



SOAP Note Template

S: Subjective

Information the patient or patient representative told you

Initials: TJ				Age: 28				Gender: Female			
Height	Weight	BP	HR	RR	Temp	SPO2	Pain	Allergies			
170cm	89kg	140/ 81	89	20	98.5 F	97%		Medication: Penicillin (rash/hives) Food: none Environment: Cats			

History of Present Illness (HPI)

Chief Complaint (CC)	"chest tightness"	<i>CC is a BRIEF statement identifying why the patient is here - in the patient's own words - for instance "headache", NOT "bad headache for 3 days". Sometimes a patient has more than one complaint. For example: If the patient presents with cough and sore throat, identify which is the CC and which may be an associated symptom</i>
Onset	Intermittent chest tightness the last couple of days after being near cats	
Location	Chest tightness all over	
Duration	Intermittently the past two days	
Characteristics	Chest tightness no pain.	
Aggravating Factors	Worse at night and lying down, cats, and dust.	
Relieving Factors	Albuterol inhaler	
Treatment	Proventil 90mcg inhaler 3 puffs every 4 hours.	

Current Medications: Include dosage, frequency, length of time used and reason for use; also include OTC or homeopathic products.

Medication (Rx, OTC, or Homeopathic)	Dosage	Frequency	Length of Time Used	Reason for Use
Proventil (albuterol) Inhalation	90mcg per puff (2-3 puffs)	PRN for asthma symptoms	Q 4hrs	Wheezing and dyspnea
N/A	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
N/A	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
N/A	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
N/A	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Past Medical History (PMHx) – Includes but not limited to immunization status (note date of last tetanus for all adults), past major illnesses, hospitalizations, and surgeries. Depending on the CC, more info may be needed.



Asthma dx age 2.5 yrs old, Diabetes dx at 24yrs old, Denies surgical history, last hospital admission at 16 yrs old for asthma exacerbation. Reports all Immunization are current at this visit, Last Flu vaccine: declines at this time Last Tetanus booster: last year

Social History (Soc Hx) - Includes but not limited to occupation and major hobbies, family status, tobacco and alcohol use, and any other pertinent data. Include health promotion such as use seat belts all the time or working smoke detectors in the house.

Supervisor at Mid-American Copy & Ship, Bachelor's accounting student, Hobbies: hanging with friends and going to church. Close with mother and sister (living together), Brother lives elsewhere, father deceased from car accident. Denies tobacco use. Alcohol use socially with friends (rum and diet coke drink of choice). Drives and uses seatbelt, working smoke detector in house.

Family History (Fam Hx) - Includes but not limited to illnesses with possible genetic predisposition, contagious or chronic illnesses. Reason for death of any deceased first degree relatives should be included. Include parents, grandparents, siblings, and children. Include grandchildren if pertinent.

Mother- high cholesterol and hypertension
Father (deceased at 58 car accident)- T2DM, high cholesterol and hypertension
Brother 25 y.o.- Obesity
Sister 14 y.o -Asthma
maternal grandma- HTN and high cholesterol
maternal grandpa- HTN and high cholesterol.
paternal grandma- HTN and high cholesterol
paternal grandpa- (deceased) colon cancer, HTN, diabetes.

Review of Systems (ROS): Address all body systems that may help rule in or out a differential diagnosis Check the box next to each positive symptom and provide additional details.

Constitutional	Skin	HEENT		
<input type="checkbox"/> Fatigue Denies <input type="checkbox"/> Weakness Denies <input type="checkbox"/> Fever/Chills Denies <input type="checkbox"/> Weight Gain Denies changes <input type="checkbox"/> Weight Loss Denies <input checked="" type="checkbox"/> Trouble Sleeping Reports trouble sleeping lately <input type="checkbox"/> Night Sweats Denies	<input type="checkbox"/> Itching Denies <input type="checkbox"/> Rashes Denies <input type="checkbox"/> Nail Changes Denies <input checked="" type="checkbox"/> Skin Color Changes Reports skin around neck darker and breaking out on face and little on back. <input checked="" type="checkbox"/> Other:	<input type="checkbox"/> Diplopia Denies <input type="checkbox"/> Eye Pain Denies <input type="checkbox"/> Eye redness Denies <input type="checkbox"/> Vision changes Denies <input type="checkbox"/> Photophobia Denies <input type="checkbox"/> Eye discharge Denies	<input type="checkbox"/> Earache Denies <input type="checkbox"/> Tinnitus Denies <input type="checkbox"/> Epistaxis Denies <input type="checkbox"/> Vertigo Denies <input type="checkbox"/> Hearing Changes Denies	<input type="checkbox"/> Hoarseness Denies <input type="checkbox"/> Oral Ulcers Denies <input type="checkbox"/> Sore Throat Denies <input type="checkbox"/> Congestion Denies <input type="checkbox"/> Rhinorrhea Denies <input type="checkbox"/> Other: Click or tap here to enter text.



