

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

Sore Throat Soap Notes Example

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McCaskill**



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