SOAP Notes Format in EMR

SOAP stands for *Subjective, Objective, Assessment*, and *Plan*

Standard Elements of SOAPnote

Date: 08/01/02
Time:
Provider:

Vital Signs:
Height, Weight, Temp, B/P, Pulse

S: This ___ yr old fe/male presents for ____
History of Present Illness symptoms:
Review Of Symptoms/Systems: (For problem-focused visit, document only pertinent information)
Past Medical History: (For problem-focused visit, document only pertinent information)
Current Medications:
Medication allergies:
Social History: (For problem-focused visit, document only pertinent information)
Family History: ((For problem-focused visit, document only pertinent information)
Genogram: 3 generations with health problems, causes of deaths, etc.
or
History of major health or genetic disorders in family, including early death, spontaneous abortions or stillbirths.

Past Medical History
Hospitalizations:
Surgical History:
T&A:
Appendectomy:
Hysterectomy:
Hernia:
Coronary Artery Bypass:
Other:
Chronic Medical Problems:
Hypertension
Diabetes
Coronary Heart Disease
Cerebrovascular Disease
Asthma or other COPD
Arthritis
Gout
Renal Disease
Thyroid Disease
Other:
Psychiatric History:
Depression
Anxiety
Substance Abuse
Other:
Immunizations:
Polio
Tetanus
Last PPD
Cholera
Childhood Illnesses:
Transfusions:
Allergies:

History of Present Illness:
Location:
Quality
Severity:
Duration:
Timing (Onset):
Timing (Frequency):
Context:
Relieved by:
Worsened by:
Associated signs and symptoms:

Review Of Symptoms (Systems):
Constitutional:
Eyes:
Ears, Nose, Mouth, Throat:
Cardiovascular:
Respiratory:
Gastrointestinal:
Genitourinary:
Musculoskeletal:
Skin and/or breasts:
Neurological:
Psychiatric:
Endocrine:
Hematologic/Lymphatic:
Allergic/Immunologic:

Social History:
Cultural Background:
Education Level:
Economic Condition:
Housing:
Number in household:
Marital Status:
Lives with:
Children:
Occupation:
Occupational Health Hazards:
Nutrition:
Exercise:
Tobacco use:
Caffeine:
Sexual activity:
Contraception:
Alcohol/recreational drug use:

Family History
Is there a family history of
Cancer:
Hypertension:
Hyperlipidemia:
Diabetes Type II:
Coronary Artery Disease:
Stroke:
Alzheimer's:
Depression:
Osteoporosis:
Domestic violence:

O: (listed are the components of the all normal physical exam)

General: Well appearing, well nourished, in no distress. Oriented x 3, normal mood and affect . Ambulating without difficulty.
Skin: Good turgor, no rash, unusual bruising or prominent lesions
Hair: Normal texture and distribution.
Nails: Normal color, no deformities
HEENT:
Head: Normocephalic, atraumatic, no visible or palpable masses, depressions, or scaring.
Eyes: Visual acuity intact, conjunctiva clear, sclera non-icteric, EOM intact, PERRL, fundi have normal optic discs and vessels, no exudates or hemorrhages
Ears: EACs clear, TMs translucent & mobile, ossicles nl appearance, hearing intact.
Nose: No external lesions, mucosa non-inflamed, septum and turbinates normal
Mouth: Mucous membranes moist, no mucosal lesions.
Teeth/Gums: No obvious caries or periodontal disease. No gingival inflammation or significant resorption.
Pharynx: Mucosa non-inflamed, no tonsillar hypertrophy or exudate
Neck: Supple, without lesions, bruits, or adenopathy, thyroid non-enlarged and non-tender
Heart: No cardiomegaly or thrills; regular rate and rhythm, no murmur or gallop
Lungs: Clear to auscultation and percussion
Abdomen: Bowel sounds normal, no tenderness, organomegaly, masses, or hernia
Back: Spine normal without deformity or tenderness, no CVA tenderness
Rectal: Normal sphincter tone, no hemorrhoids or masses palpable
Extremities: No amputations or deformities, cyanosis, edema or varicosities, peripheral pulses intact
Musculoskeletal: Normal gait and station. No misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions, decreased range of motion, instability, atrophy or abnormal strength or tone in the head, neck, spine, ribs, pelvis or extremities.
Neurologic: CN 2-12 normal. Sensation to pain, touch, and proprioception normal. DTRs normal in upper and lower extremities. No pathologic reflexes.
Psychiatric: Oriented X3, intact recent and remote memory, judgment and insight, normal mood and affect.
Pelvic: Vagina and cervix without lesions or discharge. Uterus and adnexa/parametria nontender without masses.
Breast: No nipple abnormality, dominant masses, tenderness to palpation, axillary or supraclavicular adenopathy.
G/U: Penis circumcised without lesions, urethral meatus normal location without discharge, testes and epididymides normal size without masses, scrotum without lesions.

A:

Assessment:
Includes health status and need for lifestyle changes.
Diagnosis and differential diagnosis:

P:

Laboratory:
X-Rays:
Medications:
Patient Education:
Other:

Follow-up: