Cheatography

EMR: SOAP Notes Format Cheat Sheet

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S: Subjective

This ___ yr old (fe)male presents for _____-_____

History of Present Illness symptoms: _____-_____

Review Of Symptoms/Systems: (For problem-focused visit, document only pertinent information)

Past Medical History: (For problem-focused visit, document only pertinent info)

Current Medications:

Medication allergies:

Social History: (For problem-focused visit, document only pertinent info)

Family History: ((For problem-focused visit, document only pertinent information)

Genogram: 3 generations wi/health problems, causes of deaths, etc. or History of major health or genetic disorders in family, including early death, spontaneous abortions or stillbirths.

SOAP stands for **Subjective, Objective, Assessment, and Plan**

Past Medical History

Hospitalizations:

Surgical History:

- ☐ T&A:
- ☐ Appendectomy:
- ☐ Hysterectomy:
- ☐ Hernia:
- ☐ Coronary Artery Bypass:
- ☐ Other:

Chronic Medical Problems:

- ☐ Hypertension
- ☐ Diabetes
- ☐ Coronary Heart Disease
- ☐ Cerebrovascular Disease
- ☐ Asthma or other COPD
- ☐ Arthritis
- ☐ Gout
- ☐ Renal Disease
- ☐ Thyroid Disease
- ☐ Other:

Psychiatric History:

- ☐ Depression
- ☐ Anxiety
- ☐ Substance Abuse
- ☐ Other:

Immunizations:

Past Medical History (cont)

- ☐ Polio
- ☐ Tetanus
- ☐ Last PPD
- ☐ Cholera

Childhood Illnesses:

Transfusions:

Allergies:

History of Present Illness

Location:

Quality

Severity:

Duration:

Timing (Onset):

Timing (Frequency):

Context:

Relieved by:

Worsened by:

Associated signs and symptoms:

Review Of Symptoms (Systems)

- ☐ Constitutional:
- ☐ Eyes:
- ☐ Ears, Nose, Mouth, Throat:
- ☐ Cardiovascular:
- ☐ Respiratory:
- ☐ Gastrointestinal:
- ☐ Genitourinary:
- ☐ Musculoskeletal:
- ☐ Skin and/or breasts:
- ☐ Neurological:
- ☐ Psychiatric:
- ☐ Endocrine:
- ☐ Hematologic/Lymphatic:
- ☐ Allergic/Immunologic:

Social History

- ☐ Cultural Background:
- ☐ Education Level:
- ☐ Economic Condition:
- ☐ Housing:
- ☐ Number in household:
- ☐ Marital Status:
- ☐ Lives with:
- ☐ Children:
- ☐ Occupation:
- ☐ Occupational Health
- ☐ Hazards:
- ☐ Nutrition:
- ☐ Exercise:
- ☐ Tobacco use:
- ☐ Caffeine:
- ☐ Sexual activity:
- ☐ Contraception:
- ☐ Alcohol/recreational drug use:

Family History of

- ☐ Cancer:
- ☐ Hypertension:
- ☐ Hyperlipidemia:
- ☐ Diabetes Type II:
- ☐ Coronary Artery Disease:
- ☐ Stroke:
- ☐ Alzheimer's:
- ☐ Depression:
- ☐ Osteoporosis:
- ☐ Domestic violence:

O: Observation

Part	Details
General	Well appearing, well nourished, in no distress. Oriented x 3, normal mood and affect. Ambulating without difficulty.
Skin	Good turgor, no rash, unusual bruising or prominent lesions
Hair	Normal texture and distribution.

O: Observation (cont)

HEENT	**Head:** Normocephalic, atraumatic, no visible or palpable masses, depressions, or scaring.
	Eyes: Visual acuity intact, conjunctiva clea r, sclera non-icteric, EOM intact, PERRL, fundi have normal optic discs and vessels, no exudates or hemorrhages
	Ears: EACs clear, TMs translucent & mobile, ossicles nl appearance, hearing intact.
	Nose: No external lesions, mucosa non-inflamed, septum and turbinates normal
	Mouth: Mucous membranes moist, no mucosal lesions.
	Teeth/Gums: No obvious caries or periodontal disease. No gingival inflammation or significant resorption
	Pharynx: Mucosa non-inflamed, no tonsillar hypertrophy or exudate
	Neck: Supple, without lesions, bruits, or adenopathy, thyroid non-enlarged and non-tender
Heart	No cardiomegaly or thrills; regular rate and rhythm, no murmur or gallop
Lungs	Clear to auscultation and percussion
Abdomen	Bowel sounds normal, no tenderness, organomegaly, masses, or hernia
Back	Spine normal without deformity or tenderness, no CVA tenderness
Rectal	Normal sphincter tone, no hemorrhoids or masses palpable
Extremities	No amputations or deformities, cyanosis , edema or varicosities, peripheral pulses intact

O: Observation (cont)

Musculoskeletal	Normal gait and station. No misalign ment, asymmetry, crepitation, defects, tenderness, masses, effusions, decreased range of motion, instability, atrophy or abnormal strength or tone in the head, neck, sp ine, ribs, pelvis or extremities.
Neurologic	CN 2-12 normal. Sensation to pain, touc h, and proprioception normal. DTRs normal in upper and lower extremities. No pathologic reflexes.
Psychiatric	Oriented X3, intact recent and remote memory, judgment and insight, normal mood and affect.
Pelvic	Vagina & cervix without lesions or disc harge. Uterus and adne xa/parametria nontender without masses.
Breast	No nipple abnormality, dominant masses, tenderness to palpation, axillary or supraclavicular adenopathy.
G/U	Penis circumcised without lesions, urethral meatus normal location without discharge, testes and epididymides normal size without masses, scrotum without lesions.
Nails	Normal color, no deformities

A: Assessment

{{fa-square=o}}Assessment: Includes health status and need for lifestyle changes.
{{fa-square=o}}Diagnosis and differential diagnosis:

P: Plan

- ☐ Laboratory:
- ☐ X-Rays:
- ☐ Medications:
- ☐ Patient Education:
- ☐ Other:
- ☐ Follow-up: