SOAP Note Exercise **Name: Lily Jacobs**
Date: 12/03/2021

Case 1
CC: Sudden onset substernal chest pain that "woke me up "and lasted until now (about 45 mins)

HPI: 70 y/o man with h/o hypertension, hyperlipidemia, 40 pack-years smoking history, and brother who died of MI at 60y/o brought in by ambulance to the ED with c/o substernal chest pain. The pain is described as pressure-like and radiating to the left arm and jaw, accompanied by nausea, diaphoresis, and shortness of breath. Nitroglycerin was administered sublingually, but only provided temporary relief. Aspirin was given to the patient to chew in the ambulance.

PE:
VS: BP 150/70, HR 110, Temp 37.1℃, R 30 Pulse oximetry: 96% on room air
Gen: obese, pale, diaphoretic patient
Lungs: clear to Auscultation and Percussion
Heart: RRR, S4 gallop noted
Ext: No cyanosis or edema

Labs:
CBC: Hemoglobin & hematocrit normal, WBC 11,000 (slightly high)
Electrolytes: Normal
Troponins: Troponin T and I are elevated
CK-MB: normal
EKG: sinus tachycardia, elevated ST segments in leads II, III, and AVF

Assessment: Acute Inferior wall MI

Plan: Start Morphine drip IV, O_2 via nasal cannula, Metoprolol, urgent transfer to interventional cardiology lab

The patient has a balloon angioplasty and stent placement and is transferred to the telemetry unit for monitoring. You see the patient the next day and need to document your visit in a progress note in the SOAP format.

The next day you visit the patient and must write a progress note to include the following:

A very brief synopsis of what occurred the day previously (including the treatment given in interventional cardiology)
His current medications:
Aspirin 81 mg orally, once a day
Plavix 75 mg orally, once a day
Lopressor 25 mg orally every 12 hours

His report of his condition today: much more comfortable. No pain, no shortness of breath. Some mild fatigue when walking from room to nursing station

The EKG this morning shows normal sinus rhythm with no ST elevations and no Q waves

The physical exam which includes: HR 72, BP 130/70, R 24, Temp 37.4 ℃

General: appears comfortable.
Extremities: peripheral pulses are slightly diminished and 1+
Heart: Regular rate and rhythm, no gallops or murmurs.
Lungs: clear
Groin: femoral and pedal pulses intact and 2+ . No hematoma

You believe he is doing well and that the same plan should be continued for now. You would like the nurse to check his vital signs every 4 hours for one more day and then every 8 hours.

If all goes well, he can be discharged in 3 days.

Post-op day 1

S: 70 y/o man with h/o hypertension, hyperlipidemia, 40 pack-year smoking history, and a brother who died of MI at 60y/o was admitted to the ER yesterday for Acute inferior wall MI. Patient was treated with Morphine drip IV, O_2 via nasal cannula, Metoprolol, and interventional cardiology lab. The patient also had a balloon angioplasty and stent placement. Patient was sent to the telemetry unit for monitoring. This morning, he is feeling more comfortable and denies any SOB or pain. Reports mild fatigue when walking. Currently taking Aspirin 81 mg orally QD, Plavix 75 mg orally QD, and Lopressor 25 mg orally Q12hr.

O: HR 72, BP 130/70, R 24, Temp 37.4 ℃

General: appears comfortable.
Extremities: peripheral pulses are slightly diminished and 1+
Heart: Regular rate and rhythm, no gallops or murmurs.
Lungs: clear
Groin: femoral and pedal pulses intact and 2+ . No hematoma

A:
Acute inferior wall MI improved following balloon angioplasty and stent placement

P:
-continue Aspirin 81 mg p.o, QD
-continue Plavix 75mg p.o, QD
-continue Lopressor 25 mg p.o, Q12 hours
-Monitor vital signs Q4hr x 1 day then Q8hr
-If symptoms continue to improve, patient to be discharged in 3 days

/s/ Lily Jacobs, PA-S