Comprehensive SOAP Note Template

This template is for a full history and physical from www.LifelongNursing.com

Include: Patient Name, Age, Date of Birth, Gender, Medical Record Number, Admission Date, and any relevant primary care or admitting physician, nurse practitioner, or physician assistant

SUBJECTIVE DATA: Include what the patient tells you, but organize the information.

Chief Complaint (CC): In just a few words, explain why the patient came to the clinic.

History of Present Illness (HPI): This is the symptom analysis section of your note. Thorough documentation in this section is essential for patient care, coding, and billing analysis. Paint a picture of what is wrong with the patient. You need to start EVERY HPI with age, race, and gender (e.g., 34-year-old AA male). You must include the **seven attributes of each principal symptom in paragraph form not a list**:

1. Location
2. Quality
3. Quantity or severity
4. Timing, including onset, duration, and frequency
5. Setting in which it occurs
6. Factors that have aggravated or relieved the symptom
7. Associated manifestations

Medications: Include over-the-counter, vitamin, and herbal supplements. List each one by name with dosage and frequency.

Allergies: Include specific reactions to medications, foods, insects, and environmental factors. Identify if it is an allergy or intolerance.

Past Medical History (PMH): Include illnesses (also childhood illnesses), hospitalizations.

Past Surgical History (PSH): Include dates, indications, and types of operations.

Sexual/Reproductive History: If applicable, include obstetric history, menstrual history, methods of contraception, sexual function, and risky sexual behaviors.

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Personal/Social History: Include tobacco use, alcohol use, drug use, patient's interests, ADL's and IADL's if applicable, and exercise and eating habits.

Immunization History: Include last TDap, Flu, pneumonia, etc.

Significant Family History: Include history of parents, grandparents, siblings, and children.

Lifestyle: Include cultural factors, economic factors, safety, and support systems and sexual preference.

Review of Systems: From head-to-toe, include each system that covers the Chief Complaint, History of Present Illness, and History (this includes the systems that address any previous diagnoses). Remember that the information you include in this section is based on what the patient tells you so ensure that you include all essentials in your case.

General: Include any recent weight changes, weakness, fatigue, or fever, but **do not restate HPI data here**.
HEENT:
Neck:
Breasts:
Respiratory:
Cardiovascular/Peripheral Vascular:
Gastrointestinal:
Genitourinary:
Musculoskeletal:
Psychiatric:
Neurological:
Skin:
Hematologic:
Endocrine:
Allergic/Immunologic:

OBJECTIVE DATA: From head-to-toe, include what you see, hear, and feel when doing your physical exam. You only need to examine the systems that are pertinent to the CC, HPI, and History unless you are doing a total H&P

Physical Exam:
Vital signs: Include vital signs, HT, WT, and BMI.
General: Include general state of health, posture, motor activity, and gait. This may also include dress, grooming, hygiene, odors of body or breath, facial expression, manner, level of consciousness, and affect and reactions to people and things.
HEENT:

Neck:
Chest
Lungs:
Heart
Peripheral Vascular: Abdomen:
Genital/Rectal:
Musculoskeletal:
Neurological:
Skin:

Include any labs, x-rays, or other diagnostics that are needed to develop the differential diagnoses.

ASSESSMENT: List your priority diagnosis(es). For holistic care, you need to include previous diagnoses and indicate whether these are controlled or not controlled. These should also be included in your treatment plan.

PLAN:

Treatment Plan: If applicable, include both pharmacological and non-pharmacological strategies, alternative therapies, follow-up recommendations, referrals, consultations, and any additional labs, x-ray, or other diagnostics. Support the treatment plan with evidence and guidelines.

Health Promotion: Include exercise, diet, and safety recommendations, as well as any other health promotion strategies for the patient/family. Support the health promotion recommendations and strategies with evidence and guidelines.

Disease Prevention: As appropriate for the patient's age, include disease prevention recommendations and strategies such as fasting lipid profile, mammography, colonoscopy, immunizations, etc. Support the disease prevention recommendations and strategies with evidence and guidelines.

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