SOAP note

Patient: [name or ID]

Date and time:

Clinician: [name, role]

Visit type: [new, follow-up, telehealth]

Source of history: [patient, relative, interpreter]

Consent to record: [only if the visit or dictation was recorded]

S: Subjective

Reason for visit: [in the patient's own words]

History of the problem: [onset, duration, severity, what helps or worsens it]

Past history: [medical, surgical, family and social, as relevant today]

Medications: [as the patient reports taking them]

Allergies: [substance and reaction]

Pertinent negatives: [symptoms the patient denies]

O: Objective

Vital signs:

Examination: [only the systems you examined]

Measurements and scores:

Test results: [labs, imaging, other tests, with dates]

A: Assessment

Problem 1: [diagnosis or working impression, status, reasoning]

Problem 2:

Also considered: [and why it is less likely]

P: Plan

Problem 1: [tests, treatment, referrals]

Problem 2:

Patient education: [what was explained, how it was understood]

Follow-up: [when, with whom]

Return precautions: [signs that should bring the patient back sooner]

Sign-off

Signed: [name, credentials, date and time]