**SOAP Note Format**

**Patient Information:**

ASB, 34 year old, Male, Caucasian, Self-pay (no insurance)

**S.**

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

**HPI**:

*Onset:* cough and back pain began 3 months ago, headache and back pain for 2 days after riding a horse that tried to “buck” him off

*Location:* bilateral pain to forehead, lower back pain above buttocks

*Duration:* headache and back pain continuous for past 2 days

*Characteristics:* dull, aching pain with pressure to forehead, mild severity headache, dry cough without pain, back pain mild severity but is sore and “feels tight”

*Aggravating Factors:* working outside in the heat makes the headache worse, moderate exercise and going from lying to sitting position makes back pain worse, cough gets worse after eating

*Relieving Factors:* closing eyes and rest makes headache go away, lying flat on his back decreases back pain, cough decreases with bland meals

*Treatment:* Motrin 400 mg by mouth every 4 hours taken for headache and back pain, no treatment for cough

**Current Medications**: Motrin 400 mg PO every 4-6 hours for headache and back pain

**Allergies:** No known drug, environmental, or food allergies*.*

**PMHx**: Immunizations up to date. Tetanus vaccine 2016. Influenza vaccine 2016. No major surgeries. No medical problems.

**Soc Hx**:Works as a self-employed horse trainer. Hobbies include hiking and boating. Pt lives with his parents in a ranch-style home. No children. Denies alcohol, tobacco, and drug use. Pt does not wear a helmet when horse-back riding.

**Fam Hx**:

*Maternal grandmother-* arthritis, hypertension, depression

*Maternal grandfather-* hypertension, gastroesophageal reflux disease, spontaneous pneumothorax

*Paternal grandmother-* unknown

*Paternal grandfather-* unknown

*Mother-* anxiety, depression

*Father-* unknown

**ROS**:

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

HEENT:  Eyes:  No visual loss, blurred vision, double vision or yellow sclera. Ears, Nose, Throat:  No hearing loss, sneezing, runny nose or sore throat.

SKIN:  No rash or itching.

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

RESPIRATORY:  No shortness of breath. + dry, non-productive cough

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

GENITOURINARY:  No burning with urination.

NEUROLOGICAL:  No dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities. No change in bowel or bladder control. +headache to bilateral forehead.

MUSCULOSKELETAL:  No joint pain or stiffness. + lower back pain

HEMATOLOGIC:  No anemia, bleeding or bruising.

LYMPHATICS:  No enlarged nodes. No history of splenectomy.

PSYCHIATRIC:  No history of depression or anxiety.

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**:

VITAL SIGNS: BP 112/62, T: 97.8, HR: 68, RR:16, WT 172, HT 5’11”

CONSTITUTIONAL:  Well appearing, well nourished, in no distress. Oriented x 3, normal mood and affect. Ambulating without difficulty.

HEENT:

Head: Normocephalic, atraumatic, no visible or palpable masses, depressions, or scaring. Facial features symmetrical and overall unremarkable. No weakness noted. Hair distribution, texture, and quantity overall unremarkable.

Eyes: Visual acuity intact, conjunctiva pink and without excess vascularity. No discharge, excessive tearing, or photophobia. Sclera white, EOM intact, PERRL 4mm, fundi have normal optic discs and vessels. No exudates or hemorrhages.

Ears: External auditory canals clear, TMs translucent and mobile, ossicles normal appearance, hearing intact. No lesions noted to external structures. No tenderness on retraction of pinnae or pressure to tragus. Forced whisper perceived accurately at 5 feet. Weber: midline-no lateralization. Rhinne test: AC > BC.

Nose: No external lesions, mucosa non-inflamed, septum and turbinates normal. Symmetrical without evidence of septal deviation or trauma. Nares patent and turbines intact. Mucosa is pink and without evidence of discharge, exudates, swelling, or congestion. No parasinus tenderness. Sinuses transluminate equally bilaterally.

Mouth: Mucosa pink and moist without lesions to the buccal cavity. Dentition in good repair. Gingivae pink without edema, erythema, or lesions noted. Tongue is midline without fasciculation. No coating or lesion noted. No odor present.

Throat:  Oropharynx without erythema, exudates or increased lymphoid tissue noted. Tonsils are present and otherwise unremarkable. Uvula is midline and rises symmetrically. Gag reflex intact. Phonation without hoarseness and otherwise unremarkable.

Neck: Supple with full range of motion. Symmetrical. Trachea midline. Thyroid is not enlarged and is without nodularity. No cervical spine tenderness.

SKIN:  No rash. Good turgor. Overall fair without unusual bruising or prominent lesions. Nail beds pink with good capillary refill. Skin warm and dry to touch.

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

RESPIRATORY: Respirations unlabored and even without distress. Vesicular breath sounds heard throughout without adventitious sounds noted. No egophony, whispered pectoriloguy, or bronchophony is noted.

