SOAP Chart

S

Subjective

The subjective section captures the patient's personal experiences, feelings, or perspectives regarding their health, often provided directly by the patient or someone close to them. It includes the chief complaint (CC), which is a brief statement of the patient's main concern, and the history of present illness (HPI), which elaborates on the CC with details such as onset, location, duration, and severity. Additional history, including medical, surgical, family, and social history, is also documented to provide context.

O

Objective

It contains measurable, observable data from the patient encounter. This includes vital signs, physical exam findings, and diagnostic results such as lab tests, imaging, and other objective assessments. Documentation from other clinicians may also be included to provide a complete clinical picture.

A

Assessment

The assessment combines subjective and objective data to analyze the patient's condition and arrive at a diagnosis. It includes a prioritized problem list, differential diagnoses with reasoning for their likelihood, and an explanation of the clinical decision-making process. This section synthesizes all relevant information to provide a clear understanding of the patient's health status.

P

Plan

The plan outlines the steps for addressing the patient's health concerns, including diagnostic testing, treatment, referrals, and patient education. Each problem is addressed individually, detailing specific actions such as further tests, therapies, or consultations. This section ensures continuity of care and guides future clinicians in managing the patient's condition.

Podder, V., Lew, V., & Ghassemzadeh, S. (2023, August 28). *SOAP notes.* National Library of Medicine; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK482263/