SOAP Note Template

**S:** Subjective

*Information the patient or patient representative told you*

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| Initials: Click or tap here to enter text. | Age: Click or tap here to enter text. | Gender: Click or tap here to enter text. |
| Height | Weight | BP | HR | RR | Temp | SPO2 | Pain Rating | Allergies (and reaction) |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. | Medication: Click or tap here to enter text.Food: Click or tap here to enter text.Environment: Click or tap here to enter text. |
|  **History of Present Illness (HPI)** |
| **Chief Complaint (CC)** | Click or tap here to enter text. | *CC is a BRIEF statement identifying why the patient is here - in the patient’s own words - for instance "headache", NOT "bad headache for 3 days”. Sometimes a patient has more than one complaint. For example: If the patient presents with cough and sore throat, identify which is the CC and which may be an associated symptom* |
| ***O***nset | Click or tap here to enter text. |
| ***L***ocation | Click or tap here to enter text. |
| ***D***uration | Click or tap here to enter text. |
| ***C***haracteristics | Click or tap here to enter text. |
| ***A***ggravating *Factors* | Click or tap here to enter text. |
| ***R****elieving Factors* | Click or tap here to enter text. |
| ***T***reatment | Click or tap here to enter text. |
| **Current Medications:** *Include dosage, frequency, length of time used and reason for use; also include OTC or homeopathic products.* |
| **Medication** *(Rx, OTC, or Homeopathic)* | **Dosage** | **Frequency** | **Length of Time Used** | **Reason for Use** |
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| **Past Medical History (PMHx) –** *Includes but not limited to immunization status (note date of last tetanus for all adults), past major illnesses, hospitalizations, and surgeries. Depending on the CC, more info may be needed.* |
|  |
| **Social History (Soc Hx) -** *Includes but not limited to occupation and major hobbies, family status, tobacco and alcohol use, and any other pertinent data. Include health promotion such as use seat belts all the time or working smoke detectors in the house.* |
|  |
| **Family History (Fam Hx) -** *Includes but not limited to illnesses with possible genetic predisposition, contagious or chronic illnesses. Reason for death of any deceased first degree relatives should be included. Include parents, grandparents, siblings, and children. Include grandchildren if pertinent.* |
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| **Review of Systems** **(ROS):** *Address all body systems that may help rule in or out a differential diagnosis Check the box next to each positive symptom and provide additional details.* |
| **Constitutional**If patient denies all symptoms for this system, check here: [ ]  | **Skin**If patient denies all symptoms for this system, check here: [ ]  | **HEENT**If patient denies all symptoms for this system, check here: [ ]  |
| [ ] Fatigue Click or tap here to enter text.[ ] Weakness Click or tap here to enter text.[ ] Fever/Chills Click or tap here to enter text.[ ] Weight Gain Click or tap here to enter text.[ ] Weight Loss Click or tap here to enter text.[ ] Trouble Sleeping Click or tap here to enter text.[ ] Night Sweats Click or tap here to enter text.[ ] Other:Click or tap here to enter text. | [ ] Itching Click or tap here to enter text.[ ] Rashes Click or tap here to enter text.[ ] Nail Changes Click or tap here to enter text.[ ] Skin Color Changes Click or tap here to enter text.[ ] Other:Click or tap here to enter text. | [ ] Diplopia Click or tap here to enter text.[ ] Eye Pain Click or tap here to enter text.[ ] Eye redness Click or tap here to enter text.[ ] Vision changes Click or tap here to enter text.[ ] Photophobia Click or tap here to enter text.[ ] Eye discharge Click or tap here to enter text. | [ ] Earache Click or tap here to enter text.[ ] Tinnitus Click or tap here to enter text.[ ] Epistaxis Click or tap here to enter text.[ ] Vertigo Click or tap here to enter text.[ ] Hearing Changes Click or tap here to enter text.  | [ ] Hoarseness Click or tap here to enter text.[ ] Oral Ulcers Click or tap here to enter text.[ ] Sore Throat Click or tap here to enter text.[ ] Congestion Click or tap here to enter text.[ ] Rhinorrhea Click or tap here to enter text.[ ] Other:Click or tap here to enter text. |
| **Respiratory**If patient denies all symptoms for this system, check here: [ ]  | **Neuro**If patient denies all symptoms for this system, check here: [ ]  | **Cardiac and Peripheral Vascular**If patient denies all symptoms for this system, check here: [ ]  |
| [ ] Cough Click or tap here to enter text.[ ] Hemoptysis Click or tap here to enter text.[ ] Dyspnea Click or tap here to enter text.[ ] Wheezing Click or tap here to enter text.[ ] Pain on Inspiration Click or tap here to enter text.[ ] Sputum Production  Choose an item.Choose an item.Choose an item.[ ] Other: Click or tap here to enter text. | [ ] Syncope or Lightheadedness Click or tap here to enter text.[ ] Headache Click or tap here to enter text. [ ] Numbness Click or tap here to enter text.[ ] Tingling Click or tap here to enter text.[ ] Sensation Changes Choose an item.[ ] Speech Deficits Click or tap here to enter text.[ ] Other: Click or tap here to enter text. | [ ] Chest pain Click or tap here to enter text.[ ] SOB Click or tap here to enter text.[ ] Exercise Intolerance Click or tap here to enter text.[ ] Orthopnea Click or tap here to enter text.[ ] Edema Click or tap here to enter text.[ ] Murmurs Click or tap here to enter text. | [ ] Palpitations Click or tap here to enter text.[ ] Faintness Click or tap here to enter text.[ ] Claudications Click or tap here to enter text.[ ] PND Click or tap here to enter text.[ ] Other: Click or tap here to enter text. |
| **MSK**If patient denies all symptoms for this system, check here: [ ]  | **GI**If patient denies all symptoms for this system, check here: [ ]  | **GU**If patient denies all symptoms for this system, check here: [ ]  | **PSYCH**If patient denies all symptoms for this system, check here: [ ]  |
| [ ] Pain Click or tap here to enter text.[ ] Stiffness Click or tap here to enter text.[ ] Crepitus Click or tap here to enter text.[ ] Swelling Click or tap here to enter text.[ ] Limited ROM Choose an item.[ ] Redness Click or tap here to enter text.[ ] Misalignment Click or tap here to enter text.[ ] Other: Click or tap here to enter text. | [ ] Nausea/Vomiting Click or tap here to enter text.[ ] Dysphasia Click or tap here to enter text.[ ] Diarrhea Click or tap here to enter text.[ ] Appetite Change Click or tap here to enter text.[ ] Heartburn Click or tap here to enter text.[ ] Blood in Stool Click or tap here to enter text.[ ] Abdominal Pain Click or tap here to enter text.[ ] Excessive Flatus Click or tap here to enter text.[ ] Food Intolerance Click or tap here to enter text.[ ] Rectal Bleeding Click or tap here to enter text.[ ] Other: | [ ] Urgency Click or tap here to enter text.[ ] Dysuria Click or tap here to enter text.[ ] Burning Click or tap here to enter text.[ ] Hematuria Click or tap here to enter text.[ ] Polyuria Click or tap here to enter text.[ ] Nocturia Click or tap here to enter text.[ ] Incontinence Click or tap here to enter text.[ ] Other: Click or tap here to enter text. | [ ] Stress Click or tap here to enter text.[ ] Anxiety Click or tap here to enter text.[ ] Depression Click or tap here to enter text.[ ] Suicidal/Homicidal Ideation Click or tap here to enter text.[ ] Memory Deficits Click or tap here to enter text.[ ] Mood Changes Click or tap here to enter text.[ ] Trouble Concentrating Click or tap here to enter text.[ ] Other: Click or tap here to enter text. |
| **GYN**If patient denies all symptoms for this system, check here: [ ]  | **Hematology/Lymphatics**If patient denies all symptoms for this system, check here: [ ]  | **Endocrine**If patient denies all symptoms for this system, check here: [ ]  |
| [ ] Rash Click or tap here to enter text.[ ] Discharge Click or tap here to enter text.[ ] Itching Click or tap here to enter text.[ ] Irregular Menses Click or tap here to enter text.[ ] Dysmenorrhea Click or tap here to enter text.[ ] Foul Odor Click or tap here to enter text.[ ] Amenorrhea Click or tap here to enter text.[ ] LMP: Click or tap here to enter text.[ ] Contraception Click or tap here to enter text.[ ] Other:Click or tap here to enter text. | [ ] Anemia Click or tap here to enter text.[ ]  Easy bruising/bleeding Click or tap here to enter text.[ ]  Past Transfusions Click or tap here to enter text.[ ]  Enlarged/Tender lymph node(s) Click or tap here to enter text.[ ]  Blood or lymph disorder Click or tap here to enter text.[ ]  Other Click or tap here to enter text. | [ ]  Abnormal growth Click or tap here to enter text.[ ]  Increased appetite Click or tap here to enter text.[ ]  Increased thirst Click or tap here to enter text.[ ]  Thyroid disorder Click or tap here to enter text.[ ]  Heat/cold intolerance Click or tap here to enter text.[ ]  Excessive sweating Click or tap here to enter text.[ ]  Diabetes Click or tap here to enter text.[ ]  Other Click or tap here to enter text. |

**O:** Objective

*Information gathered during the physical examination by inspection, palpation, auscultation, and percussion. If unable to assess a body system, write “Unable to assess”. Document pertinent positive and negative assessment findings. Pertinent positive are the “abnormal” findings and pertinent “negative” are the expected normal findings. Separate the assessment findings accordingly and be detailed.*

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| **Body System** | **Positive Findings** | **Negative Findings** |
| **General** Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Skin**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **HEENT**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Respiratory**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Neuro**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Cardiovascular**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Musculoskeletal**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Gastrointestinal**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Genitourinary**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Psychiatric**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |
| **Gynecological**Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. |

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| **Problem List** |
| 1. Click or tap here to enter text.
 | 6. Click or tap here to enter text. | 11. Click or tap here to enter text. |
| 2. Click or tap here to enter text. | 7. Click or tap here to enter text. | 12. Click or tap here to enter text. |
| 3. Click or tap here to enter text. | 8. Click or tap here to enter text. | 13. Click or tap here to enter text. |
| 4. Click or tap here to enter text. | 9. Click or tap here to enter text. | 14. Click or tap here to enter text. |
| 5. Click or tap here to enter text. | 10. Click or tap here to enter text. | 15. Click or tap here to enter text. |

**A: Assessment**

*Medical Diagnoses. Provide 3 differential diagnoses (DDx) which may provide an etiology for the CC. The first diagnosis (presumptive diagnosis) is the diagnosis with the highest priority. Provide the ICD-10 code and pertinent findings to support each diagnosis.*

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| --- | --- | --- |
| **Diagnosis** | **ICD-10 Code** | **Pertinent Findings** |
|  | Click or tap here to enter text. | Click or tap here to enter text. |
|  | Click or tap here to enter text. | Click or tap here to enter text. |
|  | Click or tap here to enter text. | Click or tap here to enter text. |

**P: Plan**

*Address all 5 parts of the comprehensive treatment plan. If you do not wish to order an intervention for any part of the treatment plan, write “None at this time” but do not leave any heading blank. No intervention is self-evident. Provide a rationale and evidence-based in-text citation for each intervention.*

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| **Diagnostics:** *List tests you will order this visit* |
| Test | Rationale/Citation |
| Click or tap here to enter text. | Click or tap here to enter text. |
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| **Medications:** *List medications/treatments including OTC drugs you will order and “continue meds” if pertinent.* |
| Drug | Dosage | Length of Treatment | Rationale/Citation |
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| **Referral/Consults:**  |
| Click or tap here to enter text. | Rationale/Citation | Click or tap here to enter text. |
| **Education:** |
| Click or tap here to enter text. | Rationale/Citation | Click or tap here to enter text. |
| **Follow Up:** *Indicate when patient should return to clinic and provide detailed symptomatology indicating if the patient should return sooner than scheduled or seek attention elsewhere.*  |
| Click or tap here to enter text. | Rationale/Citation | Click or tap here to enter text. |
| **References**Include at least one evidence-based peer-reviewed journal article which relates to this case. Use the correct current APA edition formatting. |
| Click or tap here to enter text. |
| Click or tap here to enter text. |