**N703 Chronic SOAP Note**

**Date Active Problems Date Resolved/ Inactive Problems**

2002 Hyperlipidemia 2002 Congestive Heart Failure

2004 Mitral Valve Disorder 2005 Pancreatitis

2004 Tricuspid Valve Disease 2005 MI

2006 Myalgia and myositis 2006 CVA

2009 Hypothyroid

**Risk Factors Problems at Risk For**

CAD Stoke, MI

HTN Stroke, MI

Post Menopausal Hormone imbalance, depression

**CC:** 1/22/09 51 year old African American female presents to the office for a follow up visit concerning her hyperlipidemia and complains of “fatigue over the past three months”.

**S: HOPI**

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**ROS:** Visual:

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 **Health Maintenance:**

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 **Family History:** Mother: HTN

 Father: HTN

 Maternal Grandmother:

 Maternal grandfather: HTN

 Paternal grandmother: DM

 Paternal Grandfather: CAD,

 **Personal/Social Profile:**

 **Medications:**

 **Allergies:**

**O:**

**Vitals:** BP = 110/80, Pulse = 80, respirations = 18, Temp = 98.5 F, Ht 157.5 cm (5feet 2 inches), Wt. 50.44 kg (111 lbs 3.2 oz), BMI 20.34

**General:** African American female who appears her age, in no acute distress. Appears to have a flat affect.

**Skin:** Light brown, warm and dry. No lesions, rashes or ulcers. Skin turgor good

**Hair:** texture is course, shoulder length black hair. Equal distribution with no areas of hair loss

**Chest:** Symmetric expansions, no rales/ rhonchi/ wheezes noted. Respirations equal and clear throughout all lung fields

**Heart:** RRR, S1 and S2 audible, No gallops or rubs, PMI @ 5th ICS @ midclavicular line, no edema noted, peripheral pulses present

**Abdomen:** Soft, non-tender, non-distended. Liver and spleen non palpable.

**Ears:** TM pearly gray, bony landmarks visible, no bulging or drainage noted bilaterally.

**Eyes:** PERRLA, no erythema or visible discharge noted bilaterally

**Nose:** No erythema or edema noted. No nasal discharge. Septum intact.

**Throat:** No visible exudates, no petechiae. Mucus membranes moist and pink. Teeth intact

**Neck:** No lymphadenopathy noted. Thyroid non-palpable

**Neuro:** CN II – XII intact, sensory intact, strength equal bilaterally, no tremors or nystagmus noted.

**Psych:** Alert and oriented X3. Recent and remote memory intact. Romberg: no drift. Gait strong and steady. Flat affect. Pt. appears quiet and distant

**Labs:** TC – 269

 **TG –** 62

 **HDL –** 75

 **LDL –** 182

 **ALT/ AST –** 21

 **GLU –** 97

 **TSH –** 3.8

 **GFR –** 94.5

 **Creatinine –** 0.82

 **Potassium –** 4.1

**A:**

1. Hyperlipidemia
2. Depression
3. Health maintenance: Mammogram due 2009

**P:** 1.) Recommended LDL goal of < 100 due to her past TIA and post menopausal state. LDL has increased 11 points from last visit 3 months ago and remains moderately elevated. Start Welchol 625 mg three tablets twice daily with meals and a full glass of water. Take this medication at least 1-2 hours apart from your other medications. Blood pressure is well controlled. This patient is advised to exercise 30 minutes at least three times per week and follow a low saturated, low Trans fat diet.

 2.) Start Zoloft 50 mg daily. Take ½ tablet for the first four days and then increase to one tablet daily. Take in evening as drowsiness may occur. Find a co worker or a friend that you can talk to and try to identify and eliminate stressors in life. Pt. is also recommended to seek out counseling. Patient’s employer offers free and confidential counseling services to employees. This patient is encouraged to call and set up an appointment. This patient is also encouraged to set up a daily routine and a set bedtime as this may help to eliminate extra feelings of fatigue. Patient is instructed to have her TSH level rechecked in 6 months.

 3.) Schedule mammogram in two weeks. Patient educations regarding calcium intake and eating three meals per day with small snacks or six small meals per day.

 4.) Follow up in 3 months. Patient instructed to return sooner if new symptoms develop.