SOAP Note Two

Student Name: Mary Spivey

Population (Geri/Adult/WH/Peds): Geri

Clinical Location and Preceptor: Fairview Clinic. Alexis Wood, CRNP.

Date of Patient Encounter: 08/18/22 Patient Identifier (Initials/number): B.Y.

Patient age/DOB: 11/11/53. 68 yrs old. Ethnicity and Gender: Caucasian, Female.

I. Chief Complaint: "Left toe pain."

II. **History of Present Illness:**

B.Y. is a 68-year-old Caucasian female presents to the clinic today with complaints of pain in the left great toe. Rates pain a 4/10 at the current visit. She states she woke up with the pain 3 days ago. The onset was gradual and the symptoms have been constant for the past 3 days. She reported awakening in the middle of the night last night with the pain more intense and decided to come in to be seen. She reports pain and swelling of the left great toe. Denies any pain or swelling in the left foot. Pt reports redness of the left toe. She denies the use of pain relievers or any other factors to alleviate the pain. She does report taking a daily medication that is supposed to "prevent something like this from happening." She denies using ice or heat on the joint. Denies any relieving factors. Aggravating factors include walking and attempting to wear close toed shoes. She denies any numbness or tingling in the foot or toes. Denies injury or trauma to the toe or foot. Denies chills and fever. Denies stiffness of the left great toe. Denies lumps, stiffness, and swelling of all additional joints. Patient reports a history of something like this in the past.

III. **Past Medical History:**

1. Childhood illnesses & developmental milestones
   a. Occasional viral colds.
2. Chronic Illnesses
   a. Hypertension, diagnosed 28 years ago. Currently controlled on antihypertensive medications.
   b. Hyperuricemia/Gout diagnosed 25 years ago and controlled by allopurinol in the past until the current attack.
   c. Paroxysmal atrial fibrillation, no known structural heart disease, diagnosed 19 years ago and is currently controlled by anticoagulants and antiarrhythmic medications. Dr. Gayle, cardiologist MD, oversees this chronic illness.
3. Prior Illnesses and Injuries (accidents and hospitalizations)
   a. Hospitalized for tonsillectomy at a young age. Pt is unsure of the length of stay. Reports no complications.
   b. Hospitalized for hysterectomy at age 40 for 2 days with no complications or residual effects. No current medications indicated.
4. Past Surgical History
   a. Pt states Tonsillectomy at a young age due to recurrent tonsilitis as a child. The procedure was done at Flowers Hospital and the patient is unsure of the surgeon. No residual effects or complications.
   b. Pt states Hysterectomy at age 40 at Flowers Hospital by Dr. Chilcreast. Patient requested to have this procedure due to heavy periods and pelvic pain. No residual effects or complications.

IV. **Current Health Status:**

1. Health Status (including potential current stress)

- Pt believes she is in poor health due to chronic illnesses, obesity, and lack of exercise. Pt states she is compliant with medications and therapies to improve or prevent worsening of health status. Pt denies current stress but states that her health history and current weight has affected her stress level in the past.