<input type="checkbox"/> Other: Click or tap here to enter text.	Reports moles on back not new.		
Respiratory	Neuro	Cardiovascular	
<input checked="" type="checkbox"/> Cough Reports cough with no sputum <input type="checkbox"/> Hemoptysis Denies <input checked="" type="checkbox"/> Dyspnea Reports trouble catching breath <input checked="" type="checkbox"/> Wheezing Reports intermittent wheezing <input type="checkbox"/> Pain on Inspiration Denies <input type="checkbox"/> Sputum Production <div></div> <div></div> <div></div> <input type="checkbox"/> Other: Click or tap here to enter text.	<input type="checkbox"/> Syncope or Lightheadedness Denies <input type="checkbox"/> Headache Denies <input type="checkbox"/> Numbness Denies <input type="checkbox"/> Tingling Denies <input type="checkbox"/> Sensation Changes <div></div> <input type="checkbox"/> Speech Deficits Denies <input type="checkbox"/> Other: Click or tap here to enter text.	<input type="checkbox"/> Chest pain Denies <input checked="" type="checkbox"/> SOB Intermittent when going up stairs or walking <input checked="" type="checkbox"/> Exercise Intolerance reports unable to exercise due to shortness of breath <input checked="" type="checkbox"/> Orthopnea Reports short of breath worse when lying down at night <input type="checkbox"/> Edema Denies <input type="checkbox"/> Murmurs Denies	<input type="checkbox"/> Palpitations Denies <input type="checkbox"/> Faintness Denies <input type="checkbox"/> OC Changes Denies <input type="checkbox"/> Claudications Denies <input type="checkbox"/> PND Denies <input type="checkbox"/> Other: Click or tap here to enter text.
MSK	GI	GU	PSYCH
<input type="checkbox"/> Pain Denies <input type="checkbox"/> Stiffness Denies <input type="checkbox"/> Crepitus Denies <input type="checkbox"/> Swelling Denies <input type="checkbox"/> Limited ROM <div></div> <input type="checkbox"/> Redness Denies <input type="checkbox"/> Misalignment Denies <input type="checkbox"/> Other: Click or tap here to enter text.	<input type="checkbox"/> Nausea/Vomiting Denies <input type="checkbox"/> Dysphasia Denies <input type="checkbox"/> Diarrhea Denies <input type="checkbox"/> Appetite Change Denies <input type="checkbox"/> Heartburn Denies <input type="checkbox"/> Blood in Stool Denies <input type="checkbox"/> Abdominal Pain Denies <input type="checkbox"/> Excessive Flatus Denies <input type="checkbox"/> Food Intolerance Denies <input type="checkbox"/> Rectal Bleeding Denies <input type="checkbox"/> Other: Click or tap here to enter text.	<input type="checkbox"/> Urgency Denies <input type="checkbox"/> Dysuria Denies <input type="checkbox"/> Burning Denies <input type="checkbox"/> Hematuria Denies <input type="checkbox"/> Polyuria Denies <input type="checkbox"/> Nocturia Denies <input type="checkbox"/> Incontinence Denies <input type="checkbox"/> Other: Click or tap here to enter text.	<input type="checkbox"/> Stress Denies <input type="checkbox"/> Anxiety Denies <input type="checkbox"/> Depression Denies <input type="checkbox"/> Suicidal/Homicidal Ideation Denies <input type="checkbox"/> Memory Deficits Denies <input type="checkbox"/> Mood Changes Denies <input type="checkbox"/> Trouble Concentrating Denies <input type="checkbox"/> Other: Click or tap here to enter text.
GYN			




<input type="checkbox"/> Rash Denies <input type="checkbox"/> Discharge Denies <input type="checkbox"/> Itching Denies	<input type="checkbox"/> Irregular Menses Denies <input type="checkbox"/> Dysmenorrhea Denies <input type="checkbox"/> Foul Odor Denies	<input type="checkbox"/> Amenorrhea Denies <input type="checkbox"/> LMP: Did not assess <input type="checkbox"/> Contraception Denies <input type="checkbox"/> Other: Click or tap here to enter text.
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O: Objective

Information gathered during the physical examination by inspection, palpation, auscultation, and palpation. If unable to assess a body system, write "Unable to assess". Document pertinent positive and negative assessment findings.



