QUESTION 2

The Subjective, Objective, Assessment, and Plan (SOAP) note is a method of documentation used by NPs and other healthcare professionals and includes:

S: subjective information provided by the patient

O: objective information obtained by the provider

A: assessment is the medical diagnosis rather than the physical assessment. *Hint, this information has already been provided to you in the case.

P: medical plan.

Write a brief SOAP note addressing Haley's presentation to the clinic and chief complaint. Be sure to include each component: SOAP. A reference is not required for this question.

Answer:

S:

"I can't stop coughing"

HPI: Haley, a 10-year old presents to the clinic accompanied by her parents complaining of a persistent cough. She has a history of asthma and reports getting up 3-4 nights to use her albuterol inhaler, in addition to this morning before the office visit. She experiences wheezing 3-4 times a week especially when at the gym or in contact with a cat. Current medications include a SABA.

PMI: history of asthma, NKDA

Family Hx: Mother- asthma; Father- hypertension, current smoker; no siblings

Social Hx: well balanced diet with occasional fast food; gym at school and plays outside daily until symptoms of asthma occur; doing well in school

Review of Systems:

- General: No recent change of weight, no fever, chills, diaphoresis
- Cardiovascular: Denies chest pain, palpations, edema, report dyspnea.
- Respiratory: reports shortness of breath, wheezing, chest tightness, cough, denies hemoptysis and pleurisy
- HEENT: Denies headache, rhinorrhea, or sinus congestion
- GI: denies constipation, diarrhea, and other stool abnormalities
- GU: denies dysurea
- Musculoskeletal: denies back/neck pain or weakness
- Psychiatric: denies depression, anxiety, or suicidal ideations

O: