Basic Elements of an Effective SOAP Note
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The SOAP note is the basic template for a patient encounter note. It has four sections:

- Subjective – the HPI and ancillary patient-provided information
- Objective – the vitals signs and physical exam
- Assessment – a one to two sentence summary of the patient and a working differential
- Plan – your proposed intervention(s) depending on your assessment

As you rotate through your third year clerkships, you’ll see many chart notes in this format, some better than others. There are a few common themes that set good notes apart. Use the opportunity in Monday Clinic to learn these habits, and be sure to ask your clinical-year student for feedback. In general, a well-written note is concise, clear, and free of esoteric terminology; it tends to be easy to write and easy to read.

Disclaimer: Everyone writes notes a little differently. During your clerkships, you will find that different specialties have slightly different ideas of what makes a well-written note. These are the collected principles that I have found to be the most universal and to work the best for a Monday Clinic setting. Take cues from your interns and residents, and instructions from staff always take precedence.

1. Organize your thoughts before writing.
After leaving the patient room, many will want to rush to the computer and start typing. Don’t do this. Take a few minutes and think about what you want to write. A good SOAP note makes the case for your diagnosis, and the reader should never be surprised when he or she gets to your assessment. It is not necessary to write your history in the same order that the patient provides. For example, if you believe the patient has a urinary tract infection, “burning during urination” or “dysuria” should be one of the first sentences in the note, even if the patient related an eloquent history of having allergies beforehand. If you’re not sure what the patient has, take time to think about what your differential is, and focus your initial documentation to those organ systems.

2. The SOAP note is not written for the general public.
In general, your audience is fellow healthcare workers, not your patient. There is no need to use complete sentences, and bullet points are acceptable. Proper grammar is generally not an issue, and nobody will get on your case for writing a sentence fragment. Don’t shy away from using medical terminology if it is appropriate.

The patient relates that he has lost 20 pounds in the past three years, though he did not intend to do so and despite eating more foods. In addition, he feels tired, felt “feverish”, and often wakes up in the middle of the night sweating. These have all been going on for the past three years as well.
The patient relates 20 lbs unintentional weight loss in the past three years, associated in the same time frame with night sweats, fatigue, and subjective fevers.

3. Omit extraneous or non-contributory information.
If the patient goes on a tangent during questioning, it is appropriate to omit this information from the SOAP note, if you are reasonably certain that it does not contribute to the diagnosis. There is generally no need to quote a patient verbatim unless he or she used specific or unusual words, or if you feel that it would contribute to the reader getting a better overall impression of the patient. Some attendings do prefer the chief complaint to be in the patient’s words. Irrespective, always use less words if possible.

The patient has been drinking Ensure with his meals and adding protein powder to his drinks, but he continues to lose weight. He initially started drinking one can per day, but he is now drinking up to five. He has a “great appetite,” and he seems to be hungry all the time.

Patient supplements diet with high-calorie shakes. Denies early satiety or diminished appetite.

A special point, never use the phrase “non-contributory”. It is unhelpful. If a patient who you suspect has cancer has no family history of cancer, it is much more prudent to write “no hx of cancer or chronic disease” in the family history section than “non-contributory.” If you write the latter, who knows what you asked? When attempting to be concise, make sure to not omit required sections of the history.

4. Avoid excessive use of acronyms or abbreviations.
Acronyms were more acceptable in the days of written charts. If you rotate through a regional or private hospital, you’ll likely still see them around. They make writing notes faster. Now that we have EMR, they are rapidly falling out of favor, because they tend to increase medical errors. If you use acronyms or shorthands, make sure they are universally known, and don’t use acronyms you’ve developed for yourself.

The USMLE publishes a list of common abbreviations you can use for the Step 2 CS notes. You can use this as a good list of universal shorthands. For 2011, they are listed on page 13 from http://www.usmle.org/Orientation/2011/2011CSinformationmanual.pdf

5. Underline abnormal findings.
As a courtesy to the reader, in your physical exam, underline findings that are abnormal. The physical exam portion of the note looks the same across the board, and it is all too easy for a hasty reader to skip over a crucial finding.

CV: RRR no m/r/g, 2+ pulses
Pulm: CTA/B no r/r/w, limited excursion left, no dullness
Abd: Soft, nt/nd, liver 2 cm below margin, no splenomegaly.
6. Date events by time from note, not absolute date.
When chronicling events in the patient’s HPI, it is usually best to date events relative to today (the patient’s disease started five days ago) and not by the absolute date (the patient’s disease started on January 2, 2012). Doing so makes it easier to follow the disease’s history.

