Format for a Focused Note

Necessary Components for the Subjective information:

Date of encounter: 4/12/20

Patient Name or initials: BF

Informant: Presents as patient, Seems reliable

Chief Complaint (CC): "Troubling chest pain in chest now and then for the past month"

History of present illness (HPI): Pain started earlier this month. Reports pain 5/10, midsternal, no radiation, aggrevated by physical activity, relieved with rest. Pain described as tight, uncomfortable and intermittent.

Allergies: codeine – nausea and vomiting. No other known allergies

Medications: (dose, frequency, indication)
Lopressor – 100 mg po daily for hypertension stage 2
Lipitor – 20 mg PO Nightly for Hyperlipidemia
Omega 3 Fish oil - 1200 mg PO BID , OTC supplement

Past History: Past medical history significant for hypertension and hyperlipidemia. Denies any surgical history, psychiatric history, trauma, or hospitalizations.

Family History:
Father: deceased – age 75 - colon cancer. History of hypertension, hyperlipidemia, obesity.
Mother- age 80. Type 2 diabetes, hypertension
Brother – Deceased – age 24 - Motor vehicle accident
Sister- age 52. Hypertension and type 2 diabetes
Maternal Grandmother – Deceased – age 65 - breast cancer
Maternal Grandfather - Deceased – Age 54 - myocardial infarction
Paternal Grandmother – Deceased – age 78 - Pneumonia
Paternal Grandfather – Deceased – age 85 – "old age"
Son – age 26 – no known medical history
Daughter – age 19 – Asthma

Personal and Social History:
Health Promotion/Maintenance Activities: up to date on immunizations, admits to 6-7 hours of sleep per night, denies regular exercise.
Tobacco Use: Never
Alcohol and Drug use: admits to 2-3 alcoholic beverages a week (beer), denies illicit drug use.
Diet: monitors sodium and fat intake but admits to eating red meat 2-3 times a week.

Pertinent Review of systems (ROS):

General: denies fever, chills, fatigue or night sweats. Denies weight loss. Admits weight gain.
HEENT: Denies dizziness, lightheadedness, sinus congestion, changes in vision or headaches.
Respiratory: denies cough or shortness of breath
Cardiovascular: admits to intermittent chest pain, rated 5/10, mid sterna with no radiation, aggravated by physical exertion and relieved by rest. Denies syncope, palpitations, or tachycardia.
Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation
Peripheral Vascular: denies intermittent claudication, thrombophlebitis, swelling, or leg cramps.
Musculoskeletal: Denies any pain with range of motion
Psychiatric: Denies no change in mood and low stress levels. Developmentally appropriate

SUBJECTIVE REFLECTION:
Reflect on your performance and interactions with the virtual patient. Include three additional questions you would ask the patient or informant and state how that information would assist you in formulating a diagnosis.

1. Have you had a recent echocardiogram? – this would provide the nurse practitioner with some baseline information as well as allow the provider to visualize the structures and function of the heart.
2. When was the last time you had your cholesterol levels checked? – could provide the provider with some information regarding potential for occlusive disease.
3. Is this the first time you have experienced chest pain like this? – This would help the nurse practitioner determine how frequently the patient is experiencing this pain.

Necessary Components for the Objective information:
Document all findings, avoid the word negative or normal. It is important that you learn to deduce that the patient has no remarkable findings.

Vital Signs: BP 146/90, HR 104, RR 19, T 36.7, O2 98% on RA
Height/Weight/BMI: 180.3 cm / 89.36 kg/ BMI - 27.5

Physical Exam

Constitutional/General survey: Well nourished, alert, oriented and in No evidence of distress. Pleasant affect. Cooperative with exam. Good eye contact.
HEENT: Normocephalic, atraumatic, PERRLA. Nares patent. Mucus membranes moist.
Neck: Neck supple and non-tender to palpation. + Bruit noted to right carotid artery with JVD 3cm above the sternal angle with positive thrill and amplitude of 3+. No bruit found to left carotid artery with no thrill and amplitude of 2+

Thorax: PMI displaced laterally with brisk tapping and diameter less than 3cm
Cardiovascular: EKG performed. Normal sinus rhythm with no ST changes. S1 and s2 audible, no murmur or gallop.
Respiratory: Anterior lung sounds clear bilaterally. Posterior lower lung fields with coarse crackles bilaterally. Bilateral upper and middle posterior lung fields clear.
Abdomen: no abdominal aortic bruit. No masses or tenderness on palpation. Liver is palpable 1cm below right costal margin. Spleen not palpable. Bowel sounds noted within all 4 quadrants.
Peripheral vascular: no clubbing, cyanosis or edema noted. Bilateral tibial, dorsalis pedal, and popliteal pulses +1 with no thrill. Femoral, radial and brachial pulses noted bilaterally +2 with no thrill. Capillary refill on bilateral hands and feet less than 3 seconds.

OBJECTIVE REFLECTION:
Reflect on your performance and interactions with the virtual patient. Identify what information is missing from the physical exam or state what additional exam elements you would have included.

Missing information that I would like to know is his baseline lab work. When asked, Brian stated his most recent cholesterol level was just under 200 but unable to state more specific details of lipid panel. Brian also reports that he has had an ekg and annual stress test previously and states “not sure of results, doctor says everything looks good.” While this is good subjective data, having a copy of those results would be beneficial in comparing to today’s studies. I would also like to see previous OCOMP results to assess electrolyte levels.

Necessary Components for the <u>Assessment</u> information:

This will depend on your findings. Your patient may be having a physical exam and not have any abnormal findings, or you may find there are abnormals in which case you would write the most significant finding and then include a short list of differential diagnoses.
For example: Knee pain possibly related to bursitis or to meniscus tear.

State the actual diagnosis along with differential diagnoses and your clinical reasoning/rationale for selecting.

Assessment:

Brian Foster, 52 yo male. Past medical history of hypertension and hyperlipidemia presents with intermittent exertional chest pain. Findings most likely consistent with stable angina pectoris as his pain is exertional, improves with rest, non-radiating, and lasts for less than 15 minutes, history of hyperlipidemia and admits to poor diet and lack of exercise (Bickley, Szilagyi and Hoffman, 2017). Unlikely myocardial infarction as EKG reads normal sinus rhythm with no ST inversions or elevations, and pain relieved with rest lasting less than 15 minutes in duration. Unlikely Pulmonary Embolism as

patient denies shortness of breath or pleuritic pain, respiratory rate 19 and pulse ox 98% on room air. Unlikely costochondritis as his chest is non-tender to palpation.

Plan:

Differential Diagnosis - Stable Angina Pectoris

- Draw cardiac enzymes to ensure no elevation.
- Echocardiogram and Stress test
- Pharmacology – Continue Lopressor for hypertension management, Lipitor for hyperlipidemia and Omega-3 fish oil. Initiate Nitroglycerin therapy PRN for chest pain episodes by reducing myocardial oxygen demand and consumption through vasodilation (Rousan, Mathew, and Thadani, 2017)
- Education: educate patient on nitroglycerin use and drug interactions, provide information on proper and routine monitoring of blood pressure, lipid levels, and cardiac markers. Educate patient on when to contact the provider. Discuss changes in diet and increasing exercise as well as initiate routine health care provider visits for monitoring and medication adjustments as needed (Bickley, Szilagyi and Hoffman, 2017)
- Refer to Cardiology for further testing and determination of need for cardiac catheterization to allow visualization of degree of stenosis of blood vessels
- Health promotion/Anticipatory Guidance: Initiation of regular light exercise as tolerated at minimum 3 days per week. Decrease consumption of red and processed meats, decrease alcohol consumption, increase stress reduction activities such as meditation.
- Follow-up: Follow up with cardiology within next 48 hours. Schedule follow up visit with our office within 2 weeks following cardiology appointment. If symptoms worsen go to emergency room.

Self Assessment:

A thorough and focused health history and physical examination was preformed focused on the cardiovascular presentation as well as a lung and musculoskeletal exam to rule out involvement. The plan developed above reflects his personal chief complaint as well as both subjective and objective findings of my examination and assessment.

Self-Assessment:

In reflection, think about your experience with this case. Based on evidence-based practices, would you have done anything differently in this case?

References:

Include two credible and current sources within the past 5 years, one of which may include the course textbook. Place in APA format. These references should be in support of your diagnoses and plan.

Rousan, T. A., Mathew, S. T., & Thadani, U. (2017). Drug therapy for stable angina pectoris. *Drugs, 77*(3), 265-284. doi:http://dx.doi.org.ezproxy2.library.drexel.edu/10.1007/s40265-017-0691-7