2. Allergies: No known drug allergies. No known environment allergies.
3. Medications: this includes over the counter and complimentary medications/treatments
   - Allopurinol (Aloprim) 200 mg daily for gout prescribed by her PCP. Has been on this medication for 15 years and it usually works well at controlling uric acid levels.
   - Diltiazem CD (Cartia XT) 180 mg, extended release 24hr daily for hypertension prescribed by her PCP. Has been on this medication for 20 years and it works well to control blood pressure.
   - Sotolol (Sotalol AF) 80 mg BID for atrial fibrillation prescribed by cardiologist, Dr. Gayle. Has been on this medication for around 8 years and it works well to control atrial fibrillation.
   - Eliquis (apixaban) 5 mg BID prescribed and managed by her cardiologist. Has been on this medication for around 8 years and it works well to control blood clots due to atrial fibrillation.
4. Tobacco Use: Pt denies the use of cigarettes, e-cigarettes, dip, cigars, and vaping. Pt denies any secondhand smoke.
5. Alcohol Use: Pt denies use of alcohol.
6. Illegal/Recreational Drug Use: Denies use of illegal or recreational drug use.
7. Environmental hazards
   - Denies daily use of sunscreen but states sunscreen use when outdoors by the pool at her daughter's house.
   - Does not use phone while driving.
   - Pt states she has a few rugs in the home but is secured by rubber rug pads.
   - Pt denies stairs in the home.
   - Pt reports pull bars in the shower.
   - Denies use of chemicals while cleaning.
8. Safety measures: Pt does wear seatbelt while driving. Does not use phone while driving. Pt has working smoke and carbon monoxide alarms in the home. Pt reports a home security system that is active.
9. Exercise & leisure: Does not exercise outside of walking to driveway to collect mail every 2-3 days. Has a treadmill in the home but currently does not use it. Enjoys attending church on Sunday morning and night. For leisure, she enjoys doing word search puzzles.
10. Sleep: Reports 7-8 hours of sleep nightly. Usually goes to bed around 10:00 pm. Does not take medications for sleep and does not have any trouble falling or staying asleep. Occasionally takes naps in her rocking chair on Sunday afternoons after church.
11. Diet: 1 cup of black coffee in the morning with breakfast, which is usually 3 scrambled eggs, pork sausage, and 2 pieces of white toast with grape jelly. Lunch she normally eats a ham or turkey sandwich along with chips and a sweat tea. For dinner last night she had fried chicken, baby red potatoes, and collard greens. She reports about 2-3 glasses of water a day along with 1-2 glasses on sweat tea per day. Pt states no restrictions to certain foods.
12. Immunizations-
    - All childhood immunizations up-to-date. Pt received DPT, polio, and MMR during childhood. Pt reports receiving both doses of MMR vaccine as a child and the last dose being around age 5.
    - Last tetanus booster 04/2021.
    - Had influenza vaccine this flu season at the current visit 08/18/22. Reports getting the vaccine yearly.
    - Unsure of Hepatitis B vaccine status.
    - COVID-19 vaccine, Moderna (3/4/2021). COVID-19 vaccine, Moderna (4/6/2021). COVID-19 Booster 02/7/2022.
    - Denies pneumococcal vaccine in the past and at current visit. Does not wish to have this vaccine.
    - Shingrix declined at wellness exam (02/2022).
13. Preventive Screening tests-
    - Routine tests and labs performed every 6 months or as needed by PCP.
    - Colon cancer screening every 10 years. Last exam was in May 2019 findings were normal.
    - Regular annual visits with a gynecologist.

- Last pap smear age 40, all previous findings normal, informed that she is no longer recommended to receive these.
- Mammogram at age 67, reports normal results, receives every 2 years as recommended.
- Patient visits the dentist every 6 months for preventive cleaning and screenings.
- Vision screening August 2021, patient wears corrective lenses, visits optometrist yearly.
- Depression screening complete at yearly wellness exam (2022). Results negative.
- DEXA scan at age 65, normal findings.

V. **Family History- should go back at least 3 generations (patient, parents, and grandparents):**

1. Maternal grandmother, deceased at age 73, unknown health hx.
2. Maternal grandfather, deceased at age 89, hx of HTN, unknown cause of death.
3. Paternal grandmother, died at age 68, unknown health hx.
4. Paternal grandfather, died at age 70, unknown health hx.
5. Mother, deceased at age 68, hx of hypertension, died of a MI.
6. Father, deceased at age 57, hx of cerebral hemorrhage.
7. Brother, died at age 57, hx of malignant melanoma.
8. Patient, age 68, hx of HTN, gout, and atrial fibrillation.

Health Risk Assessment: Pt is at risk for gout, which she already has. She is also at risk for HTN, which she already has, due to a family hx of hypertension by her maternal grandfather. Pt is also at risk for atrial fibrillation, which she already has. Pt is also at risk for a cerebral hemorrhage due to her father's health hx and her hx of hypertension and anticoagulant use increases this risk. Pt is also at risk for malignant melanoma due to her brother's health hx. Pt is also at risk for a MI due to her mother's health hx and her past hx of hypertension and atrial fibrillation increases this risk.

VI. **Social History:**

1. Education- High school diploma. Worked at Walmart supercenter for 35 years and retired at age 55. Volunteers for her local goodwill.
2. Occupation- Currently retired. Enjoys volunteer work.
3. Marital status- Only married once and has been separated since 2019.
4. Children/dependents- Has no children or dependents.
5. Type of housing & who the patient lives with- Pt lives alone in a two-bedroom one bath single story home. Has been living in home alone for the past 3 years.
6. Financial resources/insurance- Has Medicare. Pt can attend doctors' appointments and routine exams through this plan. Pt is also able to afford and pay for medications through this insurance.
7. Religion/beliefs- Baptist, attends church regularly. No religious preferences related to healthcare.
8. Social involvement- She is a member of the church and enjoys attending church events and socializing with her church family. Her hobbies include sewing and cooking. She also enjoys volunteering and socializing with the ladies at her local goodwill.
9. Travel- Pt denies any recent travel.
10. Erickson's Stage of Development:
    Generativity vs Stagnation- Pt expresses generativity by her strong connection with the church and her community. Pt believes her volunteer work with her local goodwill gives her a sense of giving back to her community. I do not believe she is in stagnation.

VII. **Review of Systems:** (Include at least 12 systems)

General/Constitutional: Denies weight change, weakness, fatigue, fever, night sweats, anorexia, malaise.
Head: Denies headache, denies head injury.
Eyes: Denies vision changes, eye pain, eye or eyelid redness, excessive tearing, diplopia, floaters, loss of any visual fields. No history of glaucoma or cataracts. Reports that she wears corrective lenses.
Ears: Denies hearing loss, change in hearing, tinnitus, pain in ears, or drainage from ears.
Nose and Sinuses: Denies nasal stuffiness, nosebleeds, sinus pain, sinus congestion, nasal discharge, nasal pain, change in ability to smell, sneezing, post-nasal drip. Reports occasional viral colds.
Mouth and throat: Denies pain while swallowing, mouth soreness, dryness, ulcers, sore tongue, bleeding gums, pyorrhea, or hoarseness. Does have dental caries and a crown on one tooth. No abscesses, extractions, extractions, caps, or dentures.

Neck: Denies swollen lymph nodes or glands, denies lumps, goiter pain. Denies issues with neck mobility/ROM.

Thorax:

Breasts: Denies lumps, pain, tenderness, and nipple discharge.

Pulmonary: Denies acute or chronic cough, dyspnea, wheezing, or hemoptysis.

Cardiovascular: Denies chest pain or palpitations. Denies complaints or history of orthopnea, murmurs, arrythmia's, dyspnea on exertion, paroxysmal nocturnal dyspnea, peripheral edema, or claudication. Pt states EKG at last cardiac appointment. Reports a hx of atrial fibrillation.

Gastrointestinal: Denies dysphagia, odynophagia, nausea, vomiting, diarrhea, or abdominal pain. Denies any changes in bowel movement or change in bowel pattern

Urinary: Denies hematuria or dysuria. Denies suprapubic pain and CVA tenderness. Denies history of frequent UTI's. Denies any penile discharge, lesions, irritation, or pain. Denies any history of STD's/STI's.

Integumentary: Denies rash, sores, lesions. Denies changes in hair or nails.

Musculoskeletal: Denies arthritis, backache, and weakness. Reports a hx of something like this in the past. Reports left toe pain. Reports redness of the left toe. Reports swelling on the side of her left toe. Denies swelling or redness of the left foot and all other joints. Denies hx of joint effusions. Denies limitations in range of motion.

Neurologic: Denies dizziness, fainting, headache, or loss of feeling. Denies weakness. Denies gait disturbances or coordination problems. Denies syncope, seizures, or numbness.

Allergic/Immunologic: Denies rhinorrhea or immunocompromise.

Psychiatric: Denies anxiety, irritability, depression, insomnia, phobias, tension, suicidal or homicidal ideations

Endocrine: Denies thyroid trouble, heat or cold intolerance, excessive sweating or flushing, excessive thirst or hunger, or urination.

Hematologic/Lymphatic: Denies anemia, easy bruising or bleeding, swollen lymph nodes in neck.

Allergic/Immunologic: Denies itchy watery eyes, hives, rhinorrhea, immunocompromise, frequent infections.

VIII. **Physical Examination**: (Include at least 10 systems)

1. **General appearance**: Appears well and non-toxic. Appears to be in stated age. Pt is obese for height and age.

Vital signs:

Height: 5'6" (167.64 cm)
Weight: 229.4 lbs (104.05 kg)
BMI: 37 (obese)
Blood pressure: Right arm: 124/80 Left arm: 126/78
Pulse: 69 bpm
Respirations: 18 breaths/min
O2 Saturation: 99%
Temp: 98.2 (taken temporal)

2. **Skin**:
No rash or lesions noted. Skin feels dry with no moisture. Edema and erythema noted on left great toe. No diaphoresis. Turgor subtle. No pallor edema or cyanosis.
3. **HEENT**:
Head:
Normocephalic with no deformities. Scalp is normal with equal hair distribution. All facial features are symmetric at rest and in motion (cranial nerve 7-facial). Facial muscles do not tremor when jaw is clinched, and no clicking is noted over the TMJ (cranial nerve 5- trigeminal).
Eyes:
No ptosis or swelling of the lids. Sclerae is white and conjunctiva is pink. Cornea is dome-shaped, translucent, and smooth. Iris is flat and brown. No edema, lesions, drainage, or discoloration. Pupils are equal, round, and react to light and accommodation. Light reflex is both direct and consensual. Visual acuity within normal limits. Fundoscopic exam grossly unremarkable upon examination. The red reflex is present and equal with no abnormal coloring. The retinal background is uniform color

with no signs of hemorrhage or discoloration. The optic disk is round, pink, with sharp edges. The vessels are visible, red, and non-tortuous. Macula and fovea visible with no deformities.
Cranial Nerve 2- (Optic): pupils= PERRLA; fundoscopic exam: the fundal background is a deep red color without exudates or lesions; optic disc and macula is well defined, no evidence of retinal vascular hemorrhages or narrowing of vessels. Snellen chart test: R- 20/20, L-20/20, B-20/20; corrected.
Cranial nerve 3, 4, 6 (oculomotor, trochlear, and abducens): + EOM in 6 directions.

Ears:

Normal pinna bilaterally. Normal external canals bilaterally. Otoscope exam grossly unremarkable upon examination. The ear canal is clear with some hair and yellow cerumen. The tympanic membrane is grey, translucent, in a neutral position, and reflects a cone of light.
Whisper test proved cranial nerve 8 (auditory) to be intact.

Nose:

Nose is midline, with no edema, redness, discharge, or lesions. Nares are patent with no discharge, or congestion. The nasal septum is intact and midline. Nasal mucosa is pink, moist, and intact. Turbinates are pink and not enlarged. No lesions or growths on the nose. The frontal and maxillary sinuses are non-palpable and non-tender.
Patient smelled an alcohol pad with eyes closed showing that cranial nerve 1 (olfactory) is intact.

Mouth/throat:

The lips are pink and symmetric with no cracking or lesions. The oral mucosa is pink, moist, and intact. No inflammation of the gingiva. No missing teeth or dental carries. No abnormal breath odor. The tongue is midline, pink, moist, with no scaling or lesions. Full symmetric movement of tongue. No buccal or palate nodules or lesions noted. Tonsils absent. The posterior pharynx is clear with no exudates. Uvula is midline and rises when he says “ahh” and gag reflex is intact (cranial nerves 9 & 10- glossopharyngeal & vagus).

Neck:

Supple, trachea midline with normal cervical ROM, no masses or swelling. Thyroid is nonpalpable and nontender. No jugular venous distention seen on examination. Auscultation did not reveal stridor over pharynx or bruit over carotid arteries.
Cranial Nerve 11 (Spinal accessory): patient can shrug her shoulders and push her head against resistance.

Nodes:

Submandibular, submental, tonsillar, pre- and post-auricular, occipital, anterior and posterior cervical triangles, supraclavicular nodes non-tender and non-palpable. Axillary, epitrochlear, and inguinal nodes non-tender and non-palpable.

4. **Respiratory and Thorax/Breast:**

   Breasts:
   Inspection and palpation- no masses, discharge, or tenderness to the left or right breast. Breasts symmetrical. No skin changes, dimpling, or fixed nodules noted. Nipples are symmetric, no discharge or tenderness noted.
   Chest:
   Symmetrical chest expansion, no deformities, AP ratio 1:2.
   Palpation-tactile fremitus present and equal bilaterally.
   Percussion-resonance noted without any hyperresonance or dullness.
   Auscultation-lungs clear to auscultation in all lung fields bilaterally. Respiratory rate, rhythm and effort are normal without retractions or use of accessory muscles. No crackles, wheezes, rhonchi, or rubs.

5. **Cardiovascular & Peripheral Pulses:**

   Inspection: no outward pulsations, no JVD, no visible PMI.
   Palpation: No lifts, heaves, or thrills.
   PMI- point of maximal impulse 5th intercostal space, midclavicular line (non-displaced). Carotid artery is palpable with equal upstroke, bilaterally.
   Auscultation: temporal and carotid arteries were equal bilaterally with no bruits. Aortic, pulmonic, erb’s point, tricuspid, and mitral locations were auscultated in the sitting, supine, and

left lateral positions. S1/S2 heard in all locations- regular rate and but irregular rhythm. No other clicks, murmurs or extra heart sounds heard.
Pulses: Carotid, brachial, femoral, popliteal, posterior tibial, and pedal pulses 2+ bilaterally.

6. **Abdomen:**
   Inspection: Rounded and symmetrical. Uniform and color and pigmentation. No scars or striae present. No respiratory retractions. No masses or nodules. No abnormal venous patterns.
   Auscultation: Bowel sounds normoactive in all quadrants. No bruits noted over aorta, renal, iliac, or femoral arteries.
   Percussion: Tympany over stomach and epigastric area. Dullness over liver.
   Palpation: No tenderness to light or deep palpation noted in abdomen. Liver and spleen palpated with no abnormalities or masses. No hernia's present, no aortic pulsations seen or palpated. Bilateral inguinal nodes are nonpalpable and nontender.
   Rectal exam declined by patient.

7. Genitourinary:
   No CVA tenderness, no suprapubic tenderness. Genital exam deferred.

8. Musculoskeletal:
   Back/spine: Full ROM, normal curvature. Normal posture. No tenderness noted. No scoliosis, lordosis, or kyphosis noted.
   Extremities: Upper and lower extremities symmetrical. No nail deformities, no clubbing, no cyanosis. No upper or lower extremity edema. No tremors.
   Full ROM with +5 muscle strength noted in shoulders, elbows, hands, and fingers. Grip strength is equal and strong.
   Full ROM in hips, knees, ankles, and feet with +5 muscle strength.
   Joints: Left big toe joint is TTP, erythematous, and swollen. Left big toe joint warm to touch. No deformities or effusions of joints.

9. Neurologic:
   Pt is A&O x 4- person, place, time, and situation with normal mentation. Normal behavior, attention, concentration, language, memory, and abstract reasoning. No signs of visible distress.
   Cranial nerves: CN I-XII was assessed and documented in HEENT sections.
   Motor - Muscle strength testing performed and documented above.
   Pt able ambulate without assistive devices. She was able to fill out paperwork demonstrating fine motor and cognitive function. No involuntary movements, rigidity, or spasticity noted in limbs. No evidence of muscle atrophy.
   Sensory - Pt can differentiate pain, temp, and touch- equal bilaterally, with eyes closed. Normal stereognosis.
   Cerebellar - No tremors or ticks noted.
   No abnormalities noted on rapid rhythmic alternating movement test, finger-to-nose test, heel-to-shin test, or Romberg test. Gait is appropriate with negative pronator drift.
   Reflexes- +2 DTR in biceps, triceps, brachioradialis, patellar, Achilles, and plantar tendons. Negative Babinski reflex.

10. Psychiatric:
   Appropriate mood and affect, normal attention and conversation. Her appearance is calm, cooperative, and appropriate.

11. Hematologic/Immunologic:
   No visible bleeding or bruising.

IX. **Diagnostic Testing**: (with rationale and results if available)

1. Uric acid level- to measure the levels of uric acid in the blood. Results pending.
2. X-ray imaging- to rule out other causes of joint inflammation. Test not done but could help differentiate a fracture from signs and symptoms of gout. Not indicated for this patient due to her denying trauma or injury to the affected joint.

X. **Differential Diagnosis with ICD-10 codes:**

Gout – M10.9

- Definition: Complex form of arthritis caused by excess uric acid in the bloodstream. It's characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe.

- Supporting Data: Patient's suspected hx of this diagnosis. Physical exam findings of left big toe redness, warmth, and swelling of the joint. Pt's medication list reveals a medication to control uric acid levels.
- Refuting Data: Pending results for uric acid level.

Rheumatoid arthritis – M06.9

- Definition: A chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility, especially in the fingers, wrists, feet, and ankles.
- Supporting Data: Physical exam of swelling and redness of left toe. Pt complaint of pain and swelling in left toe joint.
- Refuting Data: No joint deformities or immobility noted.

Osteoarthritis – M19.9

- Definition: Degeneration of joint cartilage and the underlying bone, causes pain and stiffness, especially in the hip, knee, and thumb joints.
- Supporting Data: Pt complaint of joint pain in the left big toe.
- Refuting Data: Pt denies stiffness of the joints. Hip, knee, and thumb joints are unaffected in this pt. Symptoms not consistent with progressive disease.

Septic Arthritis – M00.9

- Definition: Infection of the joint (synovial) fluid and joint tissues.
- Supporting Data: Pain in left toe joint. Physical examination of swollen, red, and warm of left big toe.
- Refuting Data: Pt reports no fever and chills. Pt afebrile on exam.

Pseudogout – M11.262

- Definition: Inflammation of the joints that is caused by deposits of calcium pyrophosphate crystals, resulting in arthritis, most commonly of the knees, wrists, shoulders, hips, and ankles. Usually affects only one or a few joints at a time.
- Supporting Data: Pt complaint of swelling in the left toe joint. Physical exam findings of inflammation in the left big toe. It is only affecting one joint at a time.
- Refuting Data: No inflammation of the knees, wrists, shoulders, hips, and ankle joints.

XI. **Definitive Diagnosis with ICD-10 code**:

Gout – M10.9

- Definition: Complex form of arthritis caused by excess uric acid in the bloodstream. It's characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe.
- Supporting Data: Patient's suspected hx of this diagnosis. Physical exam findings of left big toe redness, warmth, and swelling of the joint. Pt's medication list reveals a medication to control uric acid levels.
- Refuting Data: Pending results for uric acid level.

XII. **Chronic Health Problems with ICD code:**

- **Hypertension – I10**
- **Gout – M10.9**
- **Atrial Fibrillation – I48.91**

XIII. **Plan:** (acute and chronic illnesses)

Definite diagnosis: **Gout – M10.9**

- Plan:
    - Medications: Depo-Medrol 40 mg/mL suspension for injection - 1 mL and Dexamethasone sodium phosphate 4 mg/mL injection solution - Inject 0.5 mL by intramuscular route. Colchicine 0.6 mg tablet, take 2 tablets then 1 more an hour later once, DO NOT REPEAT DOSE FOR 3 DAYS. Continue Allopurinol (Aloprim) 200 mg daily for gout prescribed by PCP. Ice affected area 15 minutes 3-4 times a day.

- Education: Gout is a common and complex form of arthritis that can affect anyone. It's characterized by sudden, severe attacks of pain, swelling, redness and tenderness in one or more joints, most often in the big toe. An attack of gout can occur suddenly, often waking you up in the middle of the night. The affected joint is hot, swollen and so tender that even the weight of the bedsheet on it may seem intolerable. Gout develops in some people who chronically have a condition called "hyperuricemia," meaning high levels of a substance called urate (also known as uric acid) in the blood. Risk factors include obesity, high blood pressure, and chronic kidney disease. Avoid consuming high amounts of alcohol and large amounts of meat or seafood. Also avoid consuming high amounts of beverages containing high fructose corn syrup (such as non-diet sodas). For those who have a history of gout an injury, fasting, overeating, dehydration, and taking medications that induce sudden changes in blood urate levels can increase the risk of an attack. For acute attacks, your physician may recommend oral steroids or by injection to increase inflammation. Colchicine is given instead of an NSAID and is especially indicated for those on anticoagulants. Side effects include diarrhea, nausea, vomiting, and crampy abdominal pain. Take the medication as directed. Take 2 tablets at onset of gout flare then 1 more an hour later once, do not repeat for 3 days. Continue taking allopurinol as prescribed to decrease uric acid levels. It may take several months to benefit from this medication. Swallow the allopurinol tablets with water, ideally after food. Steroid injections are given to decrease inflammation associated with gout. You can only receive one injection within a 3-month period, this including PO steroids. The effects should be noticed within 24-48 hours of injection. Side effects include rash, fatigue, mood changes, insomnia, and bleeding at the site of injection. Considering that you are on an anticoagulant, monitor for signs and symptoms of bleeding.
  If you develop any allergic symptoms, please stop the medication immediately and depending on severity, call your PCP or go to the ER. Go to ER for worsening of symptoms or contact PCP. Get plenty of rest. Drink plenty of fluids.
- Follow-up information: Follow up with PCP on 08/22/2022, sooner if you are not getting better or are feeling worse.
- Referral: No referral needed at this time.

