Question 1

I understand the value of doing my own work and learning this skill to support my future independent practice as a nurse practitioner. I understand that while there may be opportunities beyond my faculty's control to collaborate or share answers with peers, that it would not benefit my own personal and professional growth to do so. I agree to do my own work and take personal responsibility for my learning.

I do not.

I do (Correct!)

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