Rachel Freundlich

SOAP #1

S:
Pt is a 57 y/o F presenting for follow up for cerumen impaction of the left ear. Pt was previously seen in the clinic 1.5 weeks ago with complaint of left cerumen impaction. Attempt to remove cerumen through washout and suctioning was unsuccessful. Pt was recommended to return to clinic after 10 days of using Debrox. Pt states she adhered to instructions and used Debrox in the left ear 2x daily for 10 days. Denies hearing loss, otalgia, otorrhea, tinnitus.

O:
Vitals: BP - 121/76, Temp - 98.3F, HR - 69, Resp 15, SpO2 - 99%
Labs: No relevant labs available.

PE:
General Appearance: A&Ox3, appears in no acute distress
HE: Normocephalic, atraumatic, EOM intact, PERRLA
Ears: Right - normal pinna, no mastoid tenderness, ear canal without erythema, edema or ulcerations. Tympanic membrane visualized without bulging, retraction or perforation
Left - normal pinna, no mastoid tenderness, impacted cerumen noted, yellow in color, difficult to visualize tympanic membrane
Lungs: Unlabored breathing, symmetrical rise of chest
Nose: No deformity, nasal mucosa pink and healthy appearing, no edema or bleeding noted
Oral cavity: good dentition, no masses noted on lips, buccal mucosa, gingiva, tongue, or palate
Oropharynx: Symmetrical palatal rise, no masses or ulcers noted
Neck: soft, non-tender, trachea midline, no LAD or masses

A/P:
57 y/o F presenting to clinic for left cerumen impaction removal. Pt completed 10 days of Debrox as instructed. No other acute ear complaints. Cerumen irrigated from left ear successfully in clinic today. Pt was advised to refrain from using q-tips and educated how to properly clean ears. Discharged from ENT clinic and recommended to follow up with PCP and return to clinic PRN.

SOAP 2:

S:
Pt. is a 46 y/o M with PMH of gastritis presenting with dysphagia x1 year. Pt reports that dysphagia began with both solids and liquids and now it is only for solids for about one year after beginning Omeprazole. Pt reports food intake was restricted for 6 months but since starting the PPI it has improved and he is no longer limiting food intake. Pt denies odynophagia, voice changes, regurgitation, halitosis and weight loss.

O:

Rachel Freundlich

Vitals: BP - 117/73, Temp - 98.7F, HR - 83, Resp 16, SpO2 - 100%
Labs: No labs available at this time.

Medications:
Omeprazole - 40mg daily
No other current known medications

PE:
General Appearance: A&Ox3, appears in no acute distress
Lungs: Unlabored breathing, symmetrical rise of chest
Face: Symmetrical movement, CN7 intact, no masses or ulcers of concern
Eyes: EOM intact, PERRLA
Nose: no deformity, mucosa healthy and pink appearing, no crusting, purulence, erythema or edema noted
Ears: Right and Left - normal pinna, no mastoid tenderness, ear canal without erythema, edema or ulcerations. Tympanic membrane visualized without bulging, retraction or perforation
Oral Cavity: Fair dentition, no ulcerations on lips, buccal mucosa, gingiva, tongue, or palate
Oropharynx: symmetrical rise of uvula
Neck: soft, non tender, trachea midline, no LAD or palpable masses

Imaging
Laryngoscopy in clinic 02/25/24: mobile vocal cords b/l, no masses noted, erythema over vallecula

A:
46y/o M with PMG of gastritis presenting with complaints of dysphagia to solid foods. Pt denies dysphagia to liquids. Pt tolerated laryngoscopy well with no significant abnormal findings.
P:
Schedule EGD
Continue Omeprazole 40mg daily
RTC after EGD to review results

SOAP 3:

S:
Pt. is a 31 y/o F presenting with bilateral wrist pain x2.5 months. She presents to clinic today for follow up post ED visit last week. Pt has a 5 month old child that she reports “holds for hours a day” and only since then noticed the pain. Pt denies recent trauma or fall. ED provided the pt with wrist splints that she reports she wears occasionally. She was also instructed to take ibuprofen as needed which she states helps the pain moderately. Pt states she is interested in injection to alleviate the pain.

O:
Vitals: BP - 11381, Temp - 98.4F, HR - 80, Resp 16, SpO2 - 100%
Labs: No labs available at this time.

Rachel Freundlich

Medications:
Cetirizine, 10mg tablet, 1 tablet daily
Diclofenac 1% gel, 4g topically 2x daily
Ferrous sulfate, 325mg tablet, 1 tablet daily
Norgestimate-ethinyl estradiol, 0.180/0.215/0.25mg- 25mcg tablet, 1 tablet daily
Prenatal vitamin, 27-1 mg tablet, 1 tablet daily

PE:
General Appearance: Well appearing in no acute distress
Skin: Good turgor, warm and dry
Head/Face: Normocephalic, atraumatic, no other gross abnormalities
Eyes: EOM intact, PERRLA
Mouth/Throat: mucosa moist; pharynx without edema or exudates, symmetrical rise of uvula
Neck: supple, no masses
Lungs: Unlabored breathing, symmetrical rise of chest
MSK: Right wrist: Tenderness present, No swelling, deformity, lacerations, bony tenderness, snuff box tenderness, or crepitus. Decreased range of motion. Normal pulse. Normal capillary refill.
Left wrist: Tenderness present, No swelling, deformity, lacerations, bony tenderness, snuff box tenderness, or crepitus. Decreased range of motion. Normal pulse, normal capillary refill
Bilateral positive Finkelsteins test.

A:
31 y/o F presenting with bilateral DeQuervain's tenosynovitis for 2.5 months. Pt has a 5 month old baby that she holds for most of the day and reports she has not experienced this pain previously. Pt was instructed to wear splints and to use analgesics and now presents for injection to alleviate her pain.

P:
1.5ml of 1% lidocaine used for topical anesthetic followed by triamcinolone acetonide 40mg/mL injection bilaterally
Pt instructed to wear bilateral wrist splints daily
Pt educated to use ibuprofen 400mg every 6 hours as needed
Pt educated to limit time holding baby
Follow up in clinic in 6 weeks to assess improvement

SOAP 4:

S:
60 y/o M with PMH of CKD stage 3, HLD, and HTN presents for left ear mass x 1 year. Pt reports that he had a similar mass on his left ear before this one appeared and that it "exploded" with foul smelling green liquid, blood and pus. He reports the mass then grew back. Pt wears an earring in his left ear regularly but

since the mass developed he has not worn an earring. The pt states that the mass does not cause him pain or affect his hearing. He presents today with interest in removing it. Pt denies otalgia, otorrhea and mastoid tenderness.

Pt had one surgery in the past (inguinal hernia repair) without complications from anesthesia.

O:
Vitals: BP - 123/83, Temp - 98.1F, HR - 78, Resp 16, SpO2 - 100%
No labs available at this time.

Medications:
Acetaminophen - 500 mg Oral every 4-6 hours PRN
Aspirin - 81mg, daily
Atorvastatin - 20mg, daily
Enalapril - 5mg, daily
Multivitamin - 3mg, daily

PE:
General Appearance: A&Ox3, appears in no acute distress
HENT: Normocephalic, atraumatic, EOM intact, PERRLA
Lungs: Unlabored breathing on room air, symmetrical rise of chest
Ear: Pinna non-tender, no mastoid tenderness, clear EAC, TM pearly gray without bulging, retraction, perforation. Post auricular cyst noted, 1cm, soft, nontender. No bleeding, erythema, swelling or heat noted.

A/P:
60 y/o M with post auricular cyst 1cm in size presents with interest in removal. Pt scheduled for postauricular cyst removal on 03/18/24. No medical clearance or labs needed in order to be cleared. Risks discussed with pt in clinic with no further questions. Consent signed in office.