

Nurse Practitioner SOAP Notes

SUBJECTIVE DATA:

Chief Complaint (CC): One to three words explaining why patient came to clinic

History of Present Illness (HPI): Paint a picture of what is wrong with the patient. You need to start EVERY HPI with age, race, gender. (Example: 34-year-old AA male) Must include the 7 attributes of each principal symptom:

1. Location
2. Quality
3. Quantity or severity
4. Timing, including onset, duration, and frequency
5. Setting in which it occurs
6. Factors that have aggravated or relieved the symptom
7. Associated manifestations

Medications: list each one by name with dosage and frequency

Allergies: include specific reactions to medications, foods, insects, environmental

Past Medical History (PMH): Illnesses, hospitalizations, risky sexual behaviors. Include childhood illnesses

Past Surgical History (PSH): Dates, indications and types of operations

OB/GYN History: Obstetric history, menstrual history, methods of contraception and sexual function

Personal/Social History: Tobacco use, Alcohol use, Drug use. Patient's interests, ADL's IADL's if applicable. Exercise, eating habits

Immunizations: Last Tdp, Flu, pneumonia, etc.

Family History: Parents, Grandparents, siblings, children

Review of Systems: Go Head to toe. Cover each system and remember this is where you 'ask' the pt/guardian of sign/symptoms not mentioned by the pt and may also be what the patient tells you.

General: any recent weight changes, weakness, fatigue, or fever

Skin: rashes, lumps, sores, itching, dryness, changes, etc.

HEENT:

Neck:

Chest:

Comment [P1]: This is all the information that the patient shares with you or from your interview of the patient during history intake.

Comment [P2]: Ex: "cough" "rash and runny nose"

Comment [P3]: Include this in the HPI and not as 1. 2. 3. Etc. or as a graph. Write as narrative: "age/gender coming in for rash that ...location..." "timing/onset..."

Race is important but not always easy to list so try to include though may not always be possible to describe

Comment [P4]: Don't forget duration: is the med to be taken forever? Every day for a particular season? 5 days? As needed?

Comment [P5]: If there are none then list "none" and same for medication section

Comment [P6]: An acceptable response is "up to date" if that is the case

Comment [P7]: This means family health history of any chronic health conditions. If there are none then list "none"

Comment [P8]: This can be a tricky and confusing section. I will accept two ways of answering where you must address each body system as is listed here:
1) "... Present..." ex: **Respiratory:** "SOB present" and/or "denies SOB, cough..."
2) "negative" if there are no positive findings
** It is confusing as you don't want to sound repetitive by only including what you already did in HPI. Think of this section as you asking additional questions where if you have positive findings you can place in the respective system and if no findings then you can just leave as "denies..." or just "negative findings" BE SURE TO ADDRESS EACH BODY SYSTEM so even if someone comes for a cold you must still address the other systems.

- Respiratory:
- Cardiovascular/peripheral vascular:
- Gastrointestinal:
- Genitourinary:
- Musculoskeletal:
- Psychiatric:
- Neurological:
- Hematologic:
- Endocrine:

OBJECTIVE DATA: This is what you see, hear, feel when doing your physical exam. **Do not use WNL or normal. You must describe what you see.**

Here is where the vital signs go. Include ht. and wt. and BMI.

General: General state of health, posture, motor activity and gait. Dress, grooming, hygiene. Odors of body or breath. Facial expression, manner, affect and reactions to people and things. Level of conscience.

SKIN:

HEENT:

Neck:

Chest/Lungs:

Heart/Peripheral Vascular:

Abdomen:

Genital:

Musculoskeletal:

Neurological:

Comment [P9]: In the section, state your findings for any/all system you examined. If you did not examine then may state 'deferred' (e.g. genitourinary etc).

Comment [P10]: Don't forget to include units for temperature "F" for farenheit etc. as well as site measured, such as ears, mouth, etc (include units in the Subjective section's HPI if you mention numeric fever values.

ASSESSMENT: Need to list your priority diagnosis(es) first. For each priority diagnosis, list at least 3 differential diagnoses. Support your selection with evidence.

Example: Migraine headache (tension headache, cluster headache, brain tumor)

Hypertension (renal disease, stress, renal artery stenosis)

PLAN: Treatment plan. Include both pharmacological and non-pharmacological strategies. Include alternative therapies. When do they need to follow-up? Any referrals? Consultations?

Health Promotion: What does the patient family need to do to promote their health? Exercise, healthy diet, safety, etc.

Disease Prevention: For the patient's age, what needs to be done to detect disease early...fasting lipid profile, mammography, colonoscopy, immunizations, etc.

Comment [P11]: Your priority dx is your final dx where you must justify with explanation why you chose this and CITE your sources.

For your differentials you must state why you thought this differential had potential to be the final diagnosis and why it is NOT the priority with CITED SOURCES along with referring back to your patient's HPI and exam findings.

Comment [P12]: Cite your sources

REFLECTION: What did you learn from this experience? What would you do differently? Do you agree with your preceptor based on the evidence? What other thoughts do you have about this particular case/patient/situation/interaction/etc?!

Comment [p13]: This should be REFLECTIVE and not just a checkbox section. Be intuitive otherwise points will be taken off!

References:

Comment [P14]: Points will be deducted if you do not list your cited sources. Sources must be scholarly and listed in APA format. |