S.O.A.P. NOTE
(SAMPLE 2)

January 1, 2050
Joe Sample - General Medicine sample

SUBJECTIVE:
24M presents to office for annual physical exam. Denies all other complaints at this time.

ROS:
Constitutional: Denies fever, chills, nausea, vomiting
Cardiovascular: Denies chest pain, palpitations
Respiratory: Denies shortness of breath, cough
Abdominal: Denies diarrhea, vomiting, constipation
Neuro: Denies numbness, tingling
MSK: Denies myalgia, falls
Derm: Denies rashes, lesions

Illnesses: none
Medications: Albuterol PRN
Allergies: NKDA (No known drug allergies)
Past Medical History: Asthma, diagnosed at 5 y/o
Past Surgical History: Appendectomy 16 y/o, no complications.

Family History: Mother - Healthy, Father - T2DM.
Social History: Denies tobacco, alcohol and illicit drug use. Exercises 20min/day by jogging. Diet mostly fast food, drive-thru.

OBJECTIVE:

Vitals:

- Temperature – (36.6 C) o
- Heart Rate – (89 beats/min) o
- Respiratory Rate – (19 breaths/min) o
- Blood Pressure – (129/81 mmHg) o
- Pulse Oximetry – (93 SpO2) o
- Pain Scale – (7/10)

Physical Exam:

Gen: NAD, cooperative, appropriate hygiene

HEENT: no conjunctival redness or discharge b/l, TMs intact and clear b/l without redness or effusion, throat non-erythematous without tonsillar erythema or discharge, nasal mucosa erythematous and boggy, maxillary and frontal sinuses are non-tender to palpation and percussion b/l

Derm: No lesions, rashes, bruising, or erythema noted throughout.

Neck: trachea midline, no cervical lymphadenopathy noted

CV: RRR without murmurs, gallops, or /rubs

Resp: No asymmetry or retractions noted on inspection, clear to auscultation b/l. No crackles, tactile fremitus, or egophony noted b/l. Chest expansion symmetrical bilaterally.

Neuro: CN II-XII intact B/L. A/O x 4. 5/5 MS in B/L UE and LE across the elbow and knee joints. +2/4 DTRs at biceps and patellar tendons B/L. Gross sensation to light touch intact at C6 and L5 dermatomes B/L. Gait coordinated and stable. Negative Romberg test.

Extremities: Cap refill <2 sec b/l (toes), no cyanosis noted on LE b/l.

ASSESSMENT:

24M with history of asthma. Physical exams with normal findings.

PLAN:

Counseled on inappropriate diet. Counseled patient on if asthma exacerbation occurs more than 2 days/wk or 3-4 night-time awakenings per month or inhaler use increases, add inhaled corticosteroids. Follow-up in 1 year.