SOAP Note One

Student Name: Mary McClain

Population (Geri/Adult/WH/Peds): Women's Health

Clinical Location: Ladies First OB/GYN | Preceptor: Lisa Gowan, CNM

Date of Patient Encounter: 08/23/22 | Patient Identifier (Initials/number): K.E.

Patient age/DOB: 43, 01/02/1979 | Ethnicity and Gender: Caucasian, female.

I. Chief Complaint: Annual Women's Wellness Exam. Pt states, "I am here for my annual visit and to update my pap smear."

II. **History of Present Illness:**

K.E. is a 43-year-old Caucasian female presenting to the clinic for an annual women's exam including a breast exam, pelvic exam, and a pap smear with no recent medical issues. First pap smear was at age 21 with no history of abnormal results. Last pap smear was on 07/2019 and was normal. Menstruation started at age 16. Last menstrual period was 8/15/22. She states that her cycles occur approximately every 28 days with 1-2 days of moderate bleeding and the last 3-4 days with light bleeding. She states she has a headache 2 days before her cycle that is relived with OTC Tylenol. She denies any fatigue, bloating, or severe abdominal cramping while on her cycle. She states for the first two days she continues with OTC Tylenol if needed for minimal to moderate cramping. She denies intermenstrual bleeding, pelvic pain, irregular or excessive bleeding, vaginal discharge, itching or lesions on the external genitalia. Pt is married and is sexually active in a monogamous, heterosexual relationship. She denies any STI/STDs in the past. She denies being on oral contraceptives or other forms of birth control due to tubal ligation after last pregnancy. G3P3 with two spontaneous vaginal deliveries and one cesarian section with tubal ligation. No history of premature deliveries, miscarriages or abortions, and ectopic pregnancies. She denies having any vaginal pain, pressure, itching, dryness, or abnormal discharge. She denies experiencing any pre-menopausal symptoms. She denies any breast tenderness or lumps during self-breast exams. Her paternal grandmother has a history of breast cancer and the patient was negative for the BRCA gene. She is up to date on her mammogram screening with the last one in 2021 with no abnormal results.

III. **Past Medical History:**

1. Childhood illnesses & developmental milestones
   a. Occasional viral colds, no residual effects.
2. Chronic Illnesses
   a. Insomnia, diagnosed at age 30. Currently controlled with melatonin. Diagnosed by her PCP, Dr. Lawrence.
3. Prior Illnesses and Injuries (accidents and hospitalizations)
   a. Vaginal delivery of children in 2002 and 2005, 2-night hospital stay after each child. Each delivery was atraumatic with no residual problems. Performed by Dr. Chilcreast, OBGYN.
   b. Cesarian section in 2009 due to large for gestational age infant with no complications or residual problems. Tubal ligation at time of cesarian section with no residual problems. Surgery performed by Dr. Chilcreast, OBGYN.
4. Past Surgical History
   a. Cesarian section in 2009 with tubal ligation. The procedure was done at Flowers Hospital by Dr. Chilcreast. No complications or residual effects.
   b. Breast Augmentation at age 30 at Dothan Plastic Surgery. No complications or residual problems.

IV. **Current Health Status:**

1. Health Status (including potential current stress)

a. Pt believes she is in overall good health. She denies current stress but states she enjoys cleaning at times that may be slightly stressful.

2. Allergies:
    a. No known drug allergies
    b. No known food and environment allergies.
3. Medications: this includes over the counter and complimentary medications/treatments
    a. Melatonin 3 mg PO at bedtime as needed for occasional relieve of insomnia. Has been on this medication as needed for 13 years and it works well at controlling her occasional insomnia.
4. Tobacco Use: Pt denies tobacco use or any second-hand exposure.
5. Alcohol Use: Pt denies use of alcohol.
6. Illegal/Recreational Drug Use: Denies use of illegal or recreational drug use.
7. Environmental hazards
    a. Pt states that she wears SPF in her daily lotion and is sure to wear sunscreen during sun exposure.
    b. Pt states she has a few rugs throughout her home but does not have a concern for falls.
    c. Pt denies stairs in the home.
    d. Pt denies pull bars or handles in the bathroom but states she has no need for them.
    e. Denies use of harsh chemicals, such as bleach 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.
9. Exercise & leisure: Reports walking with a neighborhood friend 2-3 times per week for at least a mile. Also reports cleaning houses for income and exercise 3-4 times per week lasting approximately 4 hours a house. Level of activity: Moderate. She does report enjoying reading books for leisure every night before bedtime.
10. Sleep: Reports 7-8 hours of sleep nightly. Takes Melatonin for occasional insomnia. She is in bed by 9 p.m. and reports trouble falling asleep at times but no trouble staying asleep. No daytime naps.
11. Diet: For breakfast she had a bagel with cream cheese and a cup of coffee. For lunch she had a chicken salad sandwich on wheat bread with a side of broccoli salad with a water with lemon. For dinner she had grilled steak with a baked potato and water. She reports drinking approximately 4 bottles of water per day. She reports having a cup of coffee in the morning and one diet coke during the daytime.
12. Immunizations-
    a. 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 6.
    b. Last tetanus booster unknown and pt does not desire to have one.
    c. Denies influenza vaccine in the past and denies a desire to have one in the future.
    d. COVID-19 vaccine, Moderna in 2021, both doses received. She denies receiving the booster vaccine and has no interest in receiving the booster.
13. Preventive Screening tests-
    a. Routine tests and labs performed yearly for wellness visits by PCP (last visit 2022).
    b. Regular annual visits with a gynecologist. Last visit and pap smear was in July 2019. No hx of abnormal pap smears. Pap smear and pelvic exam at today's visit.
    c. Reports monthly self-breast exams. No lumps identified in previous self-exams.
    d. Reports yearly mammograms. Last mammogram was in 2021. No hx of abnormal results.
    e. Reports yearly eye exams. Last exam in December 2021. Denies use of contacts/eyeglasses.
    f. Patient visits the dentist every 6 months for preventive cleaning. Last dental exam was in January 2022.
    g. Denies hearing screen and any problems with hearing.

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

1. Maternal grandmother, deceased at age 76, no known medical history.
2. Maternal grandfather, alive at age 79, history of hypertension.
3. Paternal grandmother, alive at age 73, diagnosed with breast cancer.
4. Paternal grandfather, deceased at unknown age, unknown medical history, died from unknown causes.

5. Mother, alive at age 65, diagnosed with hypertension.
6. Father, alive at age 69, diagnosed with hypercholesterinemia.
7. Patient, alive at age 43, history of insomnia.

Health Risk Assessment: Pt is at risk for insomnia which she already has. Pt is also at risk for hypertension which her mother and maternal grandfather has. Pt is also at risk for hypercholesterinemia, which she keeps a check on by her PCP. Pt is also at risk for breast cancer which her paternal grandmother has. She keeps mammograms up to date and performs self-breast exams. Pt also received testing for the BRCA gene which she does not have. Pt remains up to date on annual visits with her OBGYN.

VI. **Social History:**

1. Education- Associates Degree in Science.
2. Occupation- Cleans houses for extra income and enjoyment.
3. Marital status- Only married once and married for 18 years.
4. Children/dependents- Has three children, ages 13, 17, and 20.
5. Type of housing & who the patient lives with- Pt lives in a 4-bedroom one-story single-family home with her husband and two children who still are at home. They recently moved to the house last year. Due to her husband being in the service, she is unsure how long they will remain in the home.
6. Financial resources/insurance- Has Tricare for active-duty family members. She reports her husband has a steady income and she is able to clean houses on the side for extra income. She expresses no financial concerns about affording healthcare or medications.
7. Religion/beliefs- She enjoys visiting New Life Pentecostal Church for Sunday afternoon service and women's ministry groups. No religious preferences related to healthcare.
8. Social involvement- She is a member of the church and enjoys conversating on Sunday afternoons with church friends. She also reports social gatherings with her book club that meets every week and she attends whenever she can.
9. Travel- Pt denies any recent travel.
10. Erickson's Stage of Development:
    Intimacy vs Isolation- Pt expresses intimacy by fulfilling loving relationships with her husband and three children. She expresses positive relationships with her friends and states she never feels as though she has no support system. Based on this I do not believe she is in isolation.

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

General/Constitutional: Denies fever, malaise, fatigue, weight loss or gain, temperature intolerance, weakness, anorexia, chills, night sweats.
Head: Reports headache prior to menstrual cycle, 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.
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.
Mouth and throat: Denies mouth soreness, mouth dryness, ulcers, sore tongue, bleeding gums, pyorrhea, sore throat, and hoarseness. Denies trouble swallowing. Denies dental caries, 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 breast pain, lumps, tenderness, and nipple discharge. Reports monthly breast self-examinations. Reports breast augmentation for the past 13 years with no complications. Reports mammogram screening in 2021 that was normal.
Pulmonary: Denies acute or chronic cough, dyspnea, wheezing, or hemoptysis. Denies recent TB exposure or recent TB test. Denies history of pneumonia. Denies recent COVID-19 exposure and history. Denies history of environmental exposure.

Cardiovascular: Denies chest pain or palpitations. Denies complaints or history of orthopnea, murmurs, arrythmia's, dyspnea on exertion, paroxysmal nocturnal dyspnea, peripheral edema, syncope, or claudication.

Gastrointestinal: Denies dysphagia, odynophagia, nausea, vomiting, hematemesis, food intolerance, indigestion, heartburn, appetite change, early satiety, rectal bleeding, melena, constipation, diarrhea, abdominal pain or tenderness, excessive belching, hemorrhoids, jaundice, or any changes in bowel movement/pattern. Last bowel movement was this morning and stool was brown and formed. Denies abdominal bloating or pain.
Urinary: Denies hematuria or dysuria. Denies suprapubic pain and CVA tenderness. Denies nocturia, polyuria, history of stones, inguinal pain, trouble initialing urinary stream, incontinence, and history of frequent UTI's. Denies any history of STD's/STI's.
Genital track (female): Menarche age 16, last menstrual period was on 08/15/22, cycle every 28 days with 1-2 days of moderate bleeding and 3-4 days with light bleeding. Reports mild tension headache 2 days before cycle occurs. During cycle reports wearing a tampon for the first two days changing it every 3-4 hours. Reporting wearing a pad the last 3-4 days that she changes at every bathroom break. Reports mild menstrual cramps with periods. Denies intermenstrual bleeding. Denies postcoital bleeding, pain with intercourse (dyspareunia), vaginal discharge, pruritus (itching), contraceptive use, and a history of STDs. Last Pap smear was on 07/2019 with no hx of abnormal results. Denies infertility, changes in libido, and sexual difficulties. Reports two vaginal deliveries with two live births with no complications. Reports one cesarian section with tubal ligation with no complications. Denies hx of abortions, miscarriages, and ectopic pregnancy. One lifetime partner. Reports identifying sexually as female. Denies having any vaginal pain, pressure, itching, dryness, or abnormal discharge. Denies severe cramping during cycle, bloating, and severe bleeding.
Integumentary: Denies rash, sores, lesions. Denies itching, bruising, infection, changes in moles, and sensitivities. Denies coarse or dry skin. Denies changes in hair or nails.
Musculoskeletal: Denies joint pain or stiffness, arthritis, gout, backache, joint swelling or tenderness or effusion, limitations of motion, and weakness. Denies muscle cramps.
Neurologic: Denies dizziness, fainting, or loss of feeling. Denies weakness and numbness. Denies gait disturbances or coordination problems. Denies syncope and seizures. Denies memory loss.
Allergic/Immunologic: Denies allergies such as itchy, watery eyes, urticaria, and frequent infections. Denies rhinorrhea or immunocompromise.
Psychiatric: Denies irritability, depression, anxiety, phobias, tension, suicidal or homicidal ideations. Reports occasional insomnia.
Endocrine: Denies heat or cold intolerance, excessive sweating or flushing, diabetes, 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 all systems.

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

Vital signs:

Height: 5'3"/ 63 in.
Weight: 159.0 lbs. (72.1 kg)
BMI: 28.2 (overweight)
Blood pressure: Left arm: 100/86 mm Hg. Right arm: 99/86 mm Hg.
Pulse: 74 bpm
Respirations: 18 breaths/min
O2 Saturation: 98% RA
Temp: 97.8 (taken temporal)

2. **Skin**:
No rash, lesions, or ulcerations noted. Skin is pink, warm, and dry with normal perfusion and good turgor. No diaphoresis. No edema or cyanosis noted.
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 present. 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 is able to 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. **Thorax:** Breasts, Chest, Respiratory
   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. Breast implants noted bilaterally, firm on palpation.
   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 rhythm. No clicks, murmurs or extra heart sounds heard.
Pulses: Carotid, brachial, femoral, popliteal, posterior tibial, and pedal pulses 2+ bilaterally.

6. **Genitourinary:**

No CVA tenderness, no suprapubic tenderness.
Female – Normal distribution and amount of pubic hair. No evidence of folliculitis present. External genitalia normal including labia majora and minor, Bartholin gland, Skene's gland with no lesions, discharge, or evidence of inflammation. No labial fusion present. The urethral opening was noted in a normal location with no swelling, draining, or redness. Vaginal canal shows healthy, pink mucosa, no gross lesions, or discharge noted. Vaginal wall rugae normal with no lesions. Cervix examined midline with no lesions, redness, or contact bleeding during pap smear. Transformation zone noted and normal. No discharge noted. Uterus midline, anteverted, normal size, shape, and consistency, mobile, no nodules or tenderness. Cervix low, firm, and closed. Adenxa examined including the ovaries, fallopian tubes, and ligaments via bimanual exam with no obvious deformities, masses, or tenderness. Rectovaginal septum examined septum smooth and intact, no fistulae, masses, nodules, or tenderness noted. Pelvic exam performed and size, shape, and position of the uterus and ovaries are normal with no abnormal shape or masses. Inguinal nodes palpated with no tenderness or enlargement noted.
Rectal: No anoperineal lesions noted. Normal taunt tone to rectal sphincter. No external lesions or hemorrhoids. No fissures or tears. No skin lesions. Internal exam deferred.

