

Template for Clinical SOAP Note Format

Subjective – The “history” section

HPI: include symptom dimensions, chronological narrative of patient’s complains, information obtained from other sources (always identify source if not the patient).

Pertinent past medical history.

Pertinent review of systems, for example, “Patient has not had any stiffness or loss of motion of other joints.”

Current medications (list with daily dosages).

Objective – The physical exam and laboratory data section

Vital signs including oxygen saturation when indicated.

Focuses physical exam.

All pertinent labs, x-rays, etc. completed at the visit.

Assessment/Problem List – Your assessment of the patient’s problems

Assessment: A one sentence description of the patient and major problem

Problem list: A numerical list of problems identified

All listed problems need to be supported by findings in subjective and objective areas above. Try to take the assessment of the major problem to the highest level of diagnosis that you can, for example, “low back sprain caused by radiculitis involving left 5th LS nerve root.”

Provide at least 2 differential diagnoses for the major new problem identified in your note.

Plan – Your plan for the patient based on the problems you’ve identified

Develop a diagnostic and treatment plan for each differential diagnosis.

Your diagnostic plan may include tests, procedures, other laboratory studies, consultations, etc.

Your treatment plan should include: patient education, pharmacotherapy if any, other therapeutic procedures. You must also address plans for follow-up (next scheduled visit, etc.).

Also see your Bates Guide to Physical Examination for excellent examples of complete H & P and SOAP note formats.