



ReasonNotes

FREE CLINICAL RESOURCE

Primary Care Note Templates

Visit templates for annual exams, acute visits and chronic disease follow-ups.

Free to use and share in your practice.

Want notes written for you? Try ReasonNotes free at reasonnotes.com

TEMPLATE 1: Annual Physical Exam (SOAP)

SUBJECTIVE

Patient presents for annual physical examination. Reports feeling [well/concerns]. Current medications: [list]. Allergies: [list]. Social history: [tobacco/alcohol/exercise]. Family history: [relevant updates].

OBJECTIVE

Vital signs: BP [value], HR [value], Temp [value], Weight [value], BMI [value]. General appearance: [well-appearing/ill-appearing]. HEENT: [normal/abnormal findings]. Cardiovascular: [RRR/murmur]. Pulmonary: [clear/abnormal]. Abdomen: [soft/tender]. Extremities: [no edema/abnormal]. Neurologic: [intact/deficits].

ASSESSMENT

1. Health maintenance - due for [screenings].
2. [Chronic conditions] - stable/needs adjustment.
3. [New concerns] - [assessment]. Overall health status: [excellent/good/fair/poor].

PLAN

1. Continue current medications.
2. Order [lab work/imaging/screenings].
3. Lifestyle counseling: [diet/exercise/smoking cessation].
4. Follow-up in [timeframe].
5. Return PRN for concerns.

TEMPLATE 2: Diabetes Follow-up (SOAP)

SUBJECTIVE

Patient with Type [1/2] diabetes returns for routine follow-up. Blood sugars: [range/pattern]. Adherence to medications: [good/poor]. Diet and exercise: [compliant/non-compliant]. Symptoms: [polyuria/polydipsia/blurred vision/none]. Foot care: [appropriate/needs education].

OBJECTIVE

Vital signs: BP [value], Weight [value], BMI [value]. General appearance: [well]. Cardiovascular: [normal/abnormal]. Extremities: [pulses intact, no ulcers/abnormal findings]. Neurologic: [sensation intact/diminished]. Labs: HbA1c [value], glucose [value].

ASSESSMENT

Type [1/2] diabetes mellitus - [well-controlled/poorly controlled]. HbA1c [value] ([improved/stable/worsened] from [previous value]). [Complications present/absent]: [retinopathy/nephropathy/neuropathy].

PLAN

1. Continue [current diabetes medications].
2. [Adjust/maintain] current regimen.
3. Diabetes education reinforced.
4. Order [labs/referrals].
5. Follow-up in [3 months].
6. Contact for blood sugar concerns.

TEMPLATE 3: Upper Respiratory Infection (SOAP)

SUBJECTIVE

Patient presents with [duration] history of [cough/congestion/sore throat/runny nose]. Associated symptoms: [fever/headache/body aches/fatigue]. Severity: [mild/moderate/severe]. Previous treatments tried: [OTC medications/home remedies]. No recent travel or sick contacts.

OBJECTIVE

Vital signs: Temp [value], BP [value], HR [value], O2 sat [value]. General appearance: [well/mildly ill]. HEENT: [nasal congestion/erythematous throat/normal TMs]. Neck: [no lymphadenopathy/tender nodes]. Pulmonary: [clear/rhonchi/wheezes]. No respiratory distress.

ASSESSMENT

Viral upper respiratory infection. No evidence of bacterial infection. Symptoms consistent with [common cold/viral syndrome]. No complications noted.

PLAN

1. Supportive care: rest, fluids, humidifier.
2. OTC medications: [acetaminophen/ibuprofen] for comfort.
3. [Throat lozenges/saline rinses].
4. Return if symptoms worsen or persist >10 days.
5. Return for fever >101.5°F or difficulty breathing.

PHYSICAL EXAM TEMPLATES

Cardiovascular:

Normal: Regular rate and rhythm, no murmurs, rubs, or gallops. PMI non-displaced. No peripheral edema. Pulses 2+ bilaterally.

Abnormal: Irregular rhythm, [systolic/diastolic] murmur grade [I-VI]/VI, [location]. [Edema/no edema]. Pulses [diminished/absent] in [location].

Pulmonary:

Normal: Clear to auscultation bilaterally. No wheezes, rales, or rhonchi. Good air movement. No respiratory distress.

Abnormal: [Wheezes/rales/rhonchi] in [location]. Diminished breath sounds [location]. [Tachypneic/dyspneic]. Use of accessory muscles.

Abdominal:

Normal: Soft, non-tender, non-distended. Bