors: rest and hydration*

*Treatment: none*

**Current Medications**:

* Nexium 2o mg daily for acid reflux
* Chantix 0.5 mg per day for smoking cessation with 2 weeks left
* Ibuprofen 400 mg every 6 hours as needed for back pain and headache

**Allergies:** *no known allergies to food or drugs and no know allergy to a specific environmental allergy.*

**PMHx:**

* questionable GERD with no official diagnosis
* appendectomy 30 years ago
* wisdom teeth removed approx. 20 years ago
* positive history of chicken pox, no other hospitalizations,
* hepatitis B vaccine up to date, unknown last DTap
* refused flu vaccine
* high school graduate
* every 6 month dental cleanings

**Soc Hx**: *JNG is a waiter at a restaurant and a culinary arts student, playing guitar and writing music are JNG hobbies, rescued a puppy one year ago, he is a recovering alcoholic for 4 years and is working toward quitting smoking with Chantix, no other elicit drugs, JNG is married with no children, JNG states dinking an adequate amount of water and eats a healthy diet including fruits and vegetables, JNG used to run 3 miles 4 days a week but is no longer able to. He wears his seatbelt all the time, He lives in an apartment and smoke detectors and co2 detectors are in working order. JNG is red headed, fair complexion and has many freckles and regular use of sunscreen encouraged.*

**Fam Hx:**

* paternal grandfather: Barrett’s esophagus, PVD with amputation
* Paternal grandmother: passed from unknown cancer
* Maternal grandparents: unknown health history\
* Father: no health issues
* Mother: alcoholic, tremors with undiagnosed reason, anxiety
* Brothers: adopted with no health issues

**ROS:**

CONSTITUTIONAL:  No weight loss, fever, chills, sleep disturbances, night sweats, weakness or fatigue.

HEENT:

* Head: no trauma or dizziness, headache present
* Eyes:  No visual loss, blurred vision, double vision or yellow sclerae glasses present.
* Ears: no hearing loss, dizziness, pain or discharge
* Nose: present, no drainage,
* Throat: no bleeding gums, voice changes swallowing difficulty, or sore throat, dental appliance present

SKIN: no rash, many freckles noted

CARDIOVASCULAR:  No chest pain, chest pressure or chest discomfort. No palpitations or edema, dyspnea, orthopnea, syncope or edema, no leg pain or swelling,

RESPIRATORY:  No shortness of breath sputum. Nonproductive cough present, quit smoking 3 month ago after 20+ year pack a day,

GASTROINTESTINAL:  No anorexia, nausea, vomiting, melena or diarrhea, 1 soft BM every day, no jaundice,

GENITOURINARY:  no burning or frequency with urination, steady easy to start stream

NEUROLOGICAL:  No dizziness, syncope, paralysis, seizure, ataxia, numbness or tingling in the extremities. No change in bowel or bladder control. No difficulty speaking or swallowing

MUSCULOSKELETAL:  No muscle, joint pain or stiffness, swelling, instability, able to perform ADL’s and work safely, Lumbar region back pain

HEMATOLOGIC:  No anemia, bleeding or bruising.

LYMPHATICS:  No enlarged nodes. No history of splenectomy.

PSYCHIATRIC:  No history of depression or anxiety, Positive history of alcoholism

ENDOCRINOLOGIC:  No reports of sweating, cold or heat intolerance. No polyuria or polydipsia.

ALLERGIES:  No history of asthma, hives, eczema or rhinitis, worse congestion with outdoor time

**O.**

**Physical exam**:

Vital sign: BP 120/80, HR 84, RR 20, Temp 98.7 F, o2 sat 98% on RA

Constitutional: appears well developed, healthy weight, well kempt, alert and oriented x4

HEENT:

* Head: appropriate size, shape, symmetry, scalp and hair well intact*,*
* Eyes: PERRLA, intact extraocular movement, conjunctiva clear, red light reflex present
* Ears: Bilat tympanic membrane gray, translucent and intact, no tenderness or inflammation, whisper test passed bilat, (wax present R>L)
* Nose: no discharge, olfactory sense intact, (tenderness present over frontal and maxillary sinuses, inflammation noted bilat)
* Throat: no erythema, drainage or abscess present, mucosa moist, gums intact, pharynx midline
* Skin: no lesions, bruises or open areas, (scar to right lower quad of abdomen, rash to upper back)

