

Walden University

NRNP 6568

Week 6 Assignment: Focused SOAP note

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Case Study:

Edwin is a 69-year-old male who comes into the clinic today stating that over the past few days, he has had a fever and chills, cough, and has been quite fatigued. He didn't take his temperature because he did not have a thermometer but he "felt hot." He says he is coughing up a little phlegm. He states that it hurts when he takes a deep breath. He also states that his appetite has not been very good. He has been taking Tylenol with minimal relief. He has also been drinking teas to try to break up the phlegm.

Edwin is a nonsmoker and non-drinker. He has been very healthy and has no medical problems. He has never had surgery.

On exam, his vital signs: BP 130/80; P 84; R 14; T 103.2; Pulse ox: 94%.

Exam reveals decreased rales and rhonchi, more pronounced in the left lower lung fields, with increased fremitus and dullness to percussion. Chest x-ray reveals a consolidation in the left lower lobe. This appears to confirm that he has pneumonia.

Patient Information: E.W.

S.

CC: Fever, chills, cough, and fatigue.

HPI: E.W. is a 69-year-old Caucasian male who comes into the clinic today with complaints of fever, chills, cough, and fatigue that started abruptly approximately 3 days ago. He reports that it hurts to take a deep breath. He states that he has "felt hot" but has not taken his temperature because he does not have a thermometer. He reports coughing up a little phlegm that is green colored. Denies blood in the phlegm. He reports having a decreased appetite. He states he has been taking OTC Tylenol with minimal relief of symptoms. He rates his discomfort as a 6/10 scale. He reports drinking warm tea to help break up the phlegm. Patient denies tobacco and alcohol use. States that he has been very healthy and has no medical problems, other than an allergy to penicillin since childhood. He denies confusion, falls, hospitalizations, and surgeries. He denies being sick prior to this incidence or taking any antibiotics in the previous 3 months.

Current Medications: Centrum Silver for Men, Vitamin D3, OTC Tylenol.

Allergies: PCN (rash).

PMHx: He denies chronic medical conditions. Patient states he's had "all the usual childhood illnesses". Denies surgical history or hospitalizations. He reports having been born without complications.

Immunizations: Tetanus 2018, Tdap 2018, PPD 2018 negative, Shingrix 2014, Influenza vaccine 10/2021, Covid-19 vaccine (Moderna) 07/2020, Covid booster (Pfizer) 9/2021.

Soc & Substance Hx: Married with 3 children. He lives in town with his wife, and they own their home. He denies pets because they like to travel. They are both retired from the family-owned insurance sales office. Their two sons have taken over the business. The patient plays golf at least 3 times a week with his wife, his 2 brothers, or his good friends. He and his wife enjoy traveling in their RV. All three children and 7 grandchildren live in town and visit often. Patient denies smoking, alcohol, and illicit drug use. Patient reports there are 4 smoke detectors, and 2 carbon dioxide detectors in the home. He reports using seatbelts and does not use cell phones while driving. He reports having a good support system with many relatives and friends.

Fam Hx:

- Mother: deceased at age 90 of “old age”. Patient states, “she was always sickly”.
- Father: 92, enlarged heart, HTN. Resides in assisted living center.
- MGM: deceased at age 85 of colon cancer.
- MGF: deceased at age 82 of “old age”.
- PGM: deceased at 95 of “old age”.
- PGF: deceased at 72 of MI.
- Brother: 71 with controlled HTN.
- Brother: 67, alive and well.
- Son: 47, alive and well.
- Daughter: 45, alive and well
- Son: 43, alive and well
- 7 grandchildren- ages 5-17, all alive and well.

Surgical Hx: Denies surgeries. Denies hospitalizations.

Mental Hx: Denies mental health history. Denies family history of mental disorders.

Violence Hx: Denies past and present history of physical violence, or sexual abuse.

ROS:

GENERAL: Reports decreased appetite. Reports fever, chills, and fatigue. Denies weight loss or gains.

HEENT: Eyes: Denies loss of vision, blurred vision, double vision, or yellow sclerae.

Ears: Denies hearing loss. Nose: Denies stuffy nose, sneezing, or nasal congestion.

Throat: Reports slight sore throat from coughing,

SKIN: Reports feeling “hot”. Denies rash or itching. Denies lesions.

CARDIOVASCULAR: Denies chest pain. Denies palpitations or swelling of extremities.

RESPIRATORY: Reports thick green colored sputum production. Reports difficulty taking deep breaths. Reports chest tightness with breathing. Denies asthma, COPD, or history of lung disease. Denies previous pneumonia.