Andres Hernandez

SOAP Note #5

Subjective:
HPI: 31 y.o. male, with PMHx of hypertriglyceridemia, presents to the colorectal surgery clinic 6/12 for evaluation of intermittent hematochezia and hemorrhoids for the past 2 years. The patient was referred by internal medicine with the primary care physician on 2/20. Patient today endorses that any signs of bleeding while using the restroom last occurred about 3 months ago, when he noted small droplets of blood on the toilet paper. Patient denies ever feeling any mass or hemorrhoid. Denies receiving any treatments for bleeding in the past. Denies pain with bowel movements. Reports three bowel movements per day and describes his stools to be of normal consistency. Denies any nausea, vomiting, diarrhea, syncope, chest pains, or shortness of breath. Denies family history of colorectal cancer.

Review of Systems: Denies fever, chills, nausea, vomiting, CP, SOB, diarrhea, or constipation.

Current Medications
- Patient denies any current medications.

Past Medical History:
-Chronic alcoholism since 2018, desire to cut down as of 02/2024
-Balanitis, managed with clotrimazole 1% cream, 4/4/2024

Past Surgical History:
-No past surgical history

Social History:
-15 can of beer per week
-Denies any tobacco or drug use

Patient has no known allergies.

Objective:
Visit Vitals

BP	126/63 (BP Location: Right arm, Patient Position: Sitting)
Pulse	61
Temp	97.3 °F (36.3 °C) (Oral)
Resp	18
Wt	83.1 kg (183 lb 4.8 oz)
BMI	31.46 kg/m²
Smoking Status	Never

Physical Exam:

General: 31 y.o. male, A&O x 3, of medium build, appears of stated age, good posture, dressed to the weather, and in NAD.

Abdominal: Abdomen flat and symmetric with no scars or pulsations noted. Non-tender to palpation throughout all four quadrants, no guarding or rebound noted.
Anus and Rectum: No perirectal lesions or fissures. External sphincter tone intact. No perirectal warts or external hemorrhoids. Digital Exam performed. No laxity of anal sphincter, no occult blood in stool. Rectal vault without masses.

Anoscope Findings:
Indications: hemorrhoids and rectal bleeding
Scope type: anoscope
Positive internal exam findings: internal hemorrhoid
Negative internal exam findings: no intraluminal mass, no inflammation, no anal fistulae, no anal stricture and no abscess
Internal hemorrhoid prolapsed: no
Procedure termination: procedure complete
Patient tolerance: patient tolerated the procedure well with no immediate complications
Comments: Grade 1 nonbleeding internal hemorrhoids noted

Assessment:
31 y.o. Male, with no pertinent PMHx presents for evaluation of intermittent hematochezia and hemorrhoids for the past 2 years which last episode of bleeding 3 months ago. The physical exam shows no abnormalities. Anoscope is positive for grade 1 nonbleeding internal hemorrhoids.

Plan:
-Counseled patient on conservative hemorrhoid management including avoiding constipation with high fiber diet and good hydration with regular activity.
-Also recommend topical hydrocortisone cream for hemorrhoid pain and sitz baths for symptomatic relief. .
-If hematochezia recurs, recommend patient seek GI referral to obtain colonoscopy
-RTC colorectal surgery PRN

SOAP Note #6

Subjective:
HPI: 49 y.o. male with PMHx of hypertension and PSHx of laparoscopic umbilical hernia repair with mesh is admitted to the surgery department after being referred by emergency medicine with consistent upper abdominal pain, nausea, and two episodes of vomiting of one day duration. Pt admits that the pain started after having soup last night at 8 pm which was the last meal the patient ate since arrival to the hospital. The pain was very intense, 8/10 in severity and endorsed associated chills. Patient reported passing gas and having a bowel movement yesterday while in the ED. Patient denies fever, diarrhea, constipation, dysuria. Denies any sick contacts or recent travel.

Review of Systems: Denies fever, CP, SOB, diarrhea, or constipation.

Past Medical History:
-HTN

Past Surgical History:

- Laparoscopic umbilical hernia repair with mesh

Current Medications;
- amlodipine 10mg daily

Social History:
-Denies Tobacco, reports EtOH socially, denies recreational drug use

Patient has no known allergies.