GASTROINTESTINAL:  Unremarkable to inspection with normoactive bowel sounds heard in all 4 quadrants. Tympanic percussion noted throughout. No tenderness to palpation. Abdomen is without organomegaly or abdominal masses. No lateral pulsation to aortic region. No CVA tenderness. Negative for Blumberg’s sign, Illiopsoas sign, Murphy’s sign, and Rovsing’s sign.

GENITOURINARY:   Exam deferred.

NEUROLOGICAL:  Alert and oriented x 3. No mental status deficits noted. Babinski negative. Romberg negative. No motor deficits noted. Cranial nerves intact. Olfactory-Pt able to identify different smell with each nostril separately. Optic-Pt able to read with each eye and both eyes. Oculomotor-PERRLA. Trochlear- Both eyes are able to move as necessary. Trigeminal- +corneal reflexes, sensitive to pain stimuli and distinguish hot from cold. Abducens- both eyes move in coordination. Facial- Pt able to make various facial expressions without difficulty and able to distinguish between different tastes. Vestibuloccochlear- Pt able to hear equally in both ears. Pt able to ambulate in an upright position without losing balance. Glossopharyngeal- + gag reflex and able to swallow without difficulty. Vagus- able to swallow without difficulty. Speech is audible. Accessory- able to shrug shoulders and turn his head from one side to the other without difficulty or pain. Hypoglossal- able to move tongue in different directions.

MUSCULOSKELETAL:  Normal gait. Muscle strength 5/5 to all groups. Joints with full range of motion to all planes and without deformities. Spine with full range of motion and curvature normal. No paravertebral tenderness.

HEMATOLOGIC:  No bleeding or bruising noted.

LYMPHATICS:  No enlarged nodes.

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

**Diagnostic results**: *No past or recent test results available.*

In this case scenario, my primary intervention would be to complete a comprehensive neurological exam in order to rule out a mild traumatic brain injury (TBI), otherwise known as a concussion. This patient is complaining of back pain and a headache after riding a bucking horse two days ago. Since a direct impact is not required to cause a TBI, I would still need to rule out an injury to the head that could have been caused by rotational forces being applied to the brain, related to the back and forth motions that were created when the horse attempted to buck the patient off of him. Based on his negative neurological findings, neuroimaging at this time is not warranted but, rather, the patient should be given verbal and written instructions on when to seek further medical care. I would recommend that the patient be monitored at home by a responsible caregiver who also would have the ability to seek medical care for my patient if he starts to show symptoms of a concussion, which could include, but is not limited to, personality changes, confusion, delayed verbal responses, loss of consciousness, increased sleep, blurred vision, dizziness, nausea, and vomiting. My treatment plan would include advising physical rest and Tylenol. I would advise him to discontinue his usage of Motrin to treat his headache and back pain since it could cause further bleeding if he were to develop intracranial bleeding (Scorza, Raleigh, & O’Connor, 2012). I would also take this opportunity to provide education on the importance of wearing a United States Equestrian Federation approved helmet while participating in any equestrian activities, not just riding, to decrease the risk of injury (Lemoine, Tate, & Lacombe, 2017).

Regarding my patient’s complaint of low back pain, my ability to obtain an accurate history and physical exam, especially of the lumbosacral and abdominal region, is paramount in differentiating serious exam findings from benign. This patient has a normal neurologic examination of the lower extremities that assesses strength, sensation, and reflexes so my treatment for nonspecific acute low back pain would be advising the patient to take Tylenol for pain. Since I am also concerned about a possible TBI, I would also advise the patient to stay passively active without aggravating his headache and low back pain, while still avoiding complete bed rest (Casazza, 2012).

Lastly, based on his description of a dry, non-productive cough that is worse after eating, I would diagnose him with gastroesophageal reflux (GERD), where a chronic cough lasting over eight weeks long is indicative of this disease. Treatment would include prescribing him a prokinetic agent like metoclopramide (Reglan), as well as an acid suppressant with a proton pump inhibitor like esomeprazole (Nexium). Patient follow-up will be necessary to ensure that the patient continues to recover without further issues (Mahashur, 2015).

Elizabeth

References

Casazza, B. (2012). Diagnosis and treatment of acute low back pain. *American Family Physician, 85*(4), 343-350. Retrieved from http://www.aafp.org/afp/2012/0215/p343.html

Lemoine, D., Tate, B., & Lacombe, J. (2017). A retrospective cohort study of traumatic brain injury and usage of protective headgear during equestrian activities. *Journal of Trauma Nursing, 24*(4), 251-257. doi:10.1097/JTN.0000000000000300

Mahashur, A. (2015). Chronic dry cough: Diagnostic and management approaches. *Lung India, 32*(1), 44-49. doi:10.4103/0970-2113.148450

Scorza, K., Raleigh, M., & O’Connor, F. (2012). Current concepts in concussion: Evaluation and management. *American Family Physician, 85*(2), 123-132. Retrieved from <http://www.aafp.org/afp/2012/0115/p123.html>