Chronic diagnosis: **Hypertension – I10**

- Medications: Continue taking Diltiazem CD (Cartia XT) 180 mg, extended release 24hr daily for hypertension prescribed by her PCP. This medication is also managed by her cardiologist. Maintain a heart-healthy diet that is low in sodium. Continue to get plenty of exercise, at least 30 minutes three to five times per week. Minimize alcohol and tobacco consumption. Utilize stress reduction techniques.
- Medication Profile: Diltiazem 180 mg tablet PO daily.
  - Generic: Diltiazem
  - Brand: Cartia
  - MOA: Inhibits the inflow of calcium ions into the cardiac, smooth muscle during depolarization. Reduced intracellular calcium concentrations equate to increased smooth muscle relaxation resulting in arterial vasodilation and, therefore, decreased blood pressure
  - Drug Class: Calcium Channel Blockers
  - Indication: Hypertension
  - Dosage: Initial: 180 mg daily. This dose may be increased to 240 mg daily as deemed necessary by PCP.
  - Cost for a 30-day supply:
  - Walmart: $14.11
  - Publix: $17.71
  - Walgreens: $21.66
  - **https://www.goodrx.com/diltiazem**
- Education: Blood pressure refers to the pressure that blood applies to the inner walls of the arteries. Arteries carry blood from the heart to other organs and parts of the body. “Hypertension” is the medical term for high blood pressure. Untreated high blood pressure increases the strain on the heart and arteries, eventually causing organ damage. High blood pressure increases the risk of heart failure, heart attack, stroke, or kidney failure. Normal blood pressure is less than 120 over less than 80. Blood pressure should be monitored daily. Keep a blood pressure log of the dates and times when blood pressure is taken. Avoid stressful situations if possible. Maintain a low-

sodium, heart-healthy diet. The Dietary Approaches to Stop Hypertension (DASH) diet is high in vegetables fruits, low-fat dairy products, whole grains, poultry, fish, and nuts. Combining DASH diet with sodium restriction can lower blood pressure. Diltiazem is a calcium channel blocker that is used to treat hypertension (high blood pressure) or angina (chest pain). Swallow the tablet or capsule whole and do not crush, chew, or break it. Keep using your medicine even if you feel well. High blood pressure often has no symptoms. You may need to use blood pressure medicine for the rest of your life. Common side effects may include chest pain, fluttering in your chest, swelling, headache, nausea, vomiting, or a rash. Medication should be taken as prescribed (one 180 mg tablet once a day). Take at the same time each day. Take missed doses as soon as remembered; do not double doses.

Continue recommended non-pharmacological interventions to control hypertension.

- Follow-up: We will follow this problem at her subsequent visits or with cardiologist as scheduled.
- Referral: No referrals required at this time. Pt is followed by a cardiologist.

Chronic diagnosis: **Atrial Fibrillation**

- Medications: Continue taking Sotolol (Sotalol AF) 80 mg BID for atrial fibrillation prescribed by cardiologist, Dr. Gayle. Continue taking Eliquis (apixaban) 5 mg BID as prescribed. Consume a heart healthy diet rich in vegetables, fruits, and whole grains. Exercise daily. Avoid smoking tobacco and alcohol use. Keep all follow up appointments to keep a check on blood levels and platelet levels.
- Education: Atrial fibrillation (A-fib) is an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart. A-fib increases the risk of stroke, heart failure and other heart-related complications. Treatment for atrial fibrillation may include medications, therapy to reset the heart rhythm and catheter procedures to block faulty heart signals. It can be occasional, persistent, long-standing persistent, and permanent.