7. Document only what you did.
Once you reach the physical exam section, it’s easy to automatically write all the necessary normal findings. Epic makes this even easier by having a physical exam template with all the normals already pre-written. Make sure you’re doing what you’re documenting. If you reflexively write “no dullness” for the pulmonary exam because that’s what you always do, but you didn’t on this patient, you have committed potential malpractice. Don’t give in to the temptation of “being complete.” This can hurt not just your credibility but may translate into actually harming a patient. If you do this as a medical student, it will eventually be found out.

8. The assessment is, at most, two medium-length sentences.
The assessment portion is where you gather all the previous information and formulate a differential or diagnosis. The assessment portion does not repeat the subjective and objective portions, but rather takes key points and puts them together into a conclusion. Don’t be afraid to take a stand! The more sentences you’re writing in this section, the more hedging you’re doing, and the less effective your note becomes.

Mr. Johnson is a 48 year old male with a history of diabetes, HTN, current cocaine use, who presents with left-sided chest pain and sweating and ST elevation on EKG. Labs are pending. This is most concerning for an acute MI, but may also represent drug-induced vasospasm.

Mr. Johnson is a 48 year old male, history of diabetes, HTN, cocaine use, presenting with likely STEMI vs. drug-induced vasospasm.

Be sure to print your full name, title, and role underneath your signature. It is vitally important, from both legal and patient safety perspectives, that you identify yourself as a student on your notes. Though your note will be clear and compelling, if you followed this guide, it is not authoritative, and medical decisions should not be made using them. “MS” followed by your year number is sufficient, writing out “Medical Student” is better.
Here is an example of an average patient note:
Note that it is verbose at times, includes extraneous information, does not make use of readily-accepted abbreviations, and has a hedging assessment.

S: John Smith is a 53 year old AA male with chief complaint of back pain. It started on January 2, 2012, when the patient picked up a box of documents at work. He felt a sharp pain in his lower back which caused him to drop the box. Since then, he’s had almost constant pain at the same location, about 3/10 in the morning worsening to 5/10 at night. He describes the pain as alternatively stabbing or throbbing. It doesn’t move anywhere. He thinks it’s gotten a little better. He’s tried Icy-Hot, which he says improved the pain only temporarily. He hasn’t tried any medications. He doesn’t have belly pain, burning with urinating, urinary incontinence, nausea, fever, vomiting, or leg weakness. This pain has never happened before.

He has a PMH of diabetes (non-insulin dependent) and high blood pressure. He has not had any surgeries. He does not have any allergies. He is taking metformin 1000 mg bid, HCTZ 25 mg in AM, and ASA 81 mg. He has no relevant family history. Social history is non-contributory.

O: T 98.4 | BP 135/80 | P 75 | RR 18 | BMI 32
Gen – obese male in NAD
HEENT – PERLA, TM clear x 2, oropharynx clear with no exudates
CV – RRR no m/r/g, 2+ pulses x 4, good capillary refill
Pulm – CTAB no r/r/w, no dullness
Abd – + bowel sounds, soft nt/nd, aorta not appreciated
Back – no CVA tenderness, tender lumbar paraspinal muscles
Ext – no clubbing or cyanosis
Neuro – straight leg raise negative, Babinski downgoing

A/P: Mr. Smith is a 53 year old male presenting with lower back pain. Given the lack of concerning findings on exam, and the short duration of the pain, and the fact that the pain is relieved by Icy-Hot, this is most likely musculoskeletal sprain. Also possible is an acute disc herniation or vertebral fracture, though this is less likely.
- Continue activity as tolerated
- Stretching exercises
- Ibuprofen 800 mg q4h as necessary for pain
- Reassurance

/s/ Leo Spaceman, MS3
Here is an example of a well-written patient note:
Compared to the previous note, this note is (1) more concise and well-formatted, (2) does not sacrifice necessary information, and (3) has a more assertive and credible assessment.

S: John Smith is a 53 yo AA male. Chief complaint of back pain.
- Began 8 days ago when lifting heavy object at work
- 3-5/10, stabbing and throbbing, over lower back, non-radiating
- Worsened by activity, bettered by Icy-Hot
- No meds attempted
- Denies f/c/n/v, denies dysuria, urinary incontinence, leg weakness
- This is the first occurrence, he believes that it is improving slightly

PMH – NIDDM, HTN
PSH – no surgeries
NKDA
Meds – metformin 1000 mg bid, HCTZ 25 mg in AM, ASA 81 mg
FHx – mother w/diabetes, no bone or mineral metabolism history
SHx – office worker, one drink/week, no tobacco or drugs

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Ext – no clubbing or cyanosis
Neuro – straight leg raise negative, Babinski downgoing

A/P: 53 yo male with first occurrence lumbago, no alarm symptoms, likely MSK sprain.
- Continue activity as tolerated
- Stretching exercises
- Ibuprofen 800 mg q4h as necessary for pain
- Reassurance

/s/ Leo Spaceman, MS3
Medical Student