SOAP Note Two

Student Name: Mary McClain

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

Clinical Location: Andalusia Family Healthcare Preceptor: Katherine Langley, CRNP.

Date of Patient Encounter: 07/6/22 Patient Identifier (Initials/number): K.E.

Patient age/DOB: 32, 02/11/1990 Ethnicity and Gender: Caucasian, female.

I. Chief Complaint: "I have no energy, I feel unmotivated, and I have gained weight despite dieting and exercising."

II. **History of Present Illness:**

K.E. is a 32-year-old Caucasian female who presents to the clinic today with complaints of fatigue, lack of motivation, and weight gain. She states she has been feeling more tired than normal for about 4 months and it has not improved. She is able to continue normal daily activities but feels "drained and wore out and has no desire to do anything extra besides her normal routine" including taking care of her children and attending workout classes. She states that the decreased energy begins around lunch and persists throughout the day. She states that a stressful day does make her fatigue worse; however, nothing has helped. She states a continued lack of energy despite a good night's sleep and increased caffeine intake. She states that she has gained about 15 pounds over the past 4 months despite constantly dieting and attending CrossFit classes 3-4 times per week. She states that she is concerned she has hypothyroidism that it runs in her family. She denies temperature intolerance, dry skin, body and scalp hair loss, hoarseness, muscle weakness, depression, and hearing loss.

III. **Past Medical History:**

1. Childhood illnesses & developmental milestones
   a. Recurring tonsillitis as a child. No residual effects after tonsillectomy at age 7.
   b. Occasional viral colds, no residual effects.
2. Chronic Illnesses
   a. Anxiety, diagnosed at age 26. Currently controlled with Zoloft.
3. Prior Illnesses and Injuries (accidents and hospitalizations)
   a. Vaginal delivery of children in 2018 and 2020, 2-night hospital stay after each child. Each delivery was atraumatic with no residual problems.
4. Past Surgical History
   a. Tonsillectomy at age 7. The procedure was done at Flowers Hospital. The patient is unsure of the doctor's name. No lasting effects.

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 history of stress that is controlled with prescribed medication and exercise.
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. Sertraline (Zoloft) 50 mg PO daily to relieve symptoms of anxiety by Dr. Farmer and her PCP. Has been on this medication for 6 years and it works well at controlling her anxiety.
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 chemicals while cleaning her home.
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 CrossFit classes 3-4 times per week and reports walking for 20-30 min up and down her driveway on the days she does not have class. Level of activity: High. She does report enjoying shopping at T.J. Maxx and Home Goods monthly for leisure.
10. Sleep: Reports 6-8 hours of sleep nightly. Does not take medications for sleep. She is in bed by 9 p.m. and does occasionally get woken by children. Reports daytime naps with her 2-year-old daughter daily due to daytime fatigue.
11. Diet: Her typical breakfast includes arriving at The Nutrition Shack for a Herbalife energy tea in the morning and grabbing a breakfast bar. For lunch she had a turkey bacon ranch sandwich on whole grain bread with baked lays chips with an unsweet tea. For dinner she had baked chicken with zucchini and squash with a side of jasmine rice. She reports drinking a half gallon of water per day. She reports having a Herbalife tea in the morning and a Celsius energy drink before her workouts (approximately 280 mg caffeine per day).
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 (05/2020).
    c. Had influenza vaccine this past October 2021. Reports getting the vaccine yearly.
    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 2021).
    b. Depression screening complete at yearly wellness exam (February 2021). Results negative.
    c. Regular annual visits with a gynecologist. Last visit and pap smear was in January 2022. No hx of abnormal pap smears.
    d. Reports monthly self-breast exams.
    e. Reports yearly eye exams. Last exam in November 2021. Denies use of contacts/eyeglasses.
    f. Patient visits the dentist every 6 months for preventive cleaning. Last dental exam was in March 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, alive at age 75, history of depression.
2. Maternal grandfather, alive at age 76, history of hypertension.
3. Paternal grandmother, deceased at unknown age, unknown medical history, died from unknown causes.
4. Paternal grandfather, deceased at unknown age, unknown medical history, died from unknown causes.
5. Mother, alive at age 53, diagnosed with Hashimoto's disease and hypertension.
6. Father, alive at age 55, diagnosed with hypertension and hypercholesterinemia.
7. Sister, alive at age 35, diagnosed with hypothyroidism and anxiety.
8. Patient, alive at age 32, history of anxiety.

Health Risk Assessment: Pt is at risk for anxiety, which she already has, due to a family history of anxiety from her sister. She is at risk for hypothyroidism due to her sister's health hx and her mother having Hashimoto's disease. Pt is at risk for hypertension due to her mother and maternal grandfathers hx. Pt is

also at risk for high cholesterol due to her father's medical hx. Pt is at risk for depression from her maternal grandmother having depression.