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Body System	Positive Findings	Negative Findings
General <input type="text"/>	Click or tap here to enter text.	<i>Patient is alert and oriented, normal stature</i> 
Skin <input type="text"/>	<i>Moles assessed on right upper back, skin discoloration of neck, and observed facial acne.</i>	Click or tap here to enter text.
HEENT <input type="text"/>	Click or tap here to enter text.	Click or tap here to enter text.
Respiratory <input type="text"/>	<i>Auscultated adventitious breath sounds bilaterally, in posterior lower lobes, wheezing noted in bilateral posterior, lower lobes.</i>	<i>Chest inspection: symmetrical, Palpated: equal expansion bilaterally, expected fremitus, Percussed Chest wall : No dullness, Auscultated: normal breath sound in anterior upper and lower lobes.</i>
Neuro <input type="text"/>	Click or tap here to enter text.	Click or tap here to enter text.
Cardiovascular <input type="text"/>	Click or tap here to enter text.	Click or tap here to enter text.
Musculoskeletal <input type="text"/>	Click or tap here to enter text.	Click or tap here to enter text.
Gastrointestinal <input type="text"/>	Click or tap here to enter text.	Click or tap here to enter text.
Genitourinary <input type="text"/>	Click or tap here to enter text.	Click or tap here to enter text.
Psychiatric <input type="text"/>	Click or tap here to enter text.	Click or tap here to enter text.



Problem List

1. Chest tightness	6 Click or tap here to enter text.	11 Click or tap here to enter text.
2 Wheezing	7 Click or tap here to enter text.	12 Click or tap here to enter text.
3 shortness of breath	8 Click or tap here to enter text.	13 Click or tap here to enter text.
4 Click or tap here to enter text.	9 Click or tap here to enter text.	14 Click or tap here to enter text.
5 Click or tap here to enter text.	10 Click or tap here to enter text.	15 Click or tap here to enter text.

A: Assessment

Medical Diagnoses. Provide 3 differential diagnoses which may provide an etiology for the CC. The first diagnosis (presumptive diagnosis) is the diagnosis with the highest priority. Provide the ICD-10 code and pertinent findings to support each diagnosis.

Diagnosis	ICD-10 Code	Pertinent Findings
Mild intermittent asthma, with acute exacerbation	J45.21	Symptoms started after cat exposure, Reports feeling better after use of inhaler on and off.
Wheezing	R06.2	Reports wheezing and Auscultated wheezing in the posterior bilateral lower lobes of patient lungs.
Shortness of breath	R06.02	Reports trouble catching breath

P: Plan

Address all 5 parts of the comprehensive treatment plan. If you do not wish to order an intervention for any part of the treatment plan, write "None at this time" but do not leave any heading blank. No intervention is self-evident. Provide a rationale and evidence-based in-text citation for each intervention.

Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

Medications: List medications/treatments including OTC drugs you will order and "continue previous meds" if pertinent.

Drug	Dosage	Length of Treatment	Rationale/Citation
Continue previous meds	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Albuterol inhalation	90mcg	PRN	Bronchodilation (Mendes, 2019).
PO Salbutamol	4mg	PRN for bronchospasm	According to Sottas, Anderson, &



			Holford (2016). Salbutamol is a selective beta ₂ adrenoreceptor agonist widely used for the treatment of bronchospasm.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Referral/Consults:			
<i>Respiratory consult</i>		Rationale/Citation	Make sure the patient is taught proper inhaler technique to ensure they are using their inhalers correctly (Mendes, 2019).
Education:			
<i>Teach about right medication administration and give proper inhaler instructions.</i>		Rationale/Citation	Inhaler prescriptions must be accompanied by discussions about proper technique and the establishment of an asthma action plan (Mendes, 2019).
Follow Up: Indicate when patient should return to clinic and provide detailed instructions indicating if the patient should return sooner than scheduled or seek attention elsewhere.			
<i>Follow up at the clinic in 2 week if not better. If symptoms of wheezing or shortness of breath worse, seek medical attention and go to the ER if after hours and in case of an emergency. Keep a list of symptoms on when to seek medical attention and emergency numbers on the fridge.</i>		Rationale/Citation	According to Mendes (2019), patients are taught to check in regularly with their action plan and even advised to keep a copy of it on their phone and/or fridge.
References			
Include at least one evidence-based peer-reviewed journal article which relates to this case. Use the correct APA 6th edition formatting.			
Mendes, A. (2019). Raising the bar in asthma management. British Journal of Community Nursing, 24(9), 456–457. https://doi-org.chamberlainuniversity.idm.oclc.org/10.12968/bjcn.2019.24.9.456			
Sottas, C. E., Anderson, B. J., & Holford, N. H. G. (2016). Salbutamol has rapid onset pharmacodynamics as a bronchodilator. Acta Anaesthesiologica Scandinavica, 60(9), 1328–1331. https://doi-org.chamberlainuniversity.idm.oclc.org/10.1111/aas.12769			



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