Objective:
Vitals:
BP: 146/96
Pulse: 74
Resp: 18
Temp: 97.3 °F (36.3 °C)
SpO2: 99%

Physical Exam:
General Appearance: awake, alert, oriented, in no acute distress
Skin: there are no suspicious lesions or rashes of concern
Head/Face: no cervical or supraclavicular adenopathy or tenderness
Eyes: No gross abnormalities. and sclera nonicteric.
Mouth/Throat: dry mouth. No masses or lesions noted.
Lungs: breathing is regular, no distress
Heart: Heart regular rate and rhythm
Abdomen: soft, distended, tender to palpation in upper abdomen. No rebound tenderness, no rigidity, no guarding

Labs:
WBC 6.68

HGB 14.5

HCT 44.3

PLT 231

NA 137

Lab	
ALTSGPT	25
SODIUM	140
POTASSIUM	4.3
CHLORIDE	104
CO2	27.0
CREATININE	1.1

BUN	17.0

Imaging:

CT Abdomen Pelvis with IV contrast

IMPRESSION: 1.The stomach is distended with fluid and ingested material. There are numerous left upper quadrant air and fluid-filled distended small bowel loops. There is fecalization of small bowel contents in the left lower quadrant. The findings are consistent with small bowel obstruction. There is a small quantity of free fluid in the left left side of the pelvis near the transition point. There is a small quantity of free fluid in the right side of the pelvis. 2.There is diverticulosis of the colon. The transverse colon and proximal descending colon are decompressed.

Assessment:
49 y.o. male presents to the Surgery Department with consistent upper abdominal pain, nausea, and two episodes of vomiting during the past 24 hours. Physical exam and CT scan of the abdomen confirms distention specifically in the stomach and small bowel loops in the LUQ. {Physical exam and imaging confirm small bowel obstruction.

Plan:
- NPO, IVF hydration
- NGT for decompression @ LCWS (confirmatory chest x-ray)
- monitor bowel function

<u>SOAP Note #7</u>

Subjective:
HPI: 26 y.o. male with no significant PMHx who presents to the ED with 1-day hx of abdominal pain in the RLQ. Pt. admits to never having this pain before. Pain began periumbilical and has since migrated to the RLQ. Patient states that the pain yesterday was an 8/10 intensity but today is no longer painful, unless aggravated by movement such as walking or during urination. Pt states his appetite has also decreased, did not eat much past 24 hours. States having normal bowel movement without any bleeding. Pt reports having some nausea but denies having vomiting, diarrhea, fevers/chills.
.
Review of Systems: Denies fever, chills, nausea, vomiting, CP, SOB, diarrhea, or constipation.

Past Medical History:
- None

Past Surgical History:
-None

Current Medications
- No medications

Social History:
-1 cigarette daily. Admits to cocaine use, last time used one week ago.

Patient has no allergies.

Objective:

Visit Vitals

BP	122/77
Pulse	87
Temp	98.8 °F (37.1 °C)
Resp	17
Ht	1.6 m (5' 3")
Wt	70.8 kg (156 lb 1.4 oz)
SpO2	98%
BMI	27.65 kg/m²
Smoking Status	Every Day
BSA	1.74 m²

Physical Exam
Constitutional: General: He is not in acute distress. Appearance: Normal appearance. He is alert and oriented to person, place, and time.
HENT: Head: Normocephalic and atraumatic. Nose: Nose normal. No congestion or rhinorrhea.
Mouth/Throat: Mucous membranes are moist.
Eyes: Extraocular movements intact. Conjunctivae normal.
Cardiovascular: Normal Rate and Rhythm and Normal pulses.
Pulmonary: Pulmonary effort is normal. No respiratory distress.
Abdominal: The abdomen is soft. There is abdominal tenderness in the right lower quadrant palpation, no rebound tenderness no guarding. There is right CVA tenderness.There is no left CVA tenderness, guarding or rebound. Positive signs include McBurney's sign, Psoas sign and Rovsing's sign. Murphy's sign is negative.
Musculoskeletal: No deformity. Normal range of motion. Neck supple.
Skin: Skin is warm and dry. Capillary refill takes less than 2 seconds.

Labs:
WBC 11.36 (H) Range 4.30-11.00 x10(3)mcL
All other labs are within range

Imagining:
Radiology CT Abdomen and Pelvis with Contrast
The appendix is prominent measuring 1.2 cm. There is a 6 mm appendicolith at the base. Suspect additional appendicoliths at the distal appendix. There is moderate fat stranding at the right pericecal region. Findings compatible with a appendicitis.
Impression: Acute appendicitis

Assessment:

26 y.o. male presents to the ED with abdominal pain in the RLQ, and episodes of nausea and vomiting. The patient admits that pain was worse yesterday, although pain is currently stable, it is still aggravated with movement. Vitals within normal limits. On physical exams, there is RLQ tenderness without guarding or rebounding. McBurney’s, Psoas, and Rovsing’s signs are positive. CT abdomen and pelvis with contrast confirms acute appendicitis.

