CONPH Subjective, Objective, Assessment, Plan (SOAP) Notes Guide
THIS GUIDE IN NOT ALL INCLUSIVE. ALWAYS USE SOUND CLINICAL JUDGEMENT

Student Name:		**Course:**
Patient Name: (Initials ONLY)	**Date:**	**Time:**
Ethnicity:	**Age:**	**Sex:**

SUBJECTIVE (must complete this section)

CC:
What brings patient in for visit?

HPI:
Describe your symptoms in detail. When did they start and how long have they been going on?
What is the severity of your symptoms and what makes them better or worse?
What is your medical and mental health history?
What other health-related issues are you experiencing?
What medications are you taking?

Medications:
Ask details related to all medications to include prescribed, OTC, and non-traditional. Don't forget dosage and frequency.

Previous Medical History:
Allergies:
Medication Intolerances:
Chronic Illnesses/Major traumas:
Hospitalizations/Surgeries:
Ask have they ever received medical care? If so, what problems/issues were addressed? Don't exclude obstetrical related matters. Was the care continuous (i.e. provided on a regular basis by a single person) or episodic? Have they ever undergone any procedures, X-Rays, CAT scans, MRIs or other special testing? Ever been hospitalized? If so, for what? Were they ever operated on, even as a child? What year did this occur? Were there any complications? If they don't know the name of the operation, try to at least determine why it was performed. Do they participate in intercourse? With persons of the same or opposite sex? Are they involved in a stable relationship? Do they use condoms or other means of birth control? Married? Health of spouse? Divorced? Past sexually transmitted diseases? Do they have children? If so, are they healthy? Do they live with the patient? Have they experienced any adverse reactions to medications? The exact nature of the reaction should be clearly identified as it can have important clinical implications.

FAMILY HISTORY (must complete this section)

M:
MGM:
MGF:
F:
PGM:
PGF:
In particular, you are searching for heritable illnesses among first- or second-degree relatives. Most common, at least in America, are coronary artery disease, diabetes and certain malignancies. Patients should be as specific as possible. "Heart disease," for example, includes valvular disorders, coronary artery disease and congenital abnormalities, of which only coronary disease has genetic implications. Find out the age of onset of the illnesses, as this has prognostic importance for the patient. For example, a father who had an MI at age 70 is not a marker of genetic predisposition while one who had a similar event at age 40 certainly would be. Also ask about any unusual illnesses among relatives, perhaps revealing evidence for rare genetic conditions.

Social History:
What sort of work does the patient do? Have they always done the same thing? Do they enjoy it? If retired, what do they do to stay busy? If not employed, are they a student. Inquire about grades, school, bullying (if primary education) Any hobbies? Participation in sports or other physical activity? Where are they from originally?
Have they ever smoked cigarettes? If so, how many packs per day and for how many years? If they quit, when did this occur? Do they drink alcohol? If so, how much per day and what type of drink? Any drug use, past or present, should be noted. Get in the habit of asking all your patients these questions as it can be surprisingly difficult to accurately determine who is at risk strictly on the basis of appearance. Remind them that these questions are not meant to judge but rather to assist you in identifying risk factors for particular illnesses (e.g. HIV, hepatitis).

REVIEW OF SYSTEMS (must complete this section)

General:	**Cardiovascular:**
Weight change, fatigue, fever, chills, night sweats,	Chest pain, palpitations, PND, orthopnea, edema

energy level	
Skin: Delayed healing, rashes, bruising, bleeding or skin discolorations, any changes in lesions or moles	**Respiratory:** Cough, wheezing, hemoptysis, dyspnea, pneumonia hx, TB
Eyes: Corrective lenses, blurring, visual changes of any kind	**Gastrointestinal:** Abdominal pain, N/V/D, constipation, hepatitis, hemorrhoids, eating disorders, ulcers, black tarry stools
Ears: Ear pain, hearing loss, ringing in ears, discharge	**Genitourinary/Gynecological:** Urgency, frequency burning, change in color of urine. Contraception, sexual activity, STDS Fe: last pap, breast, mammo, menstrual complaints, vaginal discharge, pregnancy hx Male: prostate, PSA, urinary complaints
Nose/Mouth/Throat: Sinus problems, dysphagia, nose bleeds or discharge, dental disease, hoarseness, throat pain	**Musculoskeletal:** Back pain, joint swelling, stiffness or pain, fracture hx, osteoporosis
Breast: SBE, lumps, bumps or changes	**Neurological:** Syncope, seizures, transient paralysis, weakness, parenthesis, black out spells
Heme/Lymph/Endo: HIV status, bruising, blood transfusion hx, night sweats, swollen glands, increase thirst, increase hunger, cold or heat intolerance	**Psychiatric:** Depression, anxiety, sleeping difficulties, suicidal ideation/attempts, previous dx

OBJECTIVE (Document PERTINENT systems only. Minimum 3)

Describe what you see, instead of WNL (within normal limits) or another acronym, be descriptive with your assessment findings. Support your diagnoses solidly.)

Weight:	**Height:**	**BMI:**	**BP:**	**Temp**:	**Pulse:**	**Resp:**

General Appearance:

Skin:

HEENT:
Head and scalp normocephalic, normal hair distribution. EOM intact, red reflex visualized, PERRLA, no cataracts noted b/l, eyelids without redness or swelling. No tenderness on palpation of tragus, no erythema or effusion. Tympanic membrane translucent in bilateral ears. pearly grey with positive light reflex; landmarks easily visualized. No erythema or swelling of turbinates, no discharge and crusting seen in bilateral nares No Pharyngeal erythema and uvula midline. No ulcers noted. No foul odor from mouth, no tonsillar enlargement without exudates. Teeth are in good repair. Neck is supple without tender cervical nodes, no nuchal rigidity and thyroid tissue firm pliable and non-tender.

Cardiovascular:
HR NSR, S1, S2 with regular rate and rhythm, no murmur noted. No extra sounds, clicks, rubs or murmurs. Pulses 3+ throughout. No edema. Cap refill <2 sec in all four extremities.

Respiratory:
No cough, B/L BS clear in all fields, respirations are unlabored, no use of accessory muscles. No pain related to respiration

Gastrointestinal:
Abdomen soft/ Lower abdomen tenderness, no visual peristalsis or palpitations. BS present in all four quadrants. No mass noted

Breast:
No nodules, enlarged lymph nodes or drainage. No warmth or tenderness during palpation.

Genitourinary:
No redness, swelling, or discharge. + pelvic tenderness. Bladder is non-distended; no CVA tenderness. External genitalia reveal coarse pubic hair in normal distribution; skin color is consistent with general pigmentation. No vulvar lesions noted. Well estrogenized. A small speculum was inserted; vaginal walls are pink and well rugated; no lesions noted. Cervix is pink and nulliparous. Scant clear to cloudy drainage present. On bimanual exam, cervix is firm. No CMT. Uterus is anteverted and positioned behind a slightly distended bladder; no fullness, masses, or tenderness. No adnexal masses or tenderness. Ovaries are non-palpable. (Male: both testes palpable, no masses or lesions, no hernia, no urethral discharge.) (Rectal as appropriate: no

evidence of hemorrhoids, fissures, bleeding or masses—Males: prostrate is smooth, non-tender and free from nodules, is of normal size, sphincter tone is firm).

Musculoskeletal:
Full active ROM, gait balanced and steady. No weakness or atrophy.

Neurological:
AOX3, PEERLA, cranial nerves tested and intact. No tremors noted. Memory intact. Deep tendon equal B/L +2

Psychiatric:
Neat appearance, behavior and speech appropriate. Mood and affect normal and appropriate to situation. Patient is pleasant and cooperative. Speech clear. Good tone. Posture erect. Balance stable; gait normal.

Lab Tests:
Identify lab tests and results or pending.

Special Tests:

DIAGNOSIS

Differential Diagnoses	**Diagnosis**
• **1- Diagnosis, (ICD 10 code):** • **1- Diagnosis, (ICD 10 code):**	• **1- Presumptive diagnosis (ICD 10 code):**

Plan/Therapeutics:
- Further testing
- Medication
- Education
- Non-medication treatments

Diagnostics:
List diagnostic exams (other than labs) completed during visit, or for follow-up after visit.

Education:
Details r/t any and all education provided. Complete full dose of antibiotics even if symptoms have resolve. Take antibiotic with food to avoid stomach irritation. Take also with a full glass of water. *Follow up with PCP in one week. If symptoms worsen or you develop a fever (>100.4) go to the emergency room.