

SOAP Note Example #2:

Date/Time: MSIII Progress Note - Medicine (state which service)

S: (Subjective) Patients noted no n/v (nausea, vomiting), no d/c (diarrhea, constipation) this am. +fever with shaking chills x 1 this am. Tolerated po (oral intake) well. No complaints of dysuria or abdominal pain. Last BM (bowel movement) 2 days ago. Patient continues to cough, productive of greenish-yellow sputum. No wheezing, hemoptysis, orthopnea or PND (paroxysmal nocturnal dyspnea), +SOB (shortness of breath), + pain on R side with deep inspiration. Slept poorly.

O: (Objective):

PE: (physical examination)

VS: (vital signs) T: 100.2, Tmax (maximum temperature) 102.6, BP 128/82 (115-130/72-84 (range)), RR: 20, HR: 98, regular, Pulse O₂ 98% on 4L, I/O (in's and out's)=1.7/2.2 (liters).

Gen: A+O x 3 (alert and oriented to person, place, and time), flushed, moderate distress. MMM (mucous membranes moist), fair skin turgor; WD/WN (well-developed/well-nourished)

HEENT: (head, ears, eyes, nose, throat -- often combined into one description)

Head: NC/AT (normocephalic/atraumatic)

Eyes: PERRLA (pupils equal, round, and reactive to light and accommodation), EOMI (extraocular muscles intact).

Ears: No erythema, no discharge, tympanic membrane intact.

Throat: No erythema or exudates. Tongue protrudes straight.

Neck: No nuchal rigidity, good ROM (range of motion); No masses/LAD (lymphadenopathy)

CV: RRR (regular rate/rhythm) S1/S2, no S3 or S4, no m/g/r (murmurs, gallops, or rubs)

Pulm: + R lower lobe dullness to percussion; increased tactile fremitus, increase BS (breath sounds), - bronchial BS, + whispered pectoriloquy; +fine crackles R lower third posteriorly. - w/r/r (wheezes, rubs, or rhonchi).

Abd: Soft, NT (non-tender) ND (non-distended), +BS (bowel sounds), no rebound, guarding, masses or HSM (hepatosplenomegaly); Heme + (rectal exam positive for fecal occult blood)

Ext: no c/c/e (clubbing, cyanosis, edema), 2+ DP/PT (dorsalis pedis, posterior tibial)

Neuro: CNII (cranial nerves intact)

Labs: None

A: (Assessment) 54 y/o white male PMH (past medical history) DK +Tob ppd x 20 years, with one day h/o CAP (community-acquired pneumonia).

P: (Plan)

1. Pulm: Pneumonia Continue O₂ 4L, Day 1 Ceftriaxone 1 g q12 Codeine prn for pleuritic chest pain, Tylenol prn fever
2. Endocrine: DM Type II Continue Glipizide qd c (with) daily accu-checks
3. FEN: (fluids/electrolytes/nutrition) Full PO diet/liquids as tolerated. I/O's good, continue D51/2 NS @ 80 cc/hr
4. Dispo: Consult for Smoking Cessation Program

Jim Q. Student, MS III (always sign notes), Pager

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L Towne



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