

# SOAP Notes Format in EMR

SOAP stands for *Subjective, Objective, Assessment, and Plan*

## Standard Elements of SOAPnote

Date: 08/01/02

Time:

Provider:

Vital Signs:

Height, Weight, Temp, B/P, Pulse

**S:** This \_\_\_ yr old fe/male presents for \_\_\_\_

**History of Present Illness symptoms:**

**Review Of Symptoms/Systems:** (For problem-focused visit, document only pertinent information)

**Past Medical History:** (For problem-focused visit, document only pertinent information)

**Current Medications:**

**Medication allergies:**

**Social History:** (For problem-focused visit, document only pertinent information)

**Family History:** ((For problem-focused visit, document only pertinent information)

Genogram: 3 generations with health problems, causes of deaths, etc.

or

History of major health or genetic disorders in family, including early death, spontaneous abortions or stillbirths.

<b>Past Medical History</b> Hospitalizations: Surgical History: T&A: Appendectomy: Hysterectomy: Hernia: Coronary Artery Bypass: Other: Chronic Medical Problems: Hypertension Diabetes Coronary Heart Disease Cerebrovascular Disease Asthma or other COPD Arthritis Gout Renal Disease Thyroid Disease Other: Psychiatric History: Depression Anxiety Substance Abuse Other: Immunizations: Polio Tetanus Last PPD Cholera Childhood Illnesses: Transfusions: Allergies:	<b>History of Present Illness:</b> Location: Quality Severity: Duration: Timing (Onset): Timing (Frequency): Context: Relieved by: Worsened by: Associated signs and symptoms:	<b>Social History:</b> Cultural Background: Education Level: Economic Condition: Housing: Number in household: Marital Status: Lives with: Children: Occupation: Occupational Health Hazards: Nutrition: Exercise: Tobacco use: Caffeine: Sexual activity: Contraception: Alcohol/recreational drug use:
	<b>Review Of Symptoms (Systems):</b> Constitutional: Eyes: Ears, Nose, Mouth, Throat: Cardiovascular: Respiratory: Gastrointestinal: Genitourinary: Musculoskeletal: Skin and/or breasts: Neurological: Psychiatric: Endocrine: Hematologic/Lymphatic: Allergic/Immunologic:	<b>Family History</b> Is there a family history of Cancer: Hypertension: Hyperlipidemia: Diabetes Type II: Coronary Artery Disease: Stroke: Alzheimer's: Depression: Osteoporosis: Domestic violence:

**O:** (listed are the components of the all normal physical exam)

**General:** Well appearing, well nourished, in no distress. Oriented x 3, normal mood and affect .  
Ambulating without difficulty.

**Skin:** Good turgor, no rash, unusual bruising or prominent lesions

**Hair:** Normal texture and distribution.

**Nails:** Normal color, no deformities

**HEENT:**

Head: Normocephalic, atraumatic, no visible or palpable masses, depressions, or scaring.

Eyes: Visual acuity intact, conjunctiva clear, sclera non-icteric, EOM intact, PERRL, fundi  
have normal optic discs and vessels, no exudates or hemorrhages

Ears: EACs clear, TMs translucent & mobile, ossicles nl appearance, hearing intact.

Nose: No external lesions, mucosa non-inflamed, septum and turbinates normal

Mouth: Mucous membranes moist, no mucosal lesions.

Teeth/Gums: No obvious caries or periodontal disease. No gingival inflammation or significant  
resorption.

Pharynx: Mucosa non-inflamed, no tonsillar hypertrophy or exudate

Neck: Supple, without lesions, bruits, or adenopathy, thyroid non-enlarged and non-tender

**Heart:** No cardiomegaly or thrills; regular rate and rhythm, no murmur or gallop

**Lungs:** Clear to auscultation and percussion

**Abdomen:** Bowel sounds normal, no tenderness, organomegaly, masses, or hernia

**Back:** Spine normal without deformity or tenderness, no CVA tenderness

**Rectal:** Normal sphincter tone, no hemorrhoids or masses palpable

**Extremities:** No amputations or deformities, cyanosis, edema or varicosities, peripheral pulses  
intact

**Musculoskeletal:** Normal gait and station. No misalignment, asymmetry, crepitation, defects,  
tenderness, masses, effusions, decreased range of motion, instability, atrophy or abnormal  
strength or tone in the head, neck, spine, ribs, pelvis or extremities.

**Neurologic:** CN 2-12 normal. Sensation to pain, touch, and proprioception normal. DTRs normal  
in upper and lower extremities. No pathologic reflexes.

**Psychiatric:** Oriented X3, intact recent and remote memory, judgment and insight, normal mood  
and affect.

**Pelvic:** Vagina and cervix without lesions or discharge. Uterus and adnexa/parametria nontender  
without masses.

**Breast:** No nipple abnormality, dominant masses, tenderness to palpation, axillary or  
supraclavicular adenopathy.

**G/U:** Penis circumcised without lesions, urethral meatus normal location without discharge, testes  
and epididymides normal size without masses, scrotum without lesions.

**A:**

Assessment:

Includes health status and need for lifestyle changes.

Diagnosis and differential diagnosis:

**P:**

Laboratory:

X-Rays:

Medications:

Patient Education:

Other:

Follow-up: