SOAP NOTE #5

PATIENT PROFILE/IDENTIFYING DATA
E.S. is a 21 year old white female single college student who presents to clinic with complaints of headache for 4 weeks.

Problem List:
Headache onset 8/28/01

(No previous medical problems, no inactive problems)

SUBJECTIVE

CC/Reason for Visit: E.S. is a 21 year old white female single college student who presents to clinic stating, "I've had a headache for 4 weeks, and it's still there."

DIFFERENTIAL DIAGNOSES/RATIONALE:

1. Headache (ICD-9 code 784.00): Specifically tension headache- E.S. is in college, may be under high stress to achieve, causing a tension headache, which is the most common type headache (Meredith & Horan, 2000).
2. Brain tumor- E.S. has had a headache for 4 weeks, and could have a tumor or other brain pathology. Headache is the first symptom in ½ of patients with brain tumor (Meredith & Horan, 2000).
3. Meningitis- E.S. is in college, and around many other students, and could have been exposed to a viral illness leading to meningitis. This is low probability, because the headache has been going on for 4 weeks, and meningeal headaches are more acute. But this will remain a differential diagnosis until more information is obtained.

HPI:
21 year old single college student with complaints of daily headache for 4 weeks. She describes the headache as dull to pounding at times, from 3 to 8 on scale of 1-10 (10 being worst pain). The pain has not gotten worse, but has not gotten better either. She has no previous medical history or history of headaches or migraine headaches. Her head hurts "in the back of head and goes to the top", and is occasionally associated with dizziness (lightheadedness, denies vertigo) and nausea (although has had no emesis). She denies photophobia, blurred vision, diplopia, tearing, rhinorrhea, numbness, or sensitivity to noise. She cannot relate any provocative or palliative factors. She has taken Ibuprofen "a couple of times" with a little relief. She was given a prescription for Midrin 3 weeks ago, by another care provider, but has not gotten it filled, stating "When I would get to the store, I would forget the prescription, then I wouldn't go back, I would forget." She admits to having trouble concentrating in class at times, or at work. She describes the quality of the pain as "aching", with occasional

“throbbing” associated with the dizziness and nausea. She does not awaken with the headache, but sometimes goes to bed with the headache. It develops at various times of the day, and “comes and goes.”
She reported that she was involved in a motor vehicle crash 4 weeks ago, as a restrained passenger, and hit the back of her head against the seat when the car was struck from behind. She stated that the headache started right after the accident. She was not evaluated in an emergency room or health care provider’s office after the accident, but did see another provider 3 weeks ago, who told her it was a “stress headache.” She relates that she is under no particular stress, and that “my life is very low stress.”
Past Medical History: none. Past surgical history: none. Family History: Parents both alive and healthy, no one with headaches/migraines. Allergies: none. Medications: none.
Social History: She does not smoke, does drink beer on weekends, and does not do drugs. She lives in an apartment with one female roommate. She is taking 15 hours of classes at ECU, as well as working as a part time waitress and lifeguard. She has missed a couple of classes because of the headache, but overall has not missed work, or more than 2 classes.
ROS: above information, Skin-denies rash, urticaria, bruising, change in color, or hair loss. Lymph nodes-denies enlargement or pain. Bones, joints, muscles-denies joint pain, swelling, stiffness, or weakness. Endocrine- denies polydipsia, polyuria, polyphagia, cold/heat intolerance, no appetite or weight changes. Head- above info. Eyes- above info, denies visual loss diplopia, redness or drainage. Ears- denies hearing changes, tinnitus, vertigo, drainage, or pain. Nose- denies discharge, inflammation, obstruction, or epistaxis. Mouth- denies sores, bleeding, toothaches. Throat- denies sore throat, voice changes, hoarseness. Neck- denies stiffness, swelling, or pain. Respiratory- denies SOB, cough, wheezing, pain. Cardiovascular- denies CP or tightness, palpitatioins, DOE, edema, claudication, or history of heart murmur. GI- denies N/V/diarrhea/ constipation, abdominal pain, change in bowel habits, bloody stools, or rectal pain. Genitourinary- denies dysuria, hematuria, pain. Menstrual- denies dysmenorrhea, previous pregnancies, sexual activity, or previous venereal diseases. LMP 2 weeks before this visit. Neurologic- denies smell changes, taste changes, hearing, speech changes, swallow difficulty, weakness, paralysis, tremors, seizures, parasthesias, or confusion. She has been sleeping “alot”, goes to bed at 12 am, rises at 7 or 9 am, naps daily. She has not been exercising (she did exercise over the summer, and lost 15 lbs with the exercise) and stated “I just don’t feel like it, which isn’t good.”

Pertinent positives/negatives:

1. Tension headache- positives are that the headache is bilateral. Negatives are that the headache isn’t band like, which is typical for tension headache, and she has been under no stress. This diagnosis can be excluded at this point.
2. Brain tumor- positives are that the headache is mild to throbbing, with nausea and dizziness as it worsens. Negatives are that there are no

visual changes, vomiting, seizures. This diagnosis is unlikely, since the S&S began after trauma, but will remain in the back of my mind.