7. **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.

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: No swelling, deformities, tenderness, warmth, erythema, and effusions.

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. **Pap Smear:** Performed to screen for cervical cancer. Detects abnormal cells from the cervix; Detects potential precancerous cells in the cervix; Detects HPV.
   Results Pending.

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

- N/A

XI. **Definitive Diagnosis with CPT Code**:

- **Women's Wellness Exam – CPT G0101**

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

- **Insomnia – G47.00**

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

- **Insomnia**
  - Treatment: Continue taking Melatonin 3 mg PO PRN for occasional insomnia. Consider taking melatonin only as needed and if taken daily up to 6 months at a time. Consider avoiding heavy meals close to bedtime, limiting caffeine products throughout the day, avoiding alcohol to aid sleeping, avoiding smoking close to bedtime, avoiding naps during the daytime, and avoiding vigorous exercise close to bedtime to promote sleep.
  - Medication Profile:
    - Generic: Melatonin
    - Brand: circadin
    - MAO: Promotes sleep by regulating the sleep/wake rhythm through their actions on melatonin receptors in the SCN, a unique mechanism of action not shared by any other hypnotics.
    - Drug Class: Endogenous Hormone
    - Indication: Primary insomnia, age-related insomnia, jet lag disorder, shift work sleep disorder, post-traumatic sleep disorder, neurodegenerative disorders.
    - Dosage: 3 mg PO as needed for occasional insomnia, up to 8 mg per day.
    - Cost for a 30-day supply:
    - Walmart: $7.03
    - Publix: $4.80
    - Walgreens: $4.57
    - **https://www.goodrx.com/melatonin**
  - Education: Insomnia is a common sleep disorder that can make it hard to fall asleep, hard to stay asleep, or cause you to wake up too early and not be able to get back to sleep. You may still feel tired when you wake up. Insomnia can result from mental health disorders, medications, sleep-related conditions, caffeine, nicotine, or alcohol. Complications of insomnia may include lower job/work performance, slow reaction time while driving, mental health disorder such as anxiety or depression, and increased risk of heart related conditions. To aid in insomnia keep your bedtime and wake time consistent, stay active, check your medications, avoid naps, avoid/limit

caffeine, avoid/limit alcohol intake before bed, and avoid large meals and beverages before bed. It may also be helpful to make your bedroom comfortable for sleep and take a relaxing bath or listen to soft music. Melatonin is a hormone in your body that plays a role in sleep. The production and release of melatonin in the brain is connected to time of day, increasing when it's dark and decreasing when it's light. Melatonin production declines with age. Melatonin (circadin) is a capsule or tablet that promotes sleep by acting on receptors in your body to encourage sleep. Taking melatonin tablets adds to your body's natural supply of the hormone. Take up to 8mg of melatonin 30 minutes before bedtime and swallow the capsule whole. Don't drive or use machinery for 4-5 hours after taking melatonin. Side effects may include headache, dizziness, nausea, and drowsiness.
    - Follow-up: No follow-up required. As scheduled with PCP.
    - Referral: No referral required at this time.

- **Health promotion plan:**

    - Current recommended screenings:
        1. Continue annual dental exams and vision screenings.
        2. Keep follow-up appointments with PCP for monitoring and yearly follow-up wellness appointments.
        3. Continue monthly breast self-exams so that you know what your normal breast tissue feels like, and you can promptly report any changes to your healthcare provider.
        4. Continue annual gynecologist appointments and pap smears at least every 3 years.
        5. Continue with mammogram screening or MRI yearly due to family history.

    - Immunizations:
        1. Will offer the patient the influenza vaccine at the start of the next flu season.
        2. Will continue to offer the COVID-19 booster vaccine.
        3. Will recommend immunizations appropriate to her age at subsequent visits.

    - Lifestyle management:
        1. Continue with exercise routines of walking 2-3 times per week for at least a mile and cleaning for an additional 3-4 days per week of exercise.
        2. Avoid stressful situations.
        3. Continue with the use of sunscreen.
        4. Continue to take prescribed medications. Consider trying other forms of sleep promotion such as limiting caffeine and avoiding large meals before bed.
        5. Incorporate a diet high in fruits, vegetables, whole grains, proteins, and limiting sodium and fried foods.
        6. Adhering to the above can decrease the family risks of hypertension and hypercholesterinemia.

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.