SOAP Note Content

S = Subjective

* Chief Complaint, or CC
* This is a very brief statement of the patient (quoted) as to the purpose of the office visit or hospitalization
* include all pertinent and negative symptoms under review of body systems. Pertinent medical history, surgical history, family history, and social history, along with current medications, smoking s tatus, drug/alcohol/caffeine use, level of physical activity and allergies

O = Objective

* information that the healthcare provider observes or measures from the patient's current presentation
* vital signs, findings from physical examination, the affected systems, possible involvement of other systems, normal findings and abnormalities
* laboratory and other diagnostic reports
* medication list

A = Assessment

* a diagnosis of the patients main symptoms, a differential diagnosis
* progress since the last visit

P = Plan

* the plan to treat the patients concerns
* note what was discussed with the patient