1- The **SOAP note** (Stands for **subjective**, **objective**, **assessment**, and **plan**) is a method of documentation employed by health care providers to write out notes in a patient's chart

**Subjective component**

Initially is the patient's Chief Complaint, or CC. This is a very brief statement of the patient (quoted) as to the purpose of the office visit or hospitalization.  
  
If this is the first time a physician is seeing a patient, the physician will take a History of Present Illness, or HPI. This describes the patient's current condition in narrative form. The history or state of experienced symptoms are recorded in the patient's own words. It will include all pertinent and negative symptoms under review of body systems. Pertinent medical history, surgical history, family history, and social history, along with current medications and allergies, are also recorded. A SAMPLE history is one method of obtaining this information from a patient.  
  
Subsequent visits for the same problem briefly summarize the History of Present Illness (HPI), including pertinent testing + results, referrals, treatments, outcomes and followups.

**Objective component**

The *objective* component includes:

* Vital signs and measurements, such as weight.
* Findings from physical examinations, including basic systems of cardiac and respiratory, the affected systems, possible involvement of other systems, pertinent normal findings and abnormalities.
* Results from laboratory and other diagnostic tests already completed.

**Assessment**

A medical diagnosis for the purpose of the medical visit on the given date of the note written is a quick summary of the patient with main symptoms/diagnosis including a differential diagnosis, a list of other possible diagnoses usually in order of most likely to least likely. It is the patient's progress since the last visit, and overall progress towards the patient's goal from the physician's perspective. When used in a Problem Oriented Medical Record, relevant problem numbers or headings are included as subheadings in the assessment.

**Plan**

This is what the health care provider will do to treat the patient's concerns - such as ordering further labs, radiological work up, referrals given, procedures performed, medications given and education provided. This should address each item of the differential diagnosis. A note of what was discussed or advised with the patient as well as timings for further review or follow-up are generally include

**For Example :**

A  patient being reviewed following an appendectomy. This example resembles a surgical SOAP note; medical notes tend to be more detailed, especially in the subjective and objective sections.

|  |  |
| --- | --- |
| S: | No further Chest Pain or Shortness of Breath. "Feeling better today." Patient reports headache. |
| O: | Afebrile, P 84, R 16, BP 130/82. No acute distress. |
|  | Neck no JVD, Lungs clear |
|  | Cor RRR |
|  | Abd Bowel sounds present, mild RLQ tenderness, less than yesterday. Wounds look clean. |
|  | Ext without edema |
| A: | Patient is a 37 year old man on post-operative day 2 for laparoscopic appendectomy. |
| P: | Recovering well. Advance diet. Continue to monitor labs. Follow-up with Cardiology within three days of discharge for stress testing as an out-patient. Prepare for discharge home tomorrow morning. |

The plan itself includes various components:

Diagnostic component - continue to monitor labs

Therapeutic component - advance diet

Referrals - Follow up with Cardiology within three days of discharge for stress testing as an out-patient.

Patient education component - that is progressing well

Disposition component - discharge to home in the morning