**MN552 Advanced Health Assessment**

**Comprehensive SOAP Note Written Guide**

This guide will assist you to document history data and perform a comprehensive physical exam in an organized and systematic manner. Please include a heart exam and lung exam on all clients regardless of the reason for seeking care. So, if someone presented with cough and cold symptoms, you would examine the general appearance, HEENT, neck, heart, and lungs for a focused/episodic exam. However, this Assignment requires assessment of all body systems. The pertinent positive findings should be relevant to the chief complaint and health history data. Please follow the guide and include all previous sections of the SOAP note with corrections based on feedback, as well as the Objective and Plan sections.

**I. Subjective data**

Date of History/Interview:

Source of history and Reliability: (client, family member, chart/record, etc.-sample on page 50 of Jarvis textbook)

1. Biographical Data
	1. Name (use initials only)
	2. Address
	3. Phone number
	4. Primary language
	5. Authorized representative
	6. Age and Date of Birth
	7. Place of Birth
	8. Gender
	9. Race
	10. Marital Status
	11. Ethnic/Cultural Origin
	12. Education ( highest level completed)
	13. Occupation/Professional
	14. Health insurance
2. Chief Complaint (reason for seeking health care):
	1. Brief spontaneous statement in client’s own words
	2. Includes when the problem started ( “chest pain for 2 hours”)
3. History of Present Illness: A well organized, chronological record of client’s reason for seeking care, from time of onset to present. Please include the 8 critical characteristics using the PQRSTU pneumonic.

 P – Provocative or palliative (What brings it on? What makes it better or worse?)

Q – Quality or quantity (Describe the character and location of the symptoms; How does it look, feel, sound?)

R – Region or radiation (Where is it? Does the symptom radiate to other areas of the body?).

S – Severity (Ask the patient to quantify the symptom(s) on a scale of 0-10).

T – Timing (Inquire about time of onset, duration, frequency, etc.)

U – Understand Patient’s Perception of the problem (What do you think it means?)

1. Past Medical History
	1. Medical Hx: major illnesses during life span, injuries, hospitalizations, transfusions, and disabilities
	2. Childhood Illnesses: Measles, mumps, rubella, chickenpox, pertussis, strep throat
	3. Surgical Hx; procedures, dates, inpatient or outpatient
	4. Obstetric HX: Number of pregnancies, term deliveries, preterm births, abortions

(spontaneous or induced), number of children living

* 1. Immunizations
	2. Psychiatric Hx: childhood and adult (treated or hx of)
	3. Allergies: Medications, food, inhalants or other (what occurs with reaction)
	4. Current Medications: Include all prescription, herbal/supplements and OTC, dosage, frequency
	5. Last Examination Date: Physical, eye exam, foot exam, dental exam, hearing screen, EKG, chest X-Ray, Pap test, mammogram, serum cholesterol, stool occult blood, prostate, PSA, UA, TB skin test; other health maintenance tests for infants/children may include sickle-cell, PKU, lead level, and hematocrit
1. Family History (list FHx and design a genogram (computer)-include a key with the genogram). The Genogram must include 3 generations.
	1. Include parents, grandparents, spouse, and children.
	2. Health conditions, familial and communicable diseases/illnesses
	3. Note whether family member deceased or living

**II. Life style patterns**

* 1. Immigrant status
	2. Spiritual resources/religion
	3. Health perception
	4. Nutritional patterns: Appetite (any changes); satisfaction with current weight; gains or losses; recall of usual intake; any cultural restrictions/intolerances; amount of fluid per day and type
	5. Elimination patterns: Bowel (usual pattern and characteristics); bladder (usual pattern and characteristics); any incontinence
	6. Living environment: City, state; urban, rural, community; type of dwelling, facilities; known exposures to environmental toxins
	7. Occupational health: Known exposure to environmental toxins at work
	8. Functional assessment: ADLs, IADLs, interpersonal relationships/resources (see page 57 in Jarvis textbook)
	9. Role and family relationships: Immediate family composition; how are family decisions made; impact of family member’s health on family
	10. Cognitive function: Memory; speech; judgment; senses
	11. Rest/sleep patterns: Number of hours; naps; number of pillows; any aids for sleep
	12. Exercise patterns: Type and frequency
	13. Hobbies/recreation: Leisure activities; any travel outside of the US
	14. Social habits: Tobacco; alcohol; street drug use
	15. Intimate partner violence (review screening questions on page 58 in the Jarvis textbook)
	16. Coping/stress management: Any major life change in past 2 years; do you feel tense; source; what helps
	17. Sexual patterns: Are you sexually active; gender preference; has anything changed about your sexual health/function

**III. Review of Symptoms**

|  |  |  |
| --- | --- | --- |
|  | **Symptoms to Inquire About****(please see page 54–56 in Jarvis textbook)** | **Document pertinent negatives and/or positives****The first system is addressed to provide a guide** |
| **General** | Wgt Δ; weakness; fatigue; fevers | **Pertinent negatives**: No weight gain or losses; no weaknesses, fatigue, or fevers**Pertinent positives:** Positive weight gain over past 2 months with fatigue and weakness; no fevers |
| **Skin** | Rash; lumps; sores; itching; dryness; color change; Δ in hair/nails |  |
| **Head** | Headache; head injury; dizziness or vertigo |  |
| **Eyes** | Vision Δ; eye pain, redness or swelling, corrective lenses; last eye exam; excessive tearing; double vision; blurred vision; scotoma |  |
| **Ears** | Hearing Δ; tinnitus; earaches; infections; discharge, hearing loss, hearing aid use |  |
| **Nose/****Sinuses** | Colds; congestion; nasal obstruction, discharge; itching; hay fever or allergies; nosebleeds; change in sense of smell; sinus pain |  |
| **Throat/****Mouth** | Bleeding gums; mouth pain, tooth ache, lesions in mouth or tongue, dentures; last dental exam; sore tongue; dry mouth; sore throats; hoarse; tonsillectomy; altered taste |  |
| **Neck** | Lumps; enlarged or tender nodes, swollen glands; goiter; pain; neck stiffness; limitation of motion |  |
| **Breasts** | Lumps; pain; discomfort; nipple discharge, rash, surgeries, history of breast disease; performs self-breast exams and how often, last mammogram; any tenderness, lumps, swelling, or rash of axilla area |  |
| **Pulmonary** | Cough — productive/non-productive; hemoptysis; dyspnea; wheezing; pleuritic pains; any H/O lung disease; toxin or pollution exposure; last Chest x-ray, TB skin test |  |
| **Cardiac** | Chest pain or discomfort; palpitations; dyspnea; orthopnea; edema, cyanosis, nocturia; H/O murmurs, hypertension, anemia, or CAD |  |
| **G/I** | Appetite Δ; jaundice; nausea/emesis; dysphagia; heartburn; pain; belching/flatulence; Δ in bowel habits; hematochezia; melena; hemorrhoids; constipation; diarrhea; food intolerance |  |
| **GU** | Frequency; nocturia; urgency; dysuria; hematuria; incontinence**Females:** Use of kegal exercises after childbirth; use of birth control methods; HIV exposure; Menarche; frequency/duration of menses; dysmenorrhea; PMS symptoms: bleeding between menses or after intercourse; LMP; vaginal discharge; itching; sores; lumps; menopause; hot flashes; post-menopausal bleeding;**Males:** Caliber of urinary stream; hesitancy; dribbling; hernia, sexual habits, interest, function, satisfaction; discharge from or sores on penis; HIV exposure; testicular pain/masses; testicular exam and how often |  |
| **Peripheral Vascular** | Claudication; coldness, tingling, and numbness; leg cramps; varicose veins; H/O blood clots, discoloration of hands, ulcers |  |
| **Musculo-skeletal** | Muscle or joint pain or cramps; joint stiffness; H/O arthritis or Gout; limitation of movement; H/O disk disease |  |
| **Neuro** | Syncope; seizures; weakness; paralysis; stroke, numbness/tingling; tremors or tics; involuntary movements; coordination problems; memory disorder or mood change; H/O mental disorders or hallucinations |  |
| **Heme** | Hx of anemia; easy bruising or bleeding; blood transfusions or reactions; lymph node swelling; exposure to toxic agents or radiation |  |
| **Endo** | Heat or cold intolerance; excessive sweating; polydipsia; polyphagia; polyuria; glove or shoe size; H/O diabetes, thyroid disease; hormone replacement; abnormal hair distribution |  |
| **Psych** | Nervousness/anxiety; depression; memory changes; suicide attempts; H/O mental illnesses |  |

**IV.** **Objective Data**

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| --- |
| **General:** |
| **Skin:** |
| **HEENT & Sinuses:** |
| **Neck & Regional Lymph Nodes:** |
| **Breasts:** |
| **Lungs & Thorax:** |
| **Heart:** |
| **Gastrointestinal:** |
| **Genitourinary:** |
| **Extremities (Peripheral Vascular):** |
| **Musculoskeletal:** |
| **Neurological:** |

**V.** **Assessment**

 **A: Differential Diagnosis (include rationales and cite sources)**

1.

 2.

 3.

 **B: Nursing Diagnosis**

1.

 **C: Medical Diagnosis**

**VI. PLAN**

**A: Orders**

1. Prescriptions with dosage, route, duration, and amount prescribed and if refills provided
2. Diagnostic testing
3. Problem oriented education
4. Health promotion/maintenance needs

**B: Follow-up plans** (When will you schedule a follow-up appointment and what will you address in the subsequent visit — F/U in 2 weeks; plan to check annual labs on RTC (return to clinic).

**VII. Nursing theory and application:** Select a nursing theory and apply this to your patient’s plan and evaluation (brief statement).

VIII. Developmental stage: Identify the developmental state and provide rationales to support acquisition of skills in the stage (brief statement).

IX. Cultural characteristics, diversity, sensitivity, and ethical considerations

Discuss culturally diverse considerations you identified for this patient. Cultural diversity is a general term that can include gender, religious beliefs, culture, race, economic status, age, etc. Discuss one ethical standard relevant to the care of this patient.

**X. Evaluation of care:** Provide a brief statement sharing your thoughts about the visit and/or patient. Please share what you should have done differently.

**References:** Please include a minimum of three references. The reference list must be in APA format. All sources must be within 5 years of publication.