Dr. Lunsford and Class,

**Week 3 SOAP Note**

**Patient Information:**

*P. P., 38, Female, Caucasian, BCBS-IL*

**S.**

**CC** (chief complaint) *“headache, back pain, and cough”*

**HPI**: *Onset: “three days ago”*

*Location: frontal headache, mid-to-low back pain, productive cough.*

*Duration: three days*

*Characteristics: throbbing frontal headache, back pain which increases with cough, and cough with white-to-yellow sputum.*

*Aggravating Factors: headache and back pain increase with cough*

*Relieving Factors: Hot showers lessen headache and cough, OTC acetaminophen relieves headache and back pain*

*Treatment: OTC acetaminophen, rest, hot showers*

**Current Medications**: *acetaminophen, 650 mg, q6h; metoprolol tartrate, 50 mg., BID, St. John’s Wort, 900 mg., BID*

**Allergies:** *NKDA*

**PMHx***: Vaccinations: Influenza 2016, Tetanus 2014; hypertension, appendectomy 1990*

**Soc Hx**: *Administrative Assistant, divorced, no children, drinks alcohol socially, non-smoker, denies past or current illicit drug use, sleeps 9 hours per night, wears seat belt at all times, working smoke detectors present in home.*

**Fam Hx**: *Paternal Grandfather (deceased, cardiac arrest): HTN; Paternal Grandmother (deceased): diabetes; Maternal Grandfather (deceased, cardiac arrest): HTN, COPD, CHF; Maternal Grandmother (alive): hypercholesterolemia; Father (alive): HTN, pre-diabetes; Mother (alive): HTN*

**ROS**:

CONSTITUTIONAL:  No weight loss, fever, chills, weakness or fatigue.

HEENT:  Eyes:  No visual loss, blurred vision, double vision or yellow sclerae. Ears, Nose, Throat:  No hearing loss, sneezing, congestion, runny nose or sore throat. (“I have a bad headache if I don’t take Tylenol at least every 6 hours and my nose has been running some.”)

SKIN:  No rash or itching.

CARDIOVASCULAR:  No chest pain, chest pressure or chest discomfort. No palpitations or edema.

RESPIRATORY:  No shortness of breath, cough or sputum. (“I have been coughing for the past three days. Sometimes there is a whitish or yellowish spit.”)

GASTROINTESTINAL:  No anorexia, nausea, vomiting or diarrhea. No abdominal pain or blood.

GENITOURINARY:  No frequency or burning on urination. No pregnancies. Last menstrual period, 07/05/17.

NEUROLOGICAL:  No headache, dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities. No change in bowel or bladder control. (“I have a bad headache if I don’t take Tylenol at least every 6 hours.”)

MUSCULOSKELETAL:  No muscle, back pain, joint pain or stiffness. (“My back hurts, halfway down and my lower back, mostly when I cough.”)

HEMATOLOGIC:  No anemia, bleeding or bruising.

LYMPHATICS:  No enlarged nodes. No history of splenectomy.

PSYCHIATRIC:  No history of depression or anxiety. (History of depression. “I take St. John’s Wort and it helps.”)

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

ALLERGIES:  No history of asthma, hives, eczema or rhinitis.

**O.**

**Physical exam**:

CONSTITUTIONAL:  Ill-appearing female of childbearing age who denies weight loss, fever, chills, weakness or fatigue.

HEENT:

Head: Normocephalic, no lesions, liumps, scaling, parasites, or tenderness. Face symmetric , no weakness, no involuntary movements. (Tenderness on palpation of frontal and maxillary sinuses. Rhinorrhea present.)

Eyes: Visual acuity intact, EOMs intact, no nystagmus. No ptosis, lid lag, discharge, or crusting. Corneal light reflex symmetric, no strabismus. Conjuctivae clear. Sclera white; no leasions or redness. Pupils 3 mm resting, 2 mm constricted and equal, bilaterally. PERRLA.

Ears: No mass, lesions, scaling, discharge, or tenderness to palpation of pinna. Canals clear. Tympanic membrane pearly gray, landmarks intact, no performation. Whispered words heard bilaterally.

Nose: No deformities or tenderness to palpation. Nares patent. Mucosa pink; no lesions. Septum midline; no performation. (Rhinorrhea present.)

Mouth: Mucosa and ginivae pink; no lesions or bleeding. Dentition in good repair. Gingivae pink without edema, erythema, or lesions noted. Tongue symmetric, protrudes midline, no tremor. Pharynx pink; no exudate. Uvula rises midline on phonation. Tonsils 1+. Gag reflex present.

Neck: Supple with full ROM. Symmetric; no massess, tenderness, lymphadenopathy. Trachea midline. Thyroid nonpalpable, non-tender. Jugular veins flat at 45 degrees. Carotid arteries 2+ and equal bilaterally; no bruits.

SKIN: Uniformly tan-pink in color, warm dry, intact; turgor good. No lesions, birthmarks, edema. Nail beds pink with good capillary refill.

CARDIOVASCULAR:  No thrills, murmurs, clicks, or gallops heard. No abnormal pulsations, lifts, or heaves noted. No JVD. All pulses 2+ and equal in all extremities. No bruits.

RESPIRATORY:  Respirations unlabored, even, and without distress. Vesicular breath sounds heard throughout without adventitious sounds noted. Chest expansion symmetric. (Productive cough exacerbated with deep breathing during exam.)

GASTROINTESTINAL: Flat, symmetric. Skin smooth with no lesions, scars, or striae. Bowel sounds present, no bruits. Tympany in all four quadrants. Abdomen soft; no organomegaly; no massess or tenderness; no inguinal lymphadenopathy.

GENITOURINARY:  External genitalia without lesions. Introitus normal, vaginal walls pink and moist without lesions or evidence of trauma. There is no cervical motion tenderness and the adnexa are without masses. There is no abnormal discharge from the cervix.

NEUROLOGICAL:  Alert and oriented to person, place, and time. No mental status deficits noted. Cranial nerves intact. Babinski negative. Romberg negative. No motor deficits noted. No atrophy, weakness, or tremors.

MUSCULOSKELETAL:  Normal gait. Joints with full ROM without pain, without deformities. Spine with full ROM and curvature normal. No paravertebral tenderness. Able to mantain flexion against resistance without tenderness.

HEMATOLOGIC:  No bleeding or bruising noted.

LYMPHATICS:  No enlarged nodes.

PSYCHIATRIC:  Normal mood and affect. Intact judgment and insight.

**Diagnostic results**: *Tests performed at today’s visit will include a CBC to rule out infectious process.*

**A.**

Utilizing the data received in the subjective and objective portions of this assessment, and the patient’s stated complaints, I would consider the following differential diagnoses: sinusitis, upper respiratory infection (viral vs. bacterial), and lumbar strain.

**P.**

 My plan is to educate this patient regarding acetaminophen dosing. While she reports that she is staying within the guideline of no more than 4 grams of acetaminophen in a 24-hour period, she did make a statement during the review of systems indicating her headache is controlled if she takes it “at least every 6 hours”. I would encourage her to continue using acetaminophen to relieve the headache and back pain. I would also suggest that she try adding and OTC decongestant to help relieve the headache, rhinorrhea, and productive cough. In this regard, education would also include the necessity of reading a list of ingredients on all OTC medications, to ensure that the patient is not taking a combination decongestant/pain reliever that might also contain acetaminophen along with her current dose of acetaminophen.

Because this patient has reported the use of St. John’s Wort for treatment of depression, I would also consider offering some homeopathic suggestions to this patient. Lambeau (2016) suggests “camphor, eucalyptus, and menthol also provide symptomatic relief of nasal congestion and cough when applied to the chest or neck” (p. 95). Lambeau (2016) also states that zinc may reduce the duration of an upper respiratory infection, while honey can be used to relieve a cough (p. 95).

As mentioned earlier, I would order a CBC for this patient. The CBC would advise me of any infectious process. I would decline to prescribe antibiotics for this patient at this time.

References

Lambeau, K., (2016). Cold and cough symptom relief. *The clinical advisor: For nurse practitioners, 19*(1), 94-96.