Plan:
-NPO/IVF
-Preoperative IV abx - cefoxitin
-OR today for appendectomy

SOAP Note #8

Subjective:
HPI: 42-year-old female with PMHx of varicose veins presents to vascular clinic for follow-up after being seen by the Emergency Department on 6/8/2024 for a right ankle wound present for the past 1.5 months. Pt. admits that her husband accidentally kicked her, and his nail caused a wound in her right medial malleolus that has not healed since. As a result, there is a right ulcerated wound measuring 2.5 cm x 1.0 cm that is noted to the medial aspect of the distal lower extremity. Patient endorses that the area is tender to touch and admits that the area appears more moist than usual. While in the ED on 6/8, OM was ruled out and pt. was initiated on antibiotic therapy therapies of Bactrim and Keflex for appropriate coverage and treatment. Denies any fever, chills, shortness of breath, chest pain, palpitations, nausea/vomiting, or any other recent traumatic injuries. Denies history of DVT or PE.

Review of Systems: Denies fever, chills, nausea, vomiting, CP, SOB, diarrhea, or constipation.

Past Medical History:
-No Past Medical History

Past Surgical History:
-No Past Surgical History

Current Medications
-cephalexin (Keflex) 500 MG capsule, take 1 capsule (500 mg total) by mouth every 6 (six) hours for 7 days.,
-sulfamethoxazole-trimethoprim (Bactrim) 800-160 MG tablet
Take 1 tablet by mouth every 12 (twelve) hours for 7 days

Social History:
-Never smoker

Patient has no known allergies.

Objective:
Vital Signs
BP 130/76 (BP Location: Right arm)
Pulse 72
Temp 98.3 °F (36.8 °C) (Oral)
Resp 16
SpO2 99%
OB Status Having periods

Physical Exam:

Constitutional: Alert and Oriented x3. She is normal weight. She is not ill-appearing, toxic-appearing or diaphoretic. She is not in acute distress.
Skin: Warm and Capillary refill takes less than 2 seconds.
Head: Normocephalic and atraumatic.
Mouth/Nose: No congestion or rhinorrhea. Mucous membranes are moist.
Eyes: No scleral icterus. Extraocular movements intact.
Cardiovascular: Normal rate and regular rhythm.
Pulmonary: Pulmonary effort is normal. No respiratory distress.
Musculoskeletal: Right lower leg: No swelling. No edema. Left lower leg: No swelling. No edema. Sensorimotor intact.
Peripheral Vascular: Comments: Right ulcerated wound measuring 2.5 cm x 1.0 cm is noted to the medial aspect of the distal lower extremity. Mild unhealthy granulation tissue with surrounding erythema present. No evidence of purulent drainage. No active bleeding.
Right ulcerated wound is tender to palpation. Diffuse varicose veins noted to bilateral lower extremities. Otherwise, the extremities are normal in color, size, and temperature. Pulses are 2+ bilaterally in the lower extremities. No cyanosis or edema noted bilaterally.

Imaging:
EXAM: DX TIBIA FIBULA 2 VIEW RIGHT
AP and lateral radiographs of the tibia/fibula.
HISTORY: r/o Osteomyelitis.

Findings:
The osseous structures are intact.
There is no abnormal soft tissue calcification.
The visualized joint spaces are maintained.

IMPRESSION:
Impression:
No radiographic evidence of acute osseous abnormality.

Assessment:
42 y.o. female with PMHx of varicose veins presents to a vascular clinic for complaints of an ulcer on the right medial malleolus that has not healed in the past 1.5 months. On physical exam, Right ulcerated wound measuring 2.5 cm x 1.0 cm is noted to the medial aspect of the distal lower extremity. Mild unhealthy granulation tissue with surrounding erythema present. Patient afebrile with no evidence of acute distress. Patient is being worked up for a venous ulcer given the history of varicose veins.

Plan:
- Inform patient to complete antibiotic course as instructed by ED on 6/8, may take with food if causing upset stomach
-Lower Extremity Venous Duplex Bilateral ordered for baseline evaluation of veins
-UNNA boot placed today must remain in place until day prior to wound care appointment, may remove sooner if becomes wet.
-In case of removal recommended use of compression stocking therapy (20-30 mmHg) and leg elevation daily while maintaining skin on legs with daily hydration, alternating sitting/standing activities every 2 hours.
- Follow up with wound care weekly until ulceration resolves