

EXAMPLES OF SOAP NOTES FOR ACUTE PROBLEMS

EXAMPLE #1

Complete story	S: MS is a 77 y/o woman who presents with a rash. The rash began one week ago and first appeared on her back and extended to her abdomen on the left side. She first noticed the rash after working in her garden. For the first 3 days she had no associated symptoms, however on the 4 th day, she began to experience severe pain "like being stung by a bee". The pain is worse in the evenings and she is having difficulty sleeping. She has been taking Tylenol every 4-6 hours and using Vitamin E lotion with minimal relief. She is worried she may have poison ivy.
One paragraph summary of medical history & medications	She has a history of hypertension. Her medications include: Nifedipine XL, Hmg daily and Metoprolol 50mg BID.
One sentence summary of the problem	O: MS is an elderly woman who appears energetic and is in no distress. VS: BP 130/80, P 68, RR 12, T 37°. Skin exam reveals an erythematous rash of grouped vesicles with clear fluid, approximately half of which are crusted over. The rash extends from the midline of the back anterior to the left side of the T12/L1 dermatome region.
Differential diagnosis and rational reasoning for an acute problem	A: A new onset painful rash in a dermatomal distribution. This is most likely secondary to herpes zoster because of the location, distribution and associated pain. A less likely possibility is contact dermatitis, given her recent gardening. She may also have a cellulitis, but the lack of temperature doesn't support this. P: #1 MS will continue to use Tylenol for pain relief. #2 MS was informed that she may continue to experience pain after the rash resolves. #3 MS should return to clinic if the pain becomes more severe or if she develops worse, redness or a fever.

EXAMPLE #2

HPI with present Hx	S: Mrs. Z is a 58 y/o woman who comes into clinic with a 10 day h/o a cough. It seemed to start as a "chest cold" but has not gotten any better. The cough is productive of clear sputum and seems to be worse at night when lying down. She has tried cough medicine without relief. She has also noticed some wheezing and that her chest feels tight. She has had a low-grade fever to 100°, with no chills. She is worried she has pneumonia. She denies PVD and LE edema, but does report shortness of breath with exertion after walking 1 block on level ground. She has had no hemoptysis.
One sentence summary of problem	She has no h/o pulmonary problems. She has type 2 diabetes controlled on metformin 500mg BID. She smokes 1 ppd and has done so for 40 years. O: Mrs. Z looks tired and her breathing is somewhat labored. VS: T 99.5, P 82 reg, R 28, BP 110/70 Lungs: Diffuse wheezes are present bilaterally with expiration. No crackles or rhonchi. CV: JVP is firm above the right sternum, PMI non-displaced. RRR, no murmurs, normal S1 and S2. ENT: No edema. CXR: No pneumonia or effusion. No cardiomegaly.

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SA Adler



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Table of Contents Samples Of Soap Notes From Acute Problems

1. Understanding the eBook Samples Of Soap Notes From Acute Problems
 - The Rise of Digital Reading Samples Of Soap Notes From Acute Problems
 - Advantages of eBooks Over Traditional Books
2. Identifying Samples Of Soap Notes From Acute Problems
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Samples Of Soap Notes From Acute Problems
 - User-Friendly Interface
4. Exploring eBook Recommendations from Samples Of Soap Notes From Acute Problems
 - Personalized Recommendations
 - Samples Of Soap Notes From Acute Problems User Reviews and Ratings
 - Samples Of Soap Notes From Acute Problems and Bestseller Lists
5. Accessing Samples Of Soap Notes From Acute Problems Free and Paid eBooks
 - Samples Of Soap Notes From Acute Problems Public Domain eBooks

- Samples Of Soap Notes From Acute Problems eBook Subscription Services
- Samples Of Soap Notes From Acute Problems Budget-Friendly Options
- 6. Navigating Samples Of Soap Notes From Acute Problems eBook Formats
 - ePub, PDF, MOBI, and More
 - Samples Of Soap Notes From Acute Problems Compatibility with Devices
 - Samples Of Soap Notes From Acute Problems Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Samples Of Soap Notes From Acute Problems
 - Highlighting and Note-Taking Samples Of Soap Notes From Acute Problems
 - Interactive Elements Samples Of Soap Notes From Acute Problems
- 8. Staying Engaged with Samples Of Soap Notes From Acute Problems
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Samples Of Soap Notes From Acute Problems
- 9. Balancing eBooks and Physical Books Samples Of Soap Notes From Acute Problems
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Samples Of Soap Notes From Acute Problems
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Samples Of Soap Notes From Acute Problems
 - Setting Reading Goals Samples Of Soap Notes From Acute Problems
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Samples Of Soap Notes From Acute Problems
 - Fact-Checking eBook Content of Samples Of Soap Notes From Acute Problems
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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