  Sotalol is a medication used to treat sustained ventricular tachycardia and atrial fibrillation. It slows the heart rate and helps the heartbeat more normally and regularly. Take this medication by mouth twice per day with or without food. If taking it with food be sure to take it this way every time and vice versa. Do not take antacids containing aluminum or magnesium at the same time you take this medication. Take this medication exactly as prescribed. Stay on top of your refills to be sure you do not run out. Tiredness, slow heartbeat, and dizziness may occur. Get up slowly when rising from a sitting or lying position. Contact your physician if you experience shortness of breath, swelling of ankles/feet, unusual tiredness, and sudden weight gain.

  Take medication as prescribed. Get medical help right away if you have any very serious side effects, including severe dizziness, fainting, sudden change in heartbeat (unusually faster/slower/more irregular), chest/jaw/left arm pain. If you miss a dose, skip the missed dose. Take your next dose at the regular time. Do not double the dose to catch up.

  Eliquis is a medication used to prevent serious blood clots from forming due to a certain irregular heartbeat (atrial fibrillation). With atrial fibrillation, part of the heart does not beat the way it should. This can lead to blood clots forming, which can travel to other parts of your body (such as the lungs or legs) or increase your risk for stroke. Take this medication as prescribed with or without food. The dosage is based on your medical condition, age, weight, kidney function, response to treatment, and other medications you are taking. Side effects may include nausea, easy bruising, or minor bleeding. Contact your PCP with signs of serious bleeding: unusual pain/swelling/discomfort, unusual bruising, prolonged bleeding from cuts or gums, persistent/frequent nosebleeds, unusually heavy/prolonged menstrual flow, pink/dark urine, coughing up blood, vomit that is bloody or looks like coffee grounds, severe headache, dizziness/fainting, unusual or persistent tiredness/weakness, bloody/black/tarry stools, difficulty swallowing. A very serious allergic reaction to this drug is rare. However, get medical help right away if you notice any symptoms of a serious allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. Before having surgery or a dental procedure tell your doctor right away you are on this medication.
- Follow-up information: Follow up with cardiologist as scheduled, 02/21/2023 at 03:20 P.M.
- Referral: No referral recommended at this time. Followed by a cardiologist.

Health promotion:

- Plan:

- Continue to take prescribed medications.
- Continue to monitor blood levels as needed by your PCP and cardiologist.
- You have an appointment with Dr. Gayle on 02/21/2023 at 03:20 P.M.
- You have an appointment to follow-up on gout attack on 08/22/22 at 10:00 P.M.
- Consume a heart healthy diet including fruits, vegetables, and whole grains. Consider incorporating the DASH diet.
- Decrease consumption of sweetened beverages, including sweat tea and consume more water.
- Try to incorporate more exercise by walking on your treadmill at home for a total of 150 minutes per week as recommended by the American Heart Association. This means 20 minutes a day of exercising. I recommended walking 10 minutes in the morning and 10 minutes in the afternoon if that is better for you.
- With diet and exercise, work on losing weight in a healthy way to improve current and post medical problems.
- Follow up with PCP and cardiologist as scheduled or at least every 6 months to monitor blood work and overall health.
- Continue to attend regular dental exams at least yearly.
- Continue to receive regular vision and hearing screening.
- Continue to attend visits as scheduled with an OBGYN for yearly exams.
- Consider receiving the pneumococcal vaccine at subsequent visits to protect you against the bacterium Streptococcus pneumoniae which can lead to pneumonia, blood poisoning (sepsis) and meningitis.
- Consider receiving the Shingrix vaccine at subsequent visits to provide protection against shingles, whether you have had it before or not.
- Continue to stay up to date on colonoscopy screenings, next screening due May 2030.
- Continue to wear sunscreen while outdoors but consider applying a daily lotion on the face daily.
- Pt instructed to return to the clinic in 3-5 days of gout attack has not gotten better or is worse.

References

Dains, J.E., Baumann, L. C., & Scheibel, P. (2020) *Advanced health assessment and clinical diagnosis in primary care* (6th ed.). Elsevier Inc.

Hollier, A. (2021) *Clinical guidelines in primary care* (4th ed). Advanced Practice Associates (APEA).

Rosenthal, L.D. & Burchum, J. R. (2021*). Lehne's pharmacotherapeutics for advanced practice nurses and physician assistants* (2nd ed.). Elsevier, Inc.

Sullivan, D. D. (2019) *Guide to clinical documentation* (3rd ed.). F. A. Davis Company.