Comprehensive SOAP Note

Student: Skyler Sherrell

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| Course | NURS7446 Fall 2014 |  |  |
| Date: | 9/24/2014 | Patient: | (Select Patient) |
| Location: | Dr. Kenneth and Kish McLeod | Preceptor: | McLeod,Kish |
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| [Guidelines For Comprehensive SOAP Note](http://np.medatrax.com/login/forms/Comprehensive_SOAPNote_help.asp) | | | |
| **Subjective Data:** | |  | |
| SUBJECTIVE DATA (S):  IDENTIFYING DATA:  Initials: J.S.  Age: 18 months  Race: Caucasian  Gender: Male  Marital Status: Single  Height: 33.2 inches  Weight: 28lbs  Historian: Patient’s mother, S.F.  CHIEF COMPLAINT (CC): Patient’s mother states that she “thinks he has an ear infection.”  HISTORY OF PRESENT ILLNESS (HPI): Per the patient’s mother, he has been pulling at his left ear and running a low grade  temperature for around 2 days. The patient has been very irritable and somewhat fussy as well. She said that she gives him liquid  Tylenol in order to help with the pain and break his fever, with this working for around 6 hours before she has to give him more.  She also states that she has taken him to the local urgent care two times in the past year for the same symptoms. When this  happened, the patient was placed on antibiotics that she cannot remember the name of at this time.  • location: pain in the left ear, noted when patient cries that he pulls on the lobe of this ear  • quality: unable to assess  • severity: via the “Cries” pain scale, the patient is an 8 out of 10  • timing: symptoms started 2 days ago  • setting: N/A  • alleviating and aggravating factors: pain is relived when the patient is given Tylenol  • associated signs and symptoms: redness of the ear  PAST MEDICAL HISTORY (PMH):  • Allergies: Augmentin  • Current medications: Daily gummy multivitamin.  • Age/health status: 18 months old  • Appropriate immunization status: Up to date on all vaccines. Has had the following vaccines:  o Hep B series  o DTaP: 1st, 2nd, and 3rd dose  o IPV: 1st, 2nd, and 3rd  o MMR: 1st dose  o VAR: 1st dose  o Hep A series  • Previous screening tests result: Patient’s mother states that he is up to date on all and well baby screens. He has not yet had  his lead level checked. We will order this today and follow-up.  • Dates of illnesses during childhood: 2 ear infections over the past year, per the patients mother. She does not remember the  exact dates of these.  • Hospitalizations: No hospitalizations other than at birth.  • Developmental status: Patient has reached appropriate developmental milestones.  PREGNANCY AND BIRTH HISTORY:  • Maternal health during pregnancy: Mother had no medical problems during pregnancy. She did take a multivitamin and folic  acid during pregnancy. These were the only medications at the time. Was diagnosed with thyroid cancer on the date of patient’s  delivery.  • Gestational Age at delivery: 38 weeks  • Labor and Delivery: Patient was delivered via scheduled C-section with no complications.  FAMILY HISTORY (FH): Father has a history of type 2 diabetes, with which he was diagnosed approx 2 year ago; Mother is alive  and has a history of thyroid cancer, for which she has had radiation treatment in the past. Patient has one half brother, who lives  in Wisconsin. The patients father works at night at a local restaurant and the patients mother is a registered nurse.  SOCIAL HISTORY (SH): Patient’s parents are married. During the fall/winter months the patient’s grandmother from Las Vegas  visits and takes care of the patient during the day. She arrived approx 2 weeks ago. Before this the patient was in daycare. A brief  social history of the family was obtained and the only significant finding is that the patient’s father smokes in the home.  REVIEW OF SYSTEMS (ROS):   1. Constitutional: Patient has been more irritable and cries much more than normal, as mentioned in HPI, Has been running low   grade temp   1. HEENT-. No discharge or drainage from the eyes, nose or throat. Patient is consistently pulling at his left ear and does show   signs of guarding when approached.  3. Cardiovascular- No cardiac abnormalities noted.  4. Respiratory- No cough, wheezing or difficulty breathing.  5. Gastrointestinal- Patients mother says that he has been eating well, having normal, formed bowel movements.  6. Genitourinary- No difficulties urinating, patient has begun potty training, but still uses the diaper at bedtime.  7. Musculoskeletal- Patient is walking on his own with no difficulties.  8. Integumentary- No rash, skin lesions or mottling of the skin.  9. Neurologic- Neurologically intact.  10. Psychiatric- Patient plays well with others when in day care. Normal temperament. | |  | |
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| **Objective Data:** | |  | |
