**SOAP Note Template**

Encounter date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Initials: \_\_\_\_\_\_Gender: M/F/Transgender \_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity \_\_\_\_

Reason for Seeking Health Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HPI**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**(Drug/Food/Latex/Environmental/Herbal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current perception of Health**: Excellent Good Fair Poor

**Past Medical History**

* Major/Chronic Illnesses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Trauma/Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hospitalizations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social history**:

**Lives**: Single family House/Condo/ with stairs: \_\_\_\_\_\_\_\_\_\_\_**Marital Status**:\_\_\_\_\_\_\_\_**Employment Status**: \_\_\_\_\_\_**Current/Previous occupation type**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exposure to:** \_\_\_Smoke\_\_\_\_ ETOH\_\_\_\_Recreational Drug Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual orientation:** \_\_\_\_\_\_\_ Sexual Activity: \_\_\_\_**Contraception Use**: \_\_\_\_\_\_\_\_\_\_\_\_

**Family Composition:** Family/Mother/Father/Alone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Maintenance**

**Screening Tests: Mammogram, PSA, Colonoscopy, Pap Smear, Etc \_\_\_\_\_**

**Exposures:**

**Immunization HX:**

**Review of Systems:**

General:

HEENT:

Neck:

Lungs:

Cardiovascular:

Breast:

GI:

Male/female genital:

GU:

Neuro:

Musculoskeletal:

Activity &Exercise:

Psychosocial:

Derm:

Nutrition:

Sleep/Rest:

LMP:

STI Hx:

**Physical Exam**

BP\_\_\_\_\_\_\_\_TPR\_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_Ht. \_\_\_\_\_ Wt. \_\_\_\_\_\_BMI (**percentile**) \_\_\_\_\_

General:

HEENT:

Neck:

Pulmonary:

Cardiovascular:

Breast:

GI:

Male/female genital:

GU:

Neuro:

Musculoskeletal:

Derm:

Psychosocial:

Misc.

SignificantData/Contributing Dx/Labs/Misc.

**Plan:**

**Differential Diagnoses**

**1.**

**2.**

**3.**

**Principal Diagnoses**

**1.**

**2.**

**Plan**

**Diagnosis**

**Diagnostic Testing:**

**Pharmacological Treatment:**

**Education:**

**Referrals:**

**Follow-up:**

**Anticipatory Guidance:**

**Diagnosis**

**Diagnostic Testing:**

**Pharmacological Treatment:**

**Education:**

**Referrals:**

**Follow-up:**

**Anticipatory Guidance:**

**Signature (with appropriate credentials): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cite current evidenced based guideline(s) used to guide care (Mandatory)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DEA#: 101010101 STUClinicLIC# 10000000**

**Tel: (000) 555-1234 FAX: (000) 555-12222**

Patient Name: (Initials)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RX \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIG:**

**Dispense**: \_\_\_\_\_\_\_\_\_\_\_ **Refill:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **No Substitution**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_