**SOAP NOTE TEMPLATE**

**Please include a heart exam and lung exam on all clients regardless of the reason for seeking care.  So, if someone presented with cough and cold symptoms, you would examine the General appearance, HEENT, Neck, Heart and Lungs for a focused/episodic exam.  The pertinent positive and negative findings should be relevant to the chief complaint and health history data.  This template is a great example of information documented in a real chart in clinical practice.  The only section that will not be included in a real chart is differential diagnosis.  The term “Rule Out…” cannot be used as a diagnosis.**

**Subjective Data**

**Chief Complain (CC):**

**History of Present Illness (HPI):**

**Last Menstrual Period (LMP- if applicable)**

**Allergies:**

**Past Medical History:**

**Family History:**

**Surgery History:**

**Social History (alcohol, drug, or tobacco use):**

**Current medications:**

**Review of Systems (Remember to inquire about body systems relevant to the chief complaint and HPI)**

**Objective Data**

**Please remember to include an assessment of all relevant systems based on the CC and HPI.  The following systems are required in all SOAP notes.  If it is a child, include the Tanner stage. You will proceed to assess pertinent systems.**

**Vital Signs/ Height/Weight:**

**General Appearance:**

**HEART:**

**RESP:**

**Assessment**

**A: Differential Diagnosis  Please rule out all differential diagnosis with subjective and objective data and/or lab-work.**

**1.**

**2.**

**3.**

**B: Medical Diagnosis Rule in diagnosis with subjective and objective data and lab-work. They need to let us know how they arrived at the diagnosis.**

**1.**

**PLAN**

**A:  Orders**

**1.      Prescriptions with dosage, route, duration, amount prescribed, and if**

**refills are provided**

**2.      Diagnostic testing**

**3.      Problem oriented education**

**4.      Health Promotion/Maintenance Needs**

**5.      Referrals**

**Cultural Diversity: What cultural considerations would you suggest for this patient?**

**Patient/Family Education: If patient is currently on any medications, please address if you want them to discontinue or continue.  You always want this to be clear at the end of the visit.**

**B:  Follow-Up Plans (When will you schedule a follow-up appointment and what will you address in the subsequent visit ---F/U in 2 weeks; Plan to check annual labs on RTC (return to clinic)**

**APA Format**

**Include a title page and references with all of your papers.  There should be at least four references from textbooks, journal articles, CDC or NIH that are not older than 5 years. Please do not use Wikipedia, WebMD, dictionaries, or any websites that are not evidence based.**