| OBJECTIVE DATA (O):  1. Constitutional- VS: Temp- 101.2, BP- 98/65, HR- 110, RR- 32, Height- , 33.2 inches, Weight- 28 lbs;  2. General Appearance- Patient sitting on exam table. Moves all extremities well, was seen walking in room upon my entrance.  Appears to be irritable and cries intermittently. Patient noted to be guarding his left ear.  3. Head- Head is normocephalic, fontanels are closed, suture lines intact. Hair distribution is normal.  4. Eyes- sclerae white. Conjunctivae pink. Pupils are responsive. Extraocular movements intact.  5. Ear, Nose, Throat-  Ears: external appearance normal-no lesions, redness, or swelling; on otoscopic exam tympanic membranes and inner ear are  red, fluid is also noted behind the tympanic membrane. Hearing is intact.  Nose: appearance of nose normal with no mucous, inflammation or lesions present. Nares patent. Septum is midline. No nasal  flaring.  Mouth: pink, moist mucous membranes. Patient has 8 total teeth.  Throat: no inflammation or lesions present.  6. Cardiovascular- S1, S2. Regular rate and rhythm, no murmurs, gallops, or rubs. Cap refill less than 3 seconds on all extremities.  7. Respiratory- Even and unlabored. Clear to auscultation bilaterally without wheezes, rales, or rhonchi.  8. Gastrointestinal- abdomen soft and nontender to palpation, nondistended. No rigidity or guarding, no masses present,  BS present in all 4 quadrants  9. Genitourinary- No bladder distention. Two testes palpated. No redness or diaper rash noted.  10. Musculoskeletal- joint stability normal in all extremities, no tenderness to palpation  11. Integument/lymphatic-  Inspection: No scaling or breaks on skin, face, neck, or arms.  General palpation: no skin or subcutaneous tissue masses present, no tenderness, skin turgor normal  Face: no rash, lesion, or discoloration present  Lower Extremities: no rash, lesion, or discoloration present  Upper Extremities: no rash, lesion, or discoloration present  12. Neurologic- Communication ability within normal limits, attention and concentration normal. Sensation intact to light touch.  13. Psychiatric- Cooperative. Patient appears to be irritable.  14. Hematologic/immunologic- Lymph nodes not palpable, no tenderness or masses present, no bruising  DIAGNOSTIC TESTS:  - No diagnostic tests were ordered in the clinic | |  | |
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| **Assessment/Analysis:** | |  | |
| ASSESSMENT (A):  - Visit Level: 3  - CPT Code: 99213  1. Otitis Media  382.9: Otitis media, unspecified  Mother reports that patient has been pulling at his left ear and crying more than usual, which is a sign of pain in a pediatric patient.  He has also been running a low grade fever. Upon assessment, the ear canal and tympanic membrane are both red, with fluid noted behind the tympanic membrane.  Differential Diagnoses:  • URI  465.9 Acute upper respiratory infection  Patient is having ear pain and there is fluid noted behind the patient’s ear. Also has low grade temp. This could be an early sign  of a URI.  Refuting data: There are no respiratory symptoms, such as coughing noted.  • Sinusitis  743.9 Sinusitis  Patient has fluid behind the ear and redness noted in the ear canal. Also has low grade temp.  Refuting data: Patient does not have nasal drainage, signs or a red or sore throat or sinus tenderness.  • Otitis Externa  380.22 Acute Otitis Externa  Patient is pulling his left ear lobe and according to the patient’s mother he has been much more irritable lately.  Refuting data: The ear is red and inflamed into the canal. There is also fluid noted behind the tympanic membrane.  • Pharyngitis  462.0 Acute viral Pharyngitis  Patient is running a low grade temperature that has been present for 2 days. He is having ear pain and redness.  Refuting data: The patient is having no problems with throat soreness and the throat is not red upon physical exam. | |  | |
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| **Plan:** | |  | |
| PLAN (P):  1. Medication: Amoxicillin 150mg of 125mg/5mL BID for 10 days,  a. Indication for this patient: Treatment of Otitis Media  b. MOA (brief):  c. Usual dosage: 25 mg/kg/day in divided doses every 12 hours  d. Available as name brand, generic or both: Available as both.  e. List the names of the 3 pharmacies contacted: Coastal Pharmacy, Publix, WalMart in Foley, AL  f. Cost of prescription at each pharmacy as prescribed: $10.89, Free, $3  2. Outside Labs: Lead level (children need lead levels at 1, 2, & 3 years; he has not yet had one); CBC (to check WBC)  3. Follow-up: Two weeks or earlier if symptoms worsen. This will give the child time to have completed the full cycle of antibiotics.  4. Educations  a. Treatment plan: Reinforce the importance of completing the entire dose of antibiotics, regardless of if the patient begins to feel  better after just a few days. If he misses a dose, take the missed dose immediately.  b. Health Promotion: Smoking cessation of family members who are often around the child is very important. When a child has  multiple episodes of AOM, it is often related to smoking in the home.  c. Health Maintenance: Elsewise the patient seems to be doing very well. Positive reinforcement of parenting skills is appropriate.  d. Prevention: Encourage parent not to clean the patient’s ear with a Q-tip. Use soapy water to rinse the ear. | |  | |
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| **Intervention:** | |  | |
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| **Evaluation:** | |  | |
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