FAMILY MEDICINE

Primary care SOAP note

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

SUBJECTIVE

Reason for visit

Symptoms, onset, course and functional impact

Relevant history

Medications and allergies reviewed

Review of systems actually obtained

OBJECTIVE

Vitals measured today, with units

Examination performed and findings

Tests or records reviewed, with dates and sources

ASSESSMENT

Problems addressed today

Clinical reasoning and diagnostic uncertainty

PLAN

Management for each problem

Orders, medication decisions and counseling

Shared decisions and patient preferences

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding