# Documentation of SOAP Format

### SOAP:

**S-Subjective**. Information from the patient/family including chief complaint, history of present illness, past medical history, past surgical history, medications, allergies, reproductive history, family history, social history, nutritional assessment, and the review of systems (ROS).

**O-Objective**. Includes anything obtained by the examiner with the eyes, ears, and hands. This is the physical examination. It may also include lab and diagnosis results yielding immediate results (e.g. blood glucose check, Vital signs, etc)

**Differential Diagnosis.** This is not usually documented, but is part of the critical thinking process all NPs. This is where you determine the top possible causes of the symptom/chief complaint. For your paper, use references to support how you ruled in or out a given diagnosis.

**A-Assessment**. This is the final assessment (diagnosis), putting all the findings from subjective and objective together to form an appropriate diagnosis (or diagnoses). Often, evaluation/management codes (a 5 digit number called a “visit” code) and diagnosis codes (e.g. 477.81) are included in this section.

**P- Plan.** Management of the patient may include diagnostic testing that may be done at that visit or in the future, referral to another provider, plans for follow up, patient education, and any pharmacological or nonpharmacological treatment.

### Example of SOAP Note-Comprehensive visit

|  |  |  |
| --- | --- | --- |
| Name:  | Date of visit:  | Time seen:  |
| DOB:  | Sex:  |  |

**S:** **History (CC, HPI, PMH/PSH, Family History, Social History, Current Health Maintenance)**

**CC** – “One sentence in quotes using patient voice.”

**HPI** – Elaborate on CC using OLDCARTS or other to describe 9 attributes of a symptom. In the case of established dx’s, state when dx’d, treatment, recent relevant lab work, last medication monitoring, recent side effects or complaints related to the problems under treatment.

### PMH

Immunizations -

Medications –

Allergies – drug or food or other allergies with reaction

SH-Alchol, reacreational drugs, tobacco

Hospitalizations/Surgeries or traumatic injuries

FH-

Current Health Maintenance (or Personal and Social Hx)- Living environment, including others lived with; occupation/ school

Screenings & Self-Care -

Diet

Exercise

Sleep

Other Health Care Providers

Immunizations

Habits/Substance Use

Safety

### ROS (includes recent/current symptoms; do not include screening tests, diagnoses)

General –

Skin/Breasts –

Eyes –

Ears –

Nose/Mouth/Throat –

Neck-

Lymphatic-

Cardiovascular –

Respiratory –

Gastrointestinal –

Genitourinary:

Neurological –

Psychological:

**O: Physical Examination (VS, Exam, Rapid Diagnostics if applicable)**

Weight – Height – BMI- VS: Temp, B/P, P, R-

General –

Skin/Breasts –

Eyes –

Ears –

Nose/Mouth/Throat –

Neck-

Lymphatic-

Cardiovascular –

Respiratory –

Gastrointestinal –

Genitourinary:

Neurological –

Psychological:

## A: (Diagnoses, including E/M visit codes and diagnosis codes)

## Differential Diagnosis (*give a rationale for each diagnosis and cite a reference)*

**Final Assessment/Diagnosis:**

**P: (Plan)**