EXAMPLES OF SOAP NOTES FOR ACUTE PROBLEMS

EXAMPLE #1

Complete HPI

S: MS is a 77 y/o woman who presents with a rash. The rash began one week ago and first appeared on her back and extended to her abdomen on the left side. She first noticed the rash after working in her garden. For the first 3 days she had no associated symptoms, however on the 4th day, she began to experience severe pain "like being stung by a bee". The pain is worse in the evenings and she is having difficulty sleeping. She has been taking Tylenol every 4-6 hours and using Vitamin E lotion with minimal relief. She is worried she may have poison ivy.

One paragraph summary of medical history & medications

She has a history of hypertension. Her medications include: Nifedipine XL 30mg daily and Metoprolol 50mg BID.

O: MS is an elderly woman who appears energetic and in no distress. VS: BP 130/80, P 60, RR 12, T 37°. Skin exam reveals an erythematous rash of grouped vesicles with clear fluid, approximately half of which are crusted over. The rash extends from the midline of the back anterior to the left side of the T12/L1 dermatome region.

One sentence summary of the problem

A: A new onset painful rash in a dermatomal distribution. This is most likely secondary to herpes zoster because of the location, distribution and associated pain. A less likely possibility is contact dermatitis, given her recent gardening. She may also have a cellulitis, but the lack of temperature doesn't support this.

Differential diagnosis and clinical reasoning for an acute problem

P: #1 MS will continue to use Tylenol for pain relief.
#2 MS was informed that she may continue to experience pain after the rash resolves.
#3 MS should return to clinic if the pain becomes more severe or if she develops warm, redness or a fever.

EXAMPLE #2

HPI with pertinent ROS

S: Ms. Z is a 58 y/o woman who comes into clinic with a 10 day h/o a cough. It seemed to start as a "chest cold" but has not gotten any better. The cough is productive of clear sputum and seems to be worse at night when lying down. She has tried cough medicine without relief. She has also noticed some wheezing and that her chest feels tight. She has had a low-grade fever to 100°, with no chills. She is worried she has pneumonia. She denies PND and LE edema, but does report shortness of breath with exertion after walking 1 block on level ground. She has had no hemoptysis.

One sentence summary of problem

She has no h/o pulmonary problems. She has type 2 diabetes controlled on metformin 500mg BID. She smokes 1 ppd and has done so for 40 years.

O: Ms. Z looks tired and her breathing is somewhat labored.
VS: T 99.8, P 92 reg, R 28, BP 110/70
Lungs: Diffuse wheezes are present bilaterally with expiration. No crackles or rhonchi.
CV: JVP is 6cm above the right atrium, PMI non-displaced. RRR, no murmurs, normal S1 and S2.
EXT: No edema.
CXR: No pneumonia or effusion. No cardiomegaly.

A: Recent onset of cough and SOB. Most likely represents bronchitis complicated by bronchospasm given acute onset, fever and exam findings of diffuse wheezes. CXR and exam confirm no bacterial pneumonia, though a viral or atypical pneumonia is still possible. Congestive heart failure seems unlikely, as one would expect edema, an elevated JVP, and a S3.

Differential diagnosis and clinical reasoning for an acute problem

P: #1 Treat with albuterol inhaler 2 puffs QID.
#2 Instructed Ms. Z how to use inhaler.
#3 Advised Ms. A to quit smoking.
#4 Follow-up in clinic tomorrow. If symptoms are worse, call the on-call physician or go to the ER.

EXAMPLE #3

S: JB is a 40 y/o woman who presents with a 3 month history of increasing fatigue. She first noticed that she felt tired when she was working long hours to get a job done at work, but has been working her usual 8 hours a day for the past 2 months and has not regained her energy. She describes her fatigue as "feeling limp". Her fatigue is present throughout the day, but is worse with significant exertion such as walking more than 3-4 blocks or going up a more than one flight of stairs. She has tried to go to bed earlier, but even sleeping up to 10 hours/night (she usually gets 8 hours/night) has not resulted in less fatigue. She is concerned that there is something seriously wrong as she is usually quite full of energy and her family and friends are starting to ask her if she is sick. She also has not been able to exercise, which she usually enjoys.

Extensive pertinent +/- ROS can be included in a separate paragraph

She does not report any chest pain, shortness of breath, abdominal pain, N/V/D or any change in her stools. She has no alopecia or skin changes. She has had no fever, chills or night sweats. She has gained about 6-7 lbs in the last few months, she assumes from inactivity due to her fatigue. She does not feel depressed mood, sadness, or anhedonia. She states that she goes to bed at 10pm and wakes up feeling tired at 6am on weekdays and 8am on the weekends. Her husband states that she has "always" snored quite loudly. Her menses are regular in timing, heavy flow for 1-2 days, then lighter for another 2-3 days. This pattern is unchanged from prior to the onset of her fatigue. Her last menstrual period was one week ago.

She has a history of GERD and depression. Her medications include: Ranitidine 150 mg po qhs, Sertraline 100 mg daily, Calcium 600 mg BID

O: Generally JB appears well in no acute distress.
T 97.9, P 80reg, RR 12, BP 140/86, Ht 67 in., Wt 195lbs, BMI~30
SKIN: not pale, no rashes
NECK: No thyromegaly or thyroid nodules.
NODES: no cervical , axillary or inguinal lymphadenopathy.
CHEST: clear to auscultation and percussion bilaterally
CV: rhythm and rate are regular (RRR), (+) 2/6 systolic ejection murmur heard best at the LLSB and radiates to the apex. No S3 or S4.
ABD: normal active bowel sounds, no hepatospenomegaly by palpation or percussion, no abdominal tenderness
EXT: no edema, 2+ posterior tibialis and dorsalis pedis

Extensive exam completed because there is a broad differential diagnosis for problem

One sentence summary of problem

Differential diagnosis and clinical reasoning for an acute problem

A: Recent onset of fatigue, with no obvious inciting event. Hypothyroidism is possible especially given her weight gain, though this also may have occurred from her inactivity. It is possible that she is anemic, though her menstrual periods have not lengthened or increased and there is no other obvious source of blood loss. A recent menses makes pregnancy unlikely. Given her history of snoring and HTN, sleep apnea is possible, but her history of snoring over many years is not entirely consistent with her more recent onset of fatigue. Her use of HCTZ does put her at higher risk of hypokalemia, which if severe, could contribute to fatigue. She does not seem to have recurrence of her depression since she has no new symptoms. She does not have symptoms of infection, nor has her murmur changed, so subacute bacterial endocarditis is possible but unlikely.

P: #1 Check TSH to rule out hypothyroidism.
#2 Check CBC to rule out anemia.
#3 Check K to rule out hypokalemia.
#4 If the above are unremarkable, consider sleep study to rule out sleep apnea.
#5 Also consider blood cultures to rule our subacute bacterial endocarditis.
#6 Follow-up visit in 1 week to discuss test results and further work-up.