## SOAP Note 2

### Patient name: Rebecca Jones

**S:**

This new patient is a 26-year-old woman who presents to the primary care office complaining of “a sore throat and cold that has gotten worse.” Patent states that her cough has been productive with thick yellow-green sputum. The patient explains that she has a sore throat, stuffy nose, and a fever. Patient estimates that she has had the “cold” for the past three weeks and it has not gotten any better.

Aggravating factors: ambulation (short distances) and smoke.

Relieving factors: cold beverages, cough syrup, cough drops, rescue inhaler one to two times a week, and allergy medicine with minimal effect.

She denies any known sick contacts. She explains that she does not normally get colds that last this long but usually gets them once or twice a year. The patient reports smoking a pack of cigarettes a day and denies alcohol or drug use. The patient has no known diagnosed allergies. No additional concerns at this time.

ROS- Patient denies: chills, travel, headache, chest pain, chest tightness, palpations, wheezing, nausea, vomiting, loose stools, blurry vision, floaters, nausea, vomiting, or loose stools. No foreign body visualized, new bites, flushing, pruritus, anxiety, faintness, blunt force trauma, new foods/ medications/ hygiene products, or sense of impending doom.

Medical history per chart review and patient: asthma, upper respiratory infection on 1/9/17 treated with Z-Pack. The patient denies any cardiovascular issues.

Surgical history: laparoscopic appendectomy 3/23/14, admitted for two days. Familial history, hypertension. The patient is currently employed as a receptionist.

Social History: The patient is single and lives alone in an apartment. The patient is a one pack a day smoker.

Health Promotion: due for pneumonia vaccination (PPSV23).

Medications: Paragard IUD. Albuterol 180mcg oral inhalation two puffs with spacer every six hours as needed for shortness of breath.

**O:**

General Survey—Alert, friendly, well-kempt woman, good historian.

Vital signs: temperature 98.4, heart rate 114, respirations 25, blood pressure 112/62, SPO2 92% room air.

Head: normocephalic, no lumps or lesions.

Face: symmetrical, no drooping.

Eyes: clear sclera, clear conjunctiva, PERRLA.

Cardiovascular: regular—elevated rate, no rubs, gallops, or murmurs, no jugular vein distention, capillary refill time less than 3 seconds.

Integumentary: skin warm, dry, intact, good turgor. Lap sites scars.

Mouth: lips intact, no caries, moist erythemic mucosa, enlarged tonsils grade 2, no lesions noted.

Nose: no polyps, erythema in both nares, no blisters, petechial, ulcerations.

Throat: erythema, thick yellow-green sputum, no lesions, no difficulty swallowing.

Neck: trachea midline, no nodules, no bruits, no stridor; swollen and tender submental, submandibular, superficial cervical and posterior cervical lymph nodes.

Lungs: tachypnea, coarse inspiratory crackles in right lower lobe, diminished lung sounds in the bases, dullness sound with percussion over right lower lobe; positive tactile fremitus, bronchophony muffled, and egophony abnormal. No nasal flaring, perioral or nail bed cyanosis, sternal, subcoastal, intercostal, or supraclavicular retractions.

**A:**

Community Acquired Bacteria Pneumonia, RLL

Differential Diagnosis:

1. Nasopharyngitis
2. Postnasal drip syndrome
3. Acute Bronchitis

Possible organisms: need sputum and nasal cultures to determine organism

Haemophilus influenza

Group A beta-hemolytic streptococcus

Group C and G streptococci

Chlamydia pneumoniae

Diphtheria

Mycoplasma pneumonia

Legionella pneumophilia

Neisseria gonorrhoeae or chlamydia trachomatis

Influenza A, B

Epstein-Barr

Coccidioidomycosis

Histoplasmosis

Blastomycosis

**P:**

Diagnostic tests: rapid strep test, Influenza type A and B swabs, COVID-19 swab. Consider a 2-view chest X-ray (if swabs are negative), and complete blood count with differential.

Pharmacologic interventions: azithromycin 500 mg on day 1 followed by four days of 250 mg a day, acetaminophen 650 mg by mouth as needed for fever of pain or ibuprofen 400 mg by mouth every six hours as needed for fever or pain.

Non-pharmacologic interventions: gargle with warm saltwater (1 tsp salt to 1 cup water), avoid smoking and other respiratory irritants (smoke, automotive exhaust, pollen, dust, dander, strong scents such as perfume), increase nonalcoholic fluid intake, rest, increase room humidity.

Referrals: None at this time. Pulmonology if condition does not improve with oral antibiotics.

Education: side effects of azithromycin, antibiotic teaching about finishing treatment, cough hygiene, fluids, soft foods, when to go to the emergency room, when to call the office.

Follow-up: call the office or go to the nearest emergency room if you have a fever greater than 101, shaking, chills, confusion, blue fingernaisl or lips, have increased cough, difficulty breathing at rest, or increased shortness of breath. Please follow up in the clinic in one week.