SOAP Note

*ZellaTemplate.com*

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| --- | --- | --- | --- |
| Patient Name: |  | Date of Visit: |  |
| Date of Birth: |  | Medical Record #: |  |

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Visit Type: New Follow-Up

# S – Subjective

Document the patient's current condition in narrative form using their own words when possible. Focus on the chief complaint and the history of the present illness (HPI).

Chief Complaint (CC): “\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_”

History of Present Illness (HPI):  
• Onset:  
• Chronology:  
• Location:  
• Description:  
• Modifying Factors:  
• Associated Symptoms:  
• Previous Treatments/Consults:  
• Medication History:

Past Medical History:  
• Allergies:  
• Medications:  
• Surgical History:  
• Family History:  
• Social History (Tobacco, Alcohol, Drugs, etc.):

# O – Objective

Record measurable and observed data.

Vital Signs:  
• Temperature:  
• Blood Pressure:  
• Heart Rate:  
• Respiratory Rate:  
• Oxygen Saturation:  
• Weight:  
• Height:  
• BMI:

Physical Examination Findings:  
• General Appearance  
• HEENT  
• Respiratory  
• Cardiovascular  
• Gastrointestinal  
• Musculoskeletal  
• Neurological  
• Skin  
• Psychiatric/Mental Status

Laboratory/Diagnostic Results:  
• Blood work  
• Urinalysis  
• Imaging results  
• Other tests

Provider Observations: (e.g., behavior, responses, signs of discomfort)

# A – Assessment

Summarize findings and provide diagnoses.

Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_

Differential Diagnoses:  
1. Most likely diagnosis  
2. Second most likely  
3. Least likely

Clinical Justification: Include reasoning for diagnosis, drug-related problems, therapy considerations, and patient progress from previous visits if applicable.

# P – Plan

Describe treatment strategy and follow-up.

Management Plan:  
• Medications prescribed and instructions  
• Additional lab/imaging ordered  
• Specialist referrals (if any)  
• Procedures performed/planned  
• Non-pharmacologic therapies  
• Patient education provided  
• Follow-up schedule

Therapy Plan (if applicable):  
• Type of therapy and duration  
• Goals of therapy  
• Medications during therapy

Plan for Each Problem in Assessment:  
1. Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
2. Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_