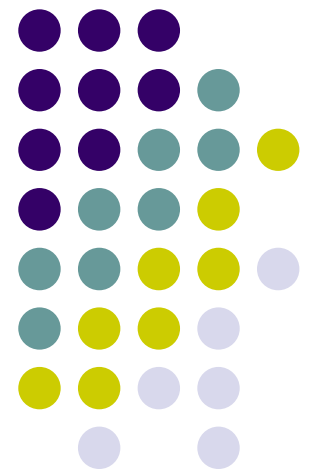
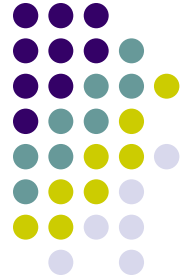


The SOAP Note and Presentation

Melanie G. Hagen, MD
Rebecca R. Pauly, MD
University of Florida

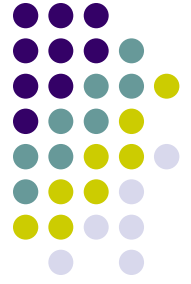


Use the SOAP Format for all Oral Presentations and Notes

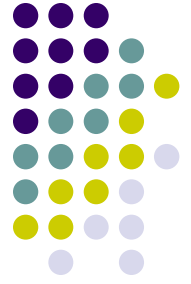


- Sometimes the term “SOAP” note is only applied to short notes but the format is used throughout medical practice for communication.
- Subjective
- Objective
- Assessment
- Plan

SOAP Notes



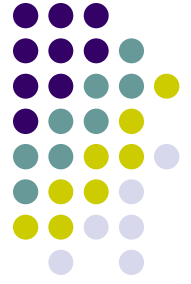
- Subjective
 - Includes information you have learned from the patient or people caring for the patient.



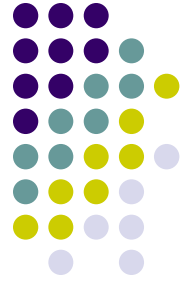
SOAP Notes

- Objective
 - This section includes observations and measurements that you have made during the physical examination.
 - Includes the vital signs.
 - Includes a general description of the patient.
 - Results of diagnostic testing also go here.
 - Laboratory results
 - Imaging
 - Pathology reports

SOAP Notes



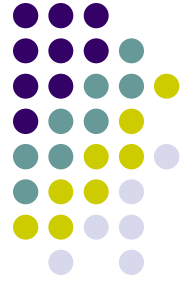
- Assessment
 - What do you feel is the patient's differential diagnosis and why?
 - This is organized by problem or organ system.



SOAP Notes

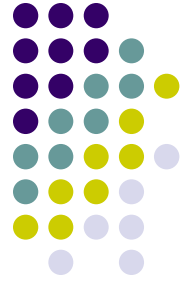
- Plan
 - For each problem what diagnostic testing will you order?
 - How will you treat each problem?
 - Medicine
 - Therapy
 - Lifestyle change
 - Tincture of time

The Complete Patient Evaluation



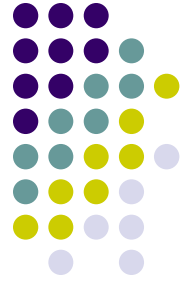
- Used for new patients in hospital or clinic
- History and Physical (H & P)
 - Complete story of their illness and medical history
 - Cc and HPI
 - Past Medical History
 - Active Medical Problems
 - Surgical and Trauma History
 - Childhood Illnesses
 - Medications and Allergies
 - Social History
 - Family History
 - Review of Systems
 - Physical Examination
 - Labs and other diagnostic studies
 - Assessment
 - Plan

The Progress Note



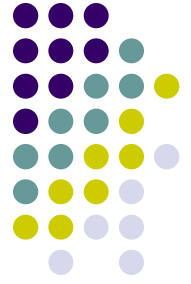
- Uses:
 - Daily evaluation of a hospitalized patient
 - Return visit in outpatient clinic
- Focused history
- Focused physical examination

The Complete History and Physical



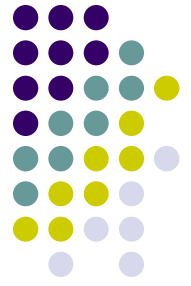
- Use the similar format for the complete history and physical as the SOAP note:
 - Subjective
 - Cc, HPI
 - Past Medical History
 - Social History
 - Family History
 - Review of Systems

The Complete History and Physical

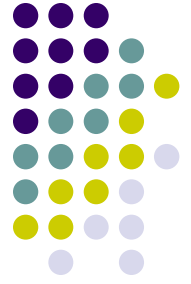


- Objective
 - Vital signs
 - Your physical exam findings
 - Any diagnostic test results
 - Lab work
 - Imaging

The Complete History and Physical

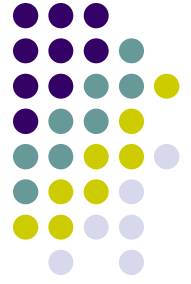


- Assessment
 - Problem list with differential diagnosis for each problem
- Plan
 - Action planned for each problem
- The assessment and plan may be combined as the A & P



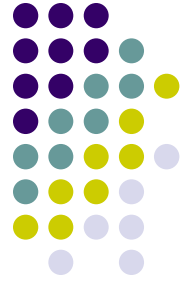
Sample SOAP note

- Subjective:
- Jennifer Myles is a 25 year old healthy single store manager complaining of right facial pain. She felt well until about three weeks ago when her allergies started acting up. At that time she had itchy watery eyes and a runny nose. She used an over the counter “Tylenol allergy” medication which gave her some relief but her nasal congestion persisted.



Sample SOAP Note

- About two weeks ago her right cheek started to hurt. The pain is 5/10 in severity and worse with leaning her head down, smiling and chewing. The over the counter medicine is no longer helping.
- She has not taken her temperature but felt she may have had a fever. She no longer has a runny nose, it just feels congested. She has no sore throat, no headache, no ear pain and no cough. Symptoms are not worse at any time of day or in any particular location. No one at work or at home has been sick.



Sample SOAP note

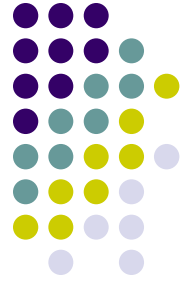
- Objective:
 - Temperature 38 F
 - B/P 120/68, HR 76, RR 16
 - Weight 129, BMI 26
 - General: Fatigued appearing young woman
 - HEENT: Face: Right maxillary tenderness. No sinus transillumination on the right side. No conjunctival injection. Oropharynx: pink mucous membranes without tonsillar exudates. Nasopharynx: thick green mucous and erythematous turbinates. Ears: tympanic membranes pearly grey with a sharp light reflex.

Sample SOAP Note

Objective (continued)

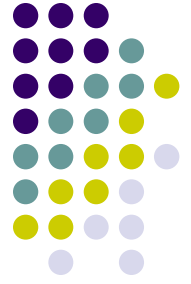


- Neck: Supple, no lymphadenopathy, no thyromegaly, no bruits.
- Lungs: Clear to auscultation and resonant to percussion.



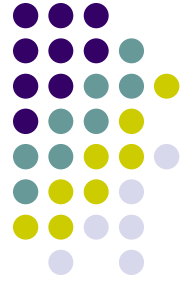
Sample SOAP Note

- Assessment
 - Acute Sinusitis
 - Allergic Rhinitis
- Plan
 - Treat with amoxicillin 500 mg three times a day and a decongestant as needed for one week. Follow up if symptoms have not improved.
 - Fluticasone nose spray for allergy symptoms when needed.



The Presentation

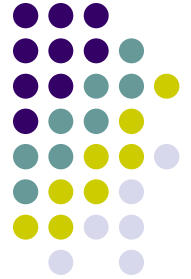
- Used for communication between clinicians.
- Should be a well-organized vignette that captures the patient and his or her clinical problem.
 - Your goal is to help your listeners to visualize the patient and understand the problem



The Presentation

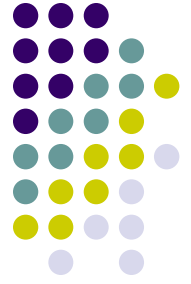
- Stay relaxed.
- Be sure to present information in the correct order.
- Try not to read your notes.
- Don't forget that you are telling a story; try to make it interesting to listen to.
- Err on the side of saying less, listeners can ask you to fill in the blanks.

The Presentation



- In clinic:
 - Immediately after you see a patient
- In the hospital:
 - On rounds

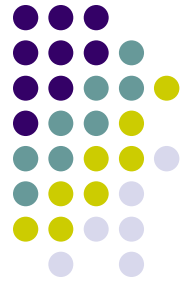




The Presentation

- Begin with an opening statement
 - “Chief complaint: Shortness of breath. Mr. Smith is an 84 year retired dentist with a history of hypertension who has new shortness of breath and lower extremity edema.”
 - “Mrs. Brooks is a 49 year old teacher with a history of fibrocystic breast disease who is anxious about a new tender breast lump.”

The Presentation

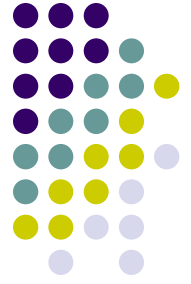


- Continue in the same order as the written report:
 - Cc and HPI
 - Past Medical History
 - Active Medical Problems
 - Surgical and Trauma History
 - Childhood Illnesses
 - Medications and Allergies
 - Social History
 - Family History
 - Review of Systems
 - Physical Examination
 - Labs and other diagnostic studies
 - Assessment
 - Plan



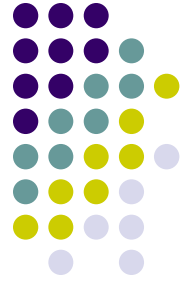
Presentations

- How much to include?
 - It varies
 - For a **new** patient you will need to present the complete medical history.
 - For a **follow-up patient** in **clinic** you will need to present active problems and the chief complaint.
 - For a **follow-up patient** in the **hospital** you will need to present the status of the patient's active problems and any new concerns.
 - Include pertinent positives and negatives in the history and physical.



In Summary

- In SOAP notes and presentations
 - Practice as much as you can.
 - The more you do the more natural it will become.
 - Remember to keep things in the right order.
 - Watch others, begin to develop role models.



Remember

- Not every doctor will write notes the same way.
- For now, use complete sentences.
- Avoid using too many acronyms and abbreviations because they may cause misunderstandings and even medical errors.