**Focused SOAP Note Template**

**Patient Information:**

Initials, Age, Sex, And Race

**S.**

**CC** (chief complaint): A brief statement identifying why the patient is here, stated in the patient’s own words (for instance "headache," not "bad headache for 3 days”).

**HPI**: This is the symptom analysis section of your note. Thorough documentation in this section is essential for patient care, coding, and billing analysis. Paint a picture of what is wrong with the patient. Use LOCATES mnemonic to complete your HPI. You need to start EVERY HPI with age, race, and gender (e.g., 34-year-old AA male). You must include the seven attributes of each principal symptom in paragraph form, not a list. If the CC was “headache,” the LOCATES for the HPI might look like the following example:

Location: head

Onset: 3 days ago

Character: pounding, pressure around the eyes and temples

Associated signs and symptoms: nausea, vomiting, photophobia, phonophobia

Timing: after being on the computer all day at work

Exacerbating/relieving factors: light bothers eyes, Aleve makes it tolerable but not completely better

Severity: 7/10 pain scale

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

**Allergies:** include medication, food, and environmental allergies separately (A description of what the allergy is, i.e., angioedema, anaphylaxis, etc. This will help determine a true reaction as opposed to intolerance).

**PMHx**: include immunization status (note date of **last tetanus** for all adults), past major illnesses and surgeries. Depending on the CC, more information is sometimes needed.   
  
**Soc & Substance Hx**: include occupation and major hobbies, family status, tobacco & alcohol use (previous and current use), any other pertinent data. Always add some health promo question here, such as whether they use seat belts all the time or whether they have working smoke detectors in the house, living environment, text/cell phone use while driving, and support system.

**Fam Hx**: 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.

**Surgical Hx:** prior surgical procedures

**Mental Hx:** diagnosis and treatment. Current concerns: Anxiety and/or depression. History of self-harm practices and/or suicidal or homicidal ideation.

**Violence Hx:** concern or issues about safety (personal, home, community, sexual . . . current & historical)

**Reproductive Hx:** menstrual history (date of LMP), Pregnant (yes or no), Nursing/lactating (yes or no), contraceptive use (method used), types of intercourse: oral, anal, vaginal, other, any sexual concerns

**ROS**: cover all body systems that may help you include or rule out a differential diagnosis You should list each system as follows: General: Head: EENT: etc. You should list these in bullet format and document the systems in order from head to toe.

Example of Complete ROS:

GENERAL: No weight loss, fever, chills, weakness or fatigue.

HEENT: Eyes: No visual loss, blurred vision, double vision or yellow sclerae. Ears, Nose, Throat: No hearing loss, sneezing, congestion, runny nose, or sore throat.

SKIN: No rash or itching.

CARDIOVASCULAR: No chest pain, chest pressure, or chest discomfort. No palpitations or edema.

RESPIRATORY: No shortness of breath, cough, or sputum.

GASTROINTESTINAL: No anorexia, nausea, vomiting, or diarrhea. No abdominal pain or blood.

GENITOURINARY: Burning on urination. Last menstrual period, MM/DD/YYYY.

NEUROLOGICAL: No headache, dizziness, syncope, paralysis, ataxia, numbness, or tingling in the extremities. No change in bowel or bladder control.

MUSCULOSKELETAL: No muscle, back pain, joint pain, or stiffness.

HEMATOLOGIC: No anemia, bleeding, or bruising.

LYMPHATICS: No enlarged nodes. No history of splenectomy.

PSYCHIATRIC: No history of depression or anxiety.

ENDOCRINOLOGIC: No reports of sweating, cold, or heat intolerance. No polyuria or polydipsia.

REPRODUCTIVE: Not pregnant and no recent pregnancy. No reports of vaginal or penile discharge. Not sexually active.

ALLERGIES: No history of asthma, hives, eczema, or rhinitis.

**O.**

**Physical exam**: From head-to-toe, includewhat you see, hear, and feel when doing your physical exam. You only need to examine the systems that are pertinent to the CC, HPI, and History. **Do not use “WNL” or “normal.” You must describe what you see.** Always document in head-to-toe format, i.e., General: Head: EENT: etc.

**Diagnostic results**: Include any labs, x-rays, or other diagnostics that are needed to develop the differential diagnoses (support with evidence and guidelines)

**A**.

**Differential Diagnoses:** List a minimum of three differential diagnoses. Your primary, or presumptive, diagnosis should be at the top of the list. For each diagnosis, provide supportive documentation with evidence-based guidelines.

**P.**

Includes documentation of diagnostic studies that will be obtained, referrals to other healthcare providers, therapeutic interventions, education, disposition of the patient, and any planned follow-up visits. Each diagnosis or condition documented in the assessment should be addressed in the plan. The details of the plan should follow an orderly manner.

Include a discussion related to health promotion and disease prevention, taking into consideration patient factors such as age and ethnic group; PMH; and other factors, such as socio-economic and cultural background.

**The reflection also is included in this section.** Reflect on this case and discuss what you learned. Were there any “aha” moments or connections you made?

**References**

You are required to include at least three evidence-based, peer-reviewed journal articles or evidence-based guidelines that relate to this case to support your diagnostics and differentials diagnoses. Be sure to use correct APA 7th edition formatting.