Clinical Visit Summary - SOAP Format

Patient Information

Patient ID:	P20250608200007
Name:	Siva
Age:	30 years
Sex:	male
Mobile:	+919966556699
Visit Date:	2025-06-08

Vital Signs

■ SpO2: 93%
✓ BP: 118/76 mmHg (Normal)
✓ HR: 98 bpm (Normal)
✓ Temp: 37.9°C (Normal)
✓ RR: 18/min (Normal)
✓ Weight: 70.0 kg
✓ Height: 170.0 cm
✓ BMI: 24.2 (Normal)

Clinical Assessment

SIVA - 30 years, Male

SUBJECTIVE: - Chief Complaint: Feeling weak for 2 days, bit of nausea, slept badly - Patient reports symptoms exactly as stated

OBJECTIVE: - Vital signs: BP 118/76 mmHg, HR 98 bpm, Temp 37.9°C, RR 18/min, SpO2 93% - Physical examination: Patient appears fatigued - LAB INTERPRETATION: No lab results available

ASSESSMENT: - Clinical Impression: Acute onset weakness, nausea, and poor sleep - Differential Diagnoses: 1. Viral illness 2. Gastroenteritis 3. Sleep disturbance - Concerns: Low SpO2 level, possible underlying infection - Risk Assessment: Moderate risk due to low SpO2 and symptoms

PLAN: - Investigations: CBC, CRP, COVID-19 test - Management: Symptomatic treatment, encourage hydration and rest - Follow up in 3 days - Red flags: Return immediately if SpO2 drops below 90%, persistent vomiting, confusion, chest pain - Safety advice: Maintain good hydration, rest adequately

Prescription

1. Tab. Paracetamol 500mg - 1 tab PRN for fever
2. Syrup Ondansetron 4mg - 5ml TDS x 3 days

Doctor's Signature & Stamp