VI. **Social History:**

1. Education- Bachelor's degree in early childhood education from The University of South Alabama.
2. Occupation- Elementary teacher at Straughn Elementary School.
3. Marital status- Only married once and married for 9 years.
4. Children/dependents- Has two children, ages 2 and 4.
5. Type of housing & who the patient lives with- Pt lives in a 4-bedroom one-story single-family home with her husband. They build the home in 2020 and have lived there for the past two years.
6. Financial resources/insurance- Has Blue Cross Blue Shield of Alabama. She reports her and her husband both have steady incomes. She expresses no financial concerns about affording healthcare or medications.
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 conversating on Sunday and Wednesdays with her church friends and family. She also reports social gatherings with other schoolteachers and enjoys gatherings for dinner or coffee.
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 two 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: Reports malaise and fatigue. Denies fever, temperature intolerance, weakness, anorexia, chills, night sweats. Reports weight gain.

Head: Denies headache, 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.

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. Reports a history of intermittent constipation.

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 12, last menstrual period was on 06/22/22, Reports a cycle that lasts anywhere from 2-4 days to 5-6 days and is irregular. Reports having moderate amount of bleeding with periods that she wears a tampon for and changes it every 3-4 hours and wears a pad at night. Reports mild

menstrual cramps with periods. Reports 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 01/2022 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. Denies hx of abortions. One lifetime partner. Reports identifying sexually as female.

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, headache, 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, insomnia, phobias, tension, suicidal or homicidal ideations. Reports a history of controlled anxiety.

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 obese for height and weight.

Vital signs:

Height: 5'0"/ 60 in.
Weight: 155.0 lbs. (70.0 kg)
BMI: 30.27 (obese)
Blood pressure: Left arm: 127/80 mm Hg. Right arm: 129/85 mm Hg.
Pulse: 67 bpm
Respirations: 18 breaths/min
O2 Saturation: 98% RA
Temp: 98.0 (taken orally)

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 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 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.
   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.
   Genital exam: Refused.
   Rectal: Refused

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. **CBC:** Performed to detect anemia as the cause of the patient's fatigue; Detects anemia; Counts red blood cells, white blood cells, and platelets.
   All results WNL.
2. **Vitamin D:** Performed to rule out Vitamin D deficiency as the cause of the patient's fatigue.
   Vitamin D Result: 50. Within normal limit range.
3. **Thyroid panel:** Performed to rule out thyroid issues due to weight gain, fatigue, and menstrual irregularities.
   TSH: 7.4 (high)
   T4 Free: 0.45 (low)
4. **TPO antibodies:** Performed to rule out autoimmune disorders as the cause of thyroid disease such as Hashimoto's disease.
   Result: Negative.

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

Hypothyroidism – E03.9

- Definition: Clinical state that results from a reduction in circulating free thyroid hormone or from resistance to the action of thyroid hormone.

- Supporting Data: Reports fatigue and inability lose weight even though she is constantly dieting and exercising. Reports family history of hypothyroidism. Pt reports a lack of energy despite increased caffeine intake and restful sleep. Reports intermittent constipation. Reports menstrual irregularities. TSH value of 7.4. T4 Free value of 0.45.
- Refuting Data: Denies temperature intolerance, swelling of hands and feet, memory loss, muscle cramps, hair loss, dry skin, brittle nails, depression, hoarseness, and decreased sweating.

Anemia – D64.9

- Definition: A condition in which you lack enough healthy red blood cells to carry adequate oxygen to your body's tissues.
- Supporting Data: Reports fatigue and malaise.
- Refuting Data: CBC within normal range. Denies palpitations, shortness of breath, dizziness, chest pain, cold hands and feet, and headache.

Hashimoto's Disease – E06.3

- Definition: An autoimmune disorder affecting the thyroid gland.
- Supporting Data: Pt's mother has the disease. Main cause of hypothyroidism. Pt reports fatigue, weight gain, occasional constipation, and irregular menstrual cycles.
- Refuting Data: Negative TPO antibodies. No goiter detected on physical exam.

Vitamin D Deficiency – E 55.9

- Definition: Lack of vitamin D in the body. Vitamin D is important in keeping bones strong, absorbing calcium, and working with the parathyroid glands.
- Supporting Data: Pt reports fatigue.
- Refuting Data: Vitamin D within normal range. Denies bone pain, muscle weakness or aches, muscle cramps, and mood changes.

Depression – F32.A

- Definition: A mood disorder that causes a persistent feeling of sadness and loss of interest. For diagnosis must have anhedonia or depression and any four or more of the following: change in appetite, change in sleep pattern, fatigue, psychomotor retardation or agitation, poor self-image, concentration difficulty, or suicidal ideation.
- Supporting Data: Reports fatigue.
- Refuting Data: Normal depression screening questionnaire on previous visits. No history of depression. Denies changes in appetite, sleep, concentration difficulties, and suicidal ideations. Denies any feelings of sadness or loss of interest in activities.

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

Hypothyroidism – E03.9

- Definition: Clinical state that results from a reduction in circulating free thyroid hormone or from resistance to the action of thyroid hormone.
- Supporting Data: Reports fatigue and inability lose weight even though she is constantly dieting and exercising. Reports family history of hypothyroidism. Pt reports a lack of energy despite increased caffeine intake and restful sleep. Reports intermittent constipation. Reports menstrual irregularities. TSH value of 7.4. T4 Free value of 0.45.
- Refuting Data: Denies temperature intolerance, swelling of hands and feet, memory loss, muscle cramps, hair loss, dry skin, brittle nails, depression, hoarseness, and decreased sweating.

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

- **Anxiety – F41.9**

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

- **Hypothyroidism**
    - Treatment: Levothyroxine (Synthroid) 75 mcg PO daily. Consume a diet high in fiber to prevent constipation. Continue consuming a healthy diet and getting adequate amounts of exercise. Avoid stressful situations.

- Education: Hypothyroidism is a high serum thyroid-stimulating hormone (TSH) concentration and a low serum free thyroxine (T4) concentration. A clinical state that results from a reduction in circulating free thyroid hormone or from resistance to the action of thyroid hormone. All patients require treatment that is lifelong. The goal of therapy is to amelioration of symptoms, normalization of serum TSH, and avoiding overtreatment. If hypothyroidism is left untreated, it can lead to a goiter, heart problems, mental health issues, peripheral neuropathy, and myxedema coma. Levothyroxine (Synthroid) is used to treat hypothyroidism. Take the medication as prescribed (75 mcg tablet daily) take this medication by mouth every day. Should be taken on an empty stomach with water, ideally 30 to 60 minutes before breakfast. If you take it at bedtime, wait four hours after your last meal or snack. Avoid eating for at least 30 min after taking the medication. If you forget to take a dose, take it as soon as you remember, if this is within a few hours of your usual time. If you do not remember until later than this, skip the dose and take the next dose at the usual time. This will be a lifelong therapy, do not stop taking your medication. Dosing may be adjusted based on blood results. Keep follow up appointments in case your dosage needs adjusting. It may take several months for you to feel better depending on how your body responds. This medication normally does not have side effects. Side effects usually occur because you are taking too much. Report sweating, chest pain, headaches, diarrhea, and being sick. Advise your PCP if you are pregnant or plan to become pregnant.
- Follow-up: Return to clinic in 4 weeks for a repeat TSH and T4 level and then every 6-8 weeks until at the goal level, then annually unless symptomatic.
- Referral: No referral required at this time.

- **Anxiety**
  - Treatment: Continue taking prescribed Sertraline (Zoloft) 50 mg PO daily by PCP. Continue to get plenty exercise and consume a healthy diet. Consider relaxation techniques. Limit caffeine intake. Avoid alcohol consumption. Get plenty of sleep.
  - Medication Profile:
    - Generic: Sertraline
    - Brand: Zoloft
    - MOA: Inhibits the reuptake of serotonin (5-HT) at the presynaptic neuronal membrane, thereby increasing serotonergic activity. This results in an increased synaptic concentration of serotonin in the CNS, which leads to numerous functional changes associated with enhanced serotonergic neurotransmission.
    - Drug Class: Selective serotonin reuptake inhibitors (SSRIs)
    - Indication: Anxiety, depression, panic attacks, obsessive compulsive disorder, social phobia, and severe forms of premenstrual syndrome.
    - Dosage: Initial: 25 mg once daily.
    - Cost for a 30-day supply:
    - Walmart: $14.00
    - Publix: $6.52
    - Walgreens: $22.20
    - **https://www.goodrx.com/zoloft**
  - Education: Generalized anxiety disorder (GAD) is characterized by persistent and excessive worry about several different things. People with GAD may anticipate disaster and may be overly concerned about money, health, family, work, or other issues. Individuals with GAD find it difficult to control their worry. They may worry more than seems warranted about actual events or may expect the worst even when there is no apparent reason for concern. Consume a healthy diet and get plenty of exercise at least 30 minutes 3-5 times per week. Avoid alcohol consumption and limit caffeine intake. Get plenty of rest at night. Zoloft is used to treat anxiety. Continue taking Zoloft 50 mg by mouth daily. Take this medication with or without food. Swallow the medication whole and do not crush or chew the medication. The dosage is based on your medical condition and response to treatment. Do not take more than prescribed. If your symptoms do not improve or worsen contact your PCP. Keep taking this medication even if you feel well. Do not stop taking this medication without consulting your PCP. You may exhibit symptoms such as mood swings, headache, tiredness, sleep changes, and a feeling of electric shock contact if stopped suddenly. Other side effects may include nausea, dizziness, drowsiness, upset stomach,

trouble sleeping, loss of appetite, dry mouth, and increased sweating. Contact your PCP if these symptoms do not go away or get worse.
    - Follow-up: We will follow this problem at her subsequent visits.
    - Referral: No referrals 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 TSH and T4 monitoring and yearly follow-up wellness appointments.
        3. Continue monthly breast self-exams.
        4. Continue annual gynecologist appointments and pap smears at least every 3 years.

    - 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 CrossFit 3-4 times per week and walking 3 days per week in between classes.
        2. Avoid stressful situations.
        3. Continue with the use of sunscreen.
        4. Continue to take prescribed medications.
        5. Continue with diet high in fruits, vegetables, whole grains, proteins, and limiting sodium and fried foods.
        6. Limit caffeine intake to no more than 300 mg a day.
        7. Adhering to the above can decrease the family risks of hypertension and high cholesterol.

References

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