Osteoporosis Case- SOAP Note

Mary is a 68 yo WF who presents to Osteoporosis Clinic by referral of her primary care physician for evaluation of her recent DEXA scan. She complains of occasional dizziness when she gets up suddenly. Results of her DEXA scan from September 2014 indicate that her Tscore of her hip is – 2.3 and her spine is – 2.6, which is statistically significantly worse from her last DEXA in 2012. In 2012 she was diagnosed with osteopenia, but did not want to add an additional medication at that time. After hearing the results from this scan, she is willing to start medications now because she “doesn’t want to break a bone”. She fell last week while gardening with no injury or loss of consciousness.

Her previous conditions include GERD that is controlled with medications, hypertension, hypothyroidism, and insomnia.

She does not currently complain of GERD symptoms and feels that her omeprazole is doing the job. She is using zolpidem most nights and often feels groggy the next morning. She has trouble falling asleep and it usually takes her up to an hour to go to sleep.

She lives with her husband and has two adult children. Her daughter and her husband and two children live next door. Her son lives in town and is married with three children. She has smoked for the past 40 years but wants to quit. Her husband recently quit because he was diagnosed with COPD and she has cut back to ½ ppd and is smoking outside because she wants to be supportive of him. She is a retired bank teller and has good insurance and no problems paying for her medications.

She enjoys gardening and grows vegetables and flowers. She plays bridge each week with her bridge club, and is active at her local church and volunteers at a nearby preschool. Her breakfast includes a glass of milk and toast; lunch is usually a salad and fruit; dinner is usually chicken or pork with vegetables with rice or pasta. She occasionally drinks alcohol at special occasions. Her favorite snacks at night are popcorn or M&Ms.

Medications: calcium carbonate with vitamin D 600 mg/400IU twice a day when she remembers, levothyroxine 100 mcg once daily, amlodipine 10 mg once daily, zolpidem 5 mg QHS PRN, omeprazole 20 mg once daily. She has no drug allergies. She occasionally uses acetaminophen for a headache.

Labs: SCr 1.0, TSH 2.5, vitamin D 18 ng/mL

Vitals: BP 130/80 sitting, 100/68 standing, HR 82 sitting, 86 standing, Weight 118 lbs, Height 5’4” (reports that she has lost 2 inches in height and that she used to be 5’6”)

Physical Exam:

Gen: Thin elderly woman in NAD

HEENT: WNL, thyroid normal

Cardiac: RRR, no murmurs, rubs, or gallops

Lungs: CTA

Abdomen: NTND

GU: deferred

Spine: kyphosis, spine not tender

EXT: distal pulses normal, 1+ pedal edema

Develop a comprehensive plan for her osteoporosis, following the formatting guidelines on the SOAP note rubric.