**SOAP NOTE WORKSHEET**

|  |  |
| --- | --- |
| S  **Subjective**  ID/CC  HPI  PMH/Habits  Meds/Allergies  Family History  Social History  ROS | *What did the patient tell you? Include pertinent history and review of systems.* |
| O  **Objective**  Vitals  Physical Exam  Office Testing  Labs  Imaging | *What were your findings?*  BP HR Temp RR O2 Weight/Height |
| A  **Assessment**  Summary Statement  Assessment Paragraph | *What is your interpretation of the subjective and objective?* |
| P  **Plan**  Diagnostics  Therapeutics  Monitoring/Follow Up  Education | *What needs to happen next?* |

***Outpatient SOAP Notes and Oral Case Presentations***

*Many clinics use the* ***SOAP*** *format for outpatient notes and OCPs.*

***S= SUBJECTIVE: What did the patient tell you?***

*Begin with ID/CC (reason for the scheduled visit).*

*A problem focused HPI includes:*

* *the patient’s story PLUS*
* *relevant information from PMH, Medications & Allergies, Family History, Social History, habits and risks factors, preventive care and ROS (pertinent positives and negatives).*
* All pertinent information related to the problem goes here, regardless of history “category.” Save physical exam findings for the objective section that follows.

***O= OBJECTIVE: What were your findings?***   
   
Include the physical exam, and any office testing, labs, or imaging studies.

Vital Signs  
General:

HEENT:

Neck:

Cardiac:

Chest:

Abdomen:

Neurologic:

Musculoskeletal:

Skin:

For most visits you will perform a focused physical exam based on the problem(s) the patient is presenting with. ***Do not perform or report a complete PE except in appointments to establish care or if required for a yearly wellness visit. Performing a complete physical exam in the outpatient setting is usually occurs during well visits and establish care visits. Report the presence or absence of findings pertinent to the visit’s concerns, keeping in mind your differential diagnosis. This will almost always include vital signs, general appearance and findings from more than one organ system.***    
   
A=ASSESSMENT: ***What’s your interpretation of the subjective and objective?***   
   
Include 2-3 item differential for acute concerns, addressing both “why?” and “why now?” when relevant.   
   
P= PLAN: ***What needs to happen next?***    
   
State what you will do to evaluate, treat, and monitor the condition and to educate the patient. *Always include a specific plan for follow up and the instructions given to the patient. Many outpatient physicians will combine the assessment and plan, offering the assessment of each problem in conjunction with that problem’s plan, then moving on to the assessment and plan for the next problem.*

***OUTPATIENT OCPs***

* *Should be 3-5 minutes long and follow the SOAP format*
* *Should* ***always*** *include an attempt at formulating an assessment and plan, even if you’ve only had a minute or two to pull your thoughts together*
* *Can end with a ‘learning question’ to guide your preceptor’s teaching:*    
     
  “My learning question is…
* *Will you confirm the lung exam with me?*
* *How would I differentiate bronchitis from a URI?”*
* *Under what circumstances would we send someone with a head injury to the ER?”*

***WHAT IF:***

***The visit addresses multiple issues?***

* *Follow the ID/CC with a statement of other issues raised by the patient or addressed by you.*    
     
  “Mr. Jones is a 63 year old man with hypertension and diabetes who presents today with an acutely swollen and painful left big toe. He also requests refills on his diabetes medications and a referral for massage for low back pain.”
* *Organize the Subjective, Assessment, and Plan sections by problem. The first paragraph under S would address the first problem, the next would address the second problem, and so on. The assessment and plan should address each of these problems individually. In this case, the assessment would address:*
  1. *Acute L big toe swelling*
  2. *Diabetes*
  3. *Low back pain*
  4. *Hypertension*

***The visit includes followup of a known problem(s)?***

* *ID/CC should include the reason for followup*   
     
  “Mr. Jones is a 63 year old man recently diagnosed with gout in the L great toe who returns for *followup and discussion of prevention.”*
* *Subjective should include for each problem:*
  1. *Interval history: what’s happened since the last visit*
  2. *History of an current status of the problem*
  3. *Current therapy and how well it is working*
  4. *Any side effects or concerns about therapy*
  5. *Any monitoring that’s due*

***The patient has come in for a yearly wellness visit?***   
   
Include an interval *history, update the family, social, past medical history and medication list, preventive health and wellness measures, specific complaints, and typically a sexual and behavioral health history.*