Clinical Visit Summary - SOAP Format

Patient Information

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| --- | --- |
| **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

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Doctor's Signature & Stamp