



SOAP Note

PRACTICE CASE / ID

DATE

SETTING

A blank template for any visit. Use it as a checklist, then cut what doesn't apply.

S SUBJECTIVE

Chief complaint In the patient's words, with duration.

History of present illness Onset, location, duration, character, aggravating/relieving factors, radiation, timing, severity. Associated symptoms and pertinent negatives.

Review of systems Systems relevant to the complaint.

Past medical / surgical history

Medications Name, dose, route, frequency.

Allergies Drug and reaction.

Family history

Social history Tobacco, alcohol, drugs, occupation, living situation.

O OBJECTIVE

Vital signs BP, HR, RR, temperature, SpO2 with oxygen source.

General Appearance, distress.

Exam By system, focused on the complaint.

Data Labs, imaging, ECG, results reviewed.

A ASSESSMENT

Summary Age, sex, relevant history, presenting problem.

Leading diagnosis With the findings that support it.

Differential What else, and why less likely. Include must-not-miss diagnoses.

P PLAN

Diagnostics Tests to order.

Treatment Medications (drug, dose, route, frequency, duration) and other therapy.

Education What you discussed.

Referrals

Follow-up When, and with whom.

Return precautions Specific warning signs.