Cardiovascular: Heart rate and rhythm regular, no murmur, click, rubS3, S4, or gallop present, no edema, no JVD, no visible pulsations, heave or lift present, Pulses present and palpable 2+, no carotid bruit, apical impulse present at 5th ICS MCL, extremities are warm and pink, no swollen lymph nodes,

Respiratory: Chest symmetrical, tactile fremitus equal bilaterally, no tenderness, lumps or lesions, resonance noted equally bilaterally, Lung sound clear without wheeze or rales, no SOB,

Gastrointestinal: abdomen soft and flat, bowel sounds present x 4, no bruit noted, liver span 12 cm, splenic dullness noted, not palpable, no CVA tenderness, no other organomegaly or masses noted

Genitourinary: No hernia, nodules, rashes, or discharge

Neurologic:

Mental status: Alert and oriented X4, answers question appropriately, recent and remote memory intact.

Cranial nerves:

* I: olfactory nerve intact, able to smell alcohol pad
* II: Vision 20/20 bilaterally, peripheral fields intact by confrontation, optic fundus normal bilaterally
* III, IV, VI: extraocular movement by cardinal positions of gaze intact bilaterally, no ptosis or nystagmus noted, PERRLA with pupil size of 2mm, palpebral fissures equal bilaterally,
* V: Sensation intact bilaterally throughout face and equal jaw strength
* VII: facial muscles intact and symmetric with smiling and puffed check test
* VIII: whispered words heard bilaterally
* IX, X: swallowing intact with positive gag reflex, uvula and soft palate rises midline, voice smooth and unstrained
* XI: shoulder shrug, head movement intact and equal bilaterally,
* XII: tongue midline with no tremors, lingual speech clear

Motor Function: gait smooth and coordinated, tandem walk completed, negative arm drift with Romberg test, finger to nose and finger to finger smooth with eyes open and closed, no atrophy, weakness or tremors or contractures noted, full ROM of all extremities,

Sensation: sharp, light and vibration intact to all extremities, Stereognosis: able to identify a safety pin, Kinesthesia intact

Reflexes: bicep, tricep, brachioradialis, quadricep and Achilles reflex intact 2+, abdominal reflex intact, plantarflexion noted with plantar reflex

Musculoskeletal: No weakness, instability, gait disturbance, ROM intact and equal, no joint swelling, tenderness or redness, no spinal deviation, movement smooth with no crepitus noted, equal strength to all extremities and able to maintain flexion with resistance

Lymphatic: no enlarged lymph nodes, lymphedema

Psychiatric: appears calm and cooperative with exam, asking appropriate questions

 In summary, this patient demonstrated a normal neurological and musculoskeletal exam with no worsening of symptoms. The headache relates mostly with a tension-type headache because there was no nausea, photophobia or phonophobia noted with migraines. Patients complaining of a headache that demonstrate a normal neurologic exam do not require further imaging or laboratory testing. Symptoms to take more seriously regarding a headache would include patient complains of first or worst headache, headache induced by cough or exertion, change in personality, older than fifty or tenderness over temporal artery (Hainer & Matheson, 2013). Managing his back would also not include imaging studies at this time but treatment with pharmacotherapy, cognitive behavior therapy, spinal manipulation and/or lifestyle modification should be initiated. NSAIDS and muscle relaxants would be my first choice but if ineffective an opioid would be indicated. I would request a CMP to ensure his kidneys are in good working order with his recent use of ibuprofen and before initiating NAIDS (Herndon, Zoberi, & Gardner, 2015)

References

Hainer, B. L., & Matheson, E. M. (2013). Approach to acute headache in adults. *American Family Physician*, *87*(10), 682-687.

Herndon, C. M., Zoberi, K. S., & Gardner, B. J. (2015). Common questions about chronic low back pain. *American Family Physician*, *91*(10), 708-714.