SOAP Note Template: This is a SOAP note template for the type of SOAP note that you will be expected to write while on the wards. These notes will vary in length and content between specialties, but this is just to get you started in thinking about how to write them. These are usually relatively short notes that are written to communicate and document the patient's current status and plan of care as opposed to complete histories and physicals which are usually done at time of admission to the hospital. They are not meant to convey everything about the patient; they are meant to relay pertinent information in a relatively concise fashion. This note style is a little different from what you will be expected to do for your senior OSCE and Step 2 CS, but more like what you will do when you are on clerkships.

Subjective:

- Chief complaint
- History of present illness (OLDCARTS)
- Pertinent review of systems
- Pertinent past medical history, family history, lifestyle, social factors

Objective:

- Vital signs
- Targeted physical exam findings (pertinent negative and positive findings)
- Medications and allergies
- Labs/diagnostic tests that have already been completed

Assessment:

- Differential diagnosis (usually in most likely order with probable etiologies)

Plan:

- Plan of treatment for each diagnosis

***SOAP notes will vary dramatically between specialties and providers. This is a rough guideline only – make sure to talk to preceptors about their specific expectations.