**SOAP NOTE**

**SUBJECTIVE (S):**

Describes what the patient reports about their condition.

For INITIAL visits gather the info below.

**ID + CC (Identification and Chief Complaint):** E.g. 29 yo El Salvadorean ♀ here for f/u of DM and vaginal itching x 5d

**HPI (History of Present Illness):** Remember OLD CAARTS (onset, location, duration, character, aggravating/alleviating factors, radiation, temporal association, severity) and Associated Symptoms (including pertinent negatives and positives).

**PMH (Past Medical History):** List any past or present medical conditions, surgeries, or other medical interventions patient has had. Specify where and what year they took place (i.e. in-home country or here).

**MEDs:** List prescribed medications patient is taking. Include dosage and frequency if known. Inquire and document any over the counter, herbal or traditional remedies.

Allergies: List any allergies the patient has and indicate the reaction.

E.g. Medications (tetracycline-> shortness of breath), foods, tape, iodine->rash

**FH (Family History):**  List relevant health history of immediate family: grandparents, parents, siblings, or children. E.g. Inquire about any cardiovascular disease, HTN, DM, cancer, or any lung, liver, renal disease.

**SHx (Social history):** patient’s work (prior and current), living situation (renting, homeless, owner), relationship status (married, single, divorced, widowed), number of children (in SF or abroad), how recently pt immigrated to US and from what country of origin.

**HRB (Health related behaviors):**  Be sure to ask in a SENSITIVE manner about: Tobacco/alcohol use (quantify, ex how much per week or day), illicit drug use (can indicate if inhaled, injected, or ingested), gender of sexual partners, # of partners in last 6 mo., vaginal/anal/oral, protected/unprotected.

**ROS (Review of Systems):** Asking about problems by organ system systematically from head-to-toe. For FOLLOW UP visits, do NOT gather all the info above, instead focus on the problem patient is following up for. E.g.: Patient here for f/up of DM. Feels well, no polyuria, polydipsia, denies hypoglycemic symptoms, etc.

**OBJECTIVE:** Physical findings you observe or find on exam.

1. Age, gender, general appearance
2. Vitals – HR, BP, RR, Temp, BMI, Weight, Glucose
3. Physical Exam: note pertinent positives and negative
4. Lab Section
5. Studies/Radiology/Pap Results Section

**ASSESSMENT:** What you think is going on with a description of why you think that is what is going on. This is usually developed based on discussions with your MD preceptor. May list differential diagnosis, in order of likely, possible, and unlikely (don’t have to nail this down if you’re in your first 2 years, but take a stab at it).

**PLAN:** Number problems if more than one (E.g. 1. HTN, 2. DM, 3. Knee sprain), and use bullet points.

1. What further tests do you need to confirm a diagnosis?
2. What do you need to treat this patient’s condition?
3. Do you need referral to a specialist?
4. What discharge instructions will you give the patient?
5. How soon should the patient come back for follow-up?