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**SOAP note**

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The **SOAP note** (an acronym for **subjective**, **objective**, **assessment**, and **plan**) is a method of documentation employed by health care providers to write out [notes](http://en.wikipedia.org/wiki/Medical_record) in a [patient](http://en.wikipedia.org/wiki/Patient)'s chart, along with other common formats, such as the [admission note](http://en.wikipedia.org/wiki/Admission_note). Documenting patient encounters in the [medical record](http://en.wikipedia.org/wiki/Medical_record) is an integral part of [practice workflow](http://en.wikipedia.org/w/index.php?title=Practice_workflow&action=edit&redlink=1) starting with patient appointment scheduling, to writing out notes, to [medical billing](http://en.wikipedia.org/wiki/Medical_billing). Prehospital care providers such as [EMTs](http://en.wikipedia.org/wiki/Emergency_medical_technician) may use the same format to communicate patient information to [emergency department](http://en.wikipedia.org/wiki/Emergency_department) clinicians. Podiatrists, Chiropractors, Physical Therapists, Massage Therapists, among other providers use this format for the patient's initial visit and to monitor progress during follow-up care.

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**Components[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=1" \o "Edit section: Components)]**

The four components of a SOAP note are Subjective, Objective, Assessment, and Plan. The length and focus of each component of a SOAP note vary depending on the specialty; for instance, a surgical SOAP note is likely to be much briefer than a medical SOAP note, and will focus on issues that relate to post-surgical status.

**Subjective component[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=2" \o "Edit section: Subjective component)]**

Initially is the patient's **Chief Complaint, or CC.** This is a very brief statement of the patient (quoted) as to the purpose of the office visit or hospitalization.

If this is the first time a physician is seeing a patient, the physician will take a **History of Present Illness, or HPI.** This describes the patient's current condition in narrative form. The history or state of experienced symptoms are recorded in the patient's own words. It will include all pertinent and negative [symptoms](http://en.wikipedia.org/wiki/Symptoms) under **review of body systems.** **Pertinent medical history, surgical history, family history, and social history, along with current medications and allergies,** are also recorded. A [SAMPLE history](http://en.wikipedia.org/wiki/SAMPLE_history) is one method of obtaining this information from a patient.

Subsequent visits for the same problem briefly summarize the History of Present Illness (HPI), including pertinent testing + results, referrals, treatments, outcomes and followups.

The mnemonic below refers to the information a physician should elicit before referring to the patient's "old charts" or "old carts." [[1]](http://en.wikipedia.org/wiki/SOAP_note#cite_note-1)

**O**nset  
**L**ocation  
**D**uration  
**CH**aracter (sharp, dull, etc.)  
**A**lleviating/**A**ggravating factors  
**R**adiation  
**T**emporal pattern (every morning, all day, etc.)  
**S**everity

Variants on this mnemonic (more than one could be listed here) include [OPQRST](http://en.wikipedia.org/wiki/OPQRST) and [LOCQSMAT](http://en.wikipedia.org/w/index.php?title=LOCQSMAT&action=edit&redlink=1)

**L**ocation  
**O**nset (when and mechanism of injury - if applicable)  
**C**hronology (better or worse since onset, episodic, variable, constant, etc.)  
**Q**uality (sharp, dull, etc.)  
**S**everity (usually a pain rating)  
**M**odifying factors (what aggravates/reduces the Sx - activities, postures, drugs, etc.)  
**A**dditional symptoms (un/related or significant symptoms to the chief complaint)  
**T**reatment (has the patient seen another provider for this symptom?)

**Objective component[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=3" \o "Edit section: Objective component)]**

The *objective* component includes:

* [Vital signs and measurements, such as weight.](http://en.wikipedia.org/wiki/Vital_signs_(medicine))
* Findings from [physical examinations](http://en.wikipedia.org/wiki/Physical_examination), including basic systems of cardiac and respiratory, the affected systems, possible involvement of other systems, pertinent normal findings and abnormalities.
* Results from laboratory and other diagnostic tests already completed.

**Assessment[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=4" \o "Edit section: Assessment)]**

A medical diagnosis for the purpose of the medical visit on the given date of the note written is a quick summary of the patient with main symptoms/diagnosis including a [differential diagnosis](http://en.wikipedia.org/wiki/Differential_diagnosis), a list of other possible diagnoses usually in order of most likely to least likely. It is the patient's progress since the last visit, and overall progress towards the patient's goal from the physician's perspective. When used in a [Problem Oriented Medical Record](http://en.wikipedia.org/w/index.php?title=Problem_Oriented_Medical_Record&action=edit&redlink=1), relevant problem numbers or headings are included as subheadings in the assessment.

**Plan[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=5" \o "Edit section: Plan)]**

This is what the health care provider will do to treat the patient's concerns - such as ordering further labs, radiological work up, referrals given, procedures performed, medications given and education provided. This should address each item of the differential diagnosis. A note of what was discussed or advised with the patient as well as timings for further review or follow-up are generally included.

Often the Assessment and Plan sections are grouped together.

**An example[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=6" \o "Edit section: An example)]**

A very rough example follows for a patient being reviewed following an appendectomy. This example resembles a surgical SOAP note; medical notes tend to be more detailed, especially in the subjective and objective sections.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | |  | Surgery Service, Dr. Jones | | S: | No further Chest Pain or Shortness of Breath. "Feeling better today." Patient reports [headache](http://en.wikipedia.org/wiki/Headache). | | O: | Afebrile, P 84, R 16, BP 130/82. No acute distress. | |  | Neck no JVD, Lungs clear | |  | Cor RRR | |  | Abd Bowel sounds present, mild RLQ tenderness, less than yesterday. Wounds look clean. | |  | Ext without edema | | A: | Patient is a 37 year old man on post-operative day 2 for [laparoscopic](http://en.wikipedia.org/wiki/Laparoscopic) [appendectomy](http://en.wikipedia.org/wiki/Appendectomy). | | P: | Recovering well. Advance diet. Continue to monitor labs. Follow-up with Cardiology within three days of discharge for stress testing as an out-patient. Prepare for discharge home tomorrow morning. | |

The plan itself includes various components:

Diagnostic component - continue to monitor labs

Therapeutic component - advance diet

Referrals - Follow up with Cardiology within three days of discharge for stress testing as an out-patient.

Patient education component - that is progressing well

Disposition component - discharge to home in the morning

**References[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=7" \o "Edit section: References)]**

1. [**Jump up ^**](http://en.wikipedia.org/wiki/SOAP_note#cite_ref-1) <http://meded.ucsd.edu/clinicalmed/history.htm>

**Further reading[[edit](http://en.wikipedia.org/w/index.php?title=SOAP_note&action=edit&section=8" \o "Edit section: Further reading)]**

* Weed, Lawrence L. (June 1964). "Medical records, patient care, and medical education". *Irish Journal of Medical Science* **39** (6): 271–282. [doi](http://en.wikipedia.org/wiki/Digital_object_identifier):[10.1007/BF02945791](http://dx.doi.org/10.1007%2FBF02945791).