Ambulatory Care: Sample Format for Oral/Written Patient Presentations

Student Name:
Date:
Clinic:

SOAP Format

Subjective (S):

Information for the subjective section of the note is obtained from interviewing the patient or caregiver. If the source is not the patient, the information source should be documented in the note. Include name of interpreter if used. Information in this section includes the following:

A. General Information (provides overall sketch of the patient)

1. For patient (HIPAA) confidentiality reasons, do not use the patient's name or initials.
2. Patient Age (Do not use if greater than 89 yrs old.)
3. Patient Sex
4. History of Present Illness (Chief Complaint)

B. Past Medical History

C. Family History

D. Social History (including employment and living arrangements if pertinent)

E. Medication History (Prescription, Nonprescription including vitamins and herbals)
Include pertinent previous medication history.

D. Allergies

Objective (O):

Information for the objective section is obtained from verifiable sources (vitals, exam, lab values, and prescription records). All information included should support the assessment of plan section.

Assessment (A):

The assessment section is used to assess the patient's medical and drug related problems. The assessment should contain a statement supporting your assessment that a problem exists and should include justification of the therapeutic goal.

Plan (P)

The plan should recommend your suggested treatment (for medications: include name, dose, frequency) and monitoring/follow up parameters (e.g. what should be measured, frequency of measurement, follow up appointment, etc.)

Therapeutic Teaching Points:

References:

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