

SOAP NOTE EXAMPLE – NURSE PRACTITIONER

SECTION	DETAILS
Subjective:	Chief Complaint (CC): Brief statement of the patient's main concern or reason for the visit. Example: "I have been experiencing a persistent cough for the last two weeks." History of Present Illness (HPI): A detailed description of the patient's symptoms, onset, duration, severity, context, modifying factors, and associated signs and symptoms. Example: Patient reports a dry, non-productive cough that started gradually two weeks ago. The cough is worse at night, and there is no relief with over-the-counter cough suppressants. The patient denies fever, chills, chest pain, or shortness of breath. Past Medical History (PMH): Summary of the patient's relevant medical history, including chronic conditions, surgeries, allergies, and medications. Example: Asthma, seasonal allergies; Appendectomy (2018); Allergic to penicillin; Currently taking montelukast 10 mg daily and fluticasone/salmeterol inhaler. Social History (SH): Information about the patient's lifestyle, occupation, and living situation. Example: Non-smoker, occasional alcohol use, works as a teacher, lives with spouse and two children. Family History (FH): Relevant health information about the patient's immediate family. Example: Mother with asthma, father with hypertension, sibling with type 2 diabetes.
Objective:	Vital Signs: Blood pressure, heart rate, respiratory rate, temperature, and oxygen saturation. Example: BP 120/80 mmHg, HR 75 bpm, RR 18 breaths/min, Temp 98.6°F (37°C), SpO2 98% on room air. Physical Exam: Documentation of the physical examination, focusing on the relevant body systems. Example: General appearance: Patient is alert and oriented, in no apparent distress. HEENT: Pupils equal, round, and reactive to light. Nasal mucosa is erythematous and swollen. No discharge. Throat is clear without exudate. Lungs: Clear to auscultation bilaterally, no wheezing or

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Table of Contents Sore Throat Soap Notes Example

1. Understanding the eBook Sore Throat Soap Notes Example
 - The Rise of Digital Reading Sore Throat Soap Notes Example
 - Advantages of eBooks Over Traditional Books
2. Identifying Sore Throat Soap Notes Example
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Sore Throat Soap Notes Example
 - User-Friendly Interface
4. Exploring eBook Recommendations from Sore Throat Soap Notes Example
 - Personalized Recommendations
 - Sore Throat Soap Notes Example User Reviews and Ratings
 - Sore Throat Soap Notes Example and Bestseller Lists
5. Accessing Sore Throat Soap Notes Example Free and Paid eBooks
 - Sore Throat Soap Notes Example Public Domain eBooks

- Sore Throat Soap Notes Example eBook Subscription Services
- Sore Throat Soap Notes Example Budget-Friendly Options
- 6. Navigating Sore Throat Soap Notes Example eBook Formats
 - ePub, PDF, MOBI, and More
 - Sore Throat Soap Notes Example Compatibility with Devices
 - Sore Throat Soap Notes Example Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Sore Throat Soap Notes Example
 - Highlighting and Note-Taking Sore Throat Soap Notes Example
 - Interactive Elements Sore Throat Soap Notes Example
- 8. Staying Engaged with Sore Throat Soap Notes Example
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Sore Throat Soap Notes Example
- 9. Balancing eBooks and Physical Books Sore Throat Soap Notes Example
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Sore Throat Soap Notes Example
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Sore Throat Soap Notes Example
 - Setting Reading Goals Sore Throat Soap Notes Example
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Sore Throat Soap Notes Example
 - Fact-Checking eBook Content of Sore Throat Soap Notes Example
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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