3. Meningitis- positives are none. Negatives are that there is no altered consciousness, rigidity, fever. This diagnosis can be excluded at this point.
4. Post traumatic headache- This diagnosis can be added at this point, due to the onset of these symptoms after she was involved in a wreck. Positives are that the headache began after she was involved in a motor vehicle collision, suggestive of post traumatic headache. Also she has occasional dizziness and nausea, when the headache occasionally worsens, and daily dull aching headache in between exacerbations. Negatives are none.

OBJECTIVE:

Vital Signs: Weight 179 lbs, Height 65 inches, Temperature 99.2 orally, Pulse 76, Resp 20, BP 114/72.

Physical Exam:
Cooperative, calm patient with clear and appropriate speech and language. Head normocephalic, atraumatic, no hematomas, or tenderness to palpation. Neck supple with full ROM. Eyes symmetric, lids symmetric, conjunctiva clear without redness. Visual fields full to confrontation. EOM's full, no ptosis. PERRLA, optic discs sharp without papilledema, macula intact. Facial sensation intact, facial motor movement symmetric. Hearing intact to whispered words. External ears without trauma or drainage. Auricle, tragus, mastoid nontender to palpation. Ear canal and tympanic membrance visualized, landmarks intact. Gag reflex and tongue movement intact and full. No lymphadenopathy. Moves all extremities 5/5 strength. Coordination intact with finger to nose testing. Sensation intact to pin prick and touch throughout. Reflexes 2+ throughout, with plantar responses downgoing. Romberg testing negative.

DDX:

1. Tension headache- pertinent positives/negatives same as above. Probably not likely since this headache began after MVC and she denies stress and tension.
2. Brain tumor- pertinent positives/negatives same as above. Also, no papilledema noted or other signs of increased intracranial pressure. Not likely since headache started after MVC, but will keep this diagnosis on back burner, to keep in mind.
3. Meningitis- pertinent positives from examining this patient are none, she has no meningismus or nuchal rigidity, no fever, confusion, irritability and no photophobia, and the headache has been present for several weeks, so if it is meningitis, she would have been much sicker, sooner. Meningitis is usually acute, developing over 24-36 hours with fever, h/a, vomiting, nuchal rigidity, lethargy (Meredith & Horan, 2000). This diagnosis is not likely.

4. Post-traumatic headache- positives/negatives same as above. This is the most likely diagnosis at this point.

ASSESSMENT/PLAN

1. Post-traumatic headache-most likely diagnosis based on all above information (ICD code for general headache is 784.0, and she will be coded as such until further evaluation). Post concussional syndrome (ICD code 310.02) is common and has varied severity. The patient may not have lost consciousness (as in this patient) but suffered trauma (can be minimal as in this patient). The triad of symptoms includes headaches, dizziness, and poor concentration (Patten, 1996). To further evaluate her, an MRI of the brain was scheduled for the next day, in order to rule out other causes of headache. This is essential in this case, because a subdural hematoma or brain tumor could be life threatening. Once these are ruled out, her code will be post concussional syndrome (310.02). Headaches, post trauma, (tension type or migraine type) can be treated with the usual symptomatic/prophylactic medications. Most patients improve after 3 months, and reassurance serves maximum benefit (Goetz, 1999). She was counseled on the length of time of these headaches, sometimes weeks to months, and encouraged to try Midrin which she already has the prescription for, to try to alleviate the headaches when they increase in severity. She was also prescribed Motrin 800mg TID, and told to take the Midrin for breakthrough severe pain. She verbalized understanding and was relieved that a scan would be done to rule out serious problems.
She will followup the following week to review the MRI results (of course she will be notified immediately of any serious findings that require immediate treatment) and evaluate how her headaches are responding to the Motrin and Midrin.

1. Health Maintenance-For E.S.'s age group, one of the major concerns is immunization updates. Her DTP, MMR, varicella, polio vaccines are probably already up to date, but need to be double checked to make sure there are none missing in her history. Hepatitis B would be recommended if she is going into health care in her college courses, or if she has close contact with high risk individuals. Meningitis vaccine should be offered, especially because she is a college student and meningitis is a high risk among students. Need to establish when her last pelvic exam with pap smear was performed and stress that she get regular pap smears, atleast every 3 years (US Preventive Services Task Force recommendations-Clinician's Handbook of Preventive Services, 1998). This testing should begin at the age she begins intercourse, or at age 18. Low socioeconomic status or multiple partners would indicate need for more frequent pap smears. STD prevention and contraception issues would also need to be addressed. Use of seatbelts while driving needs to be stressed as well as helmet use with bikeriding, motorcycle riding, or ATV use. Diet should be limited fats and cholesterol, while maintaining caloric intake, emphasizing fruits, vegetables, and grains. Regular physical activity and adequate calcium intake should also be encouraged (Uphold & Graham, 1998).

With E.S. in particular, she has a pap smear in the last year, and is not presently sexually active, but stated that she would use condoms for STD prevention and would seek contraception if she were to become sexually active. Her immunizations are up to date, and she was reminded of the meningitis vaccine available at ECU for students. She uses seatbelts regularly. She does not ride a bike or motorcycle/ATV, but was encouraged to wear a helmet if she were to do so. Her diet consists of mostly balanced meals, with alot of snacks in between, sodas and chips. She was encouraged to limit sodas/chips as much as possible and try more healthy snacks such as fruits/vegetables. She has not exercised at all this semester, as opposed to the summer when she worked out regularly at the ECU gym. She was encouraged to try to get back into exercising as able, when her headaches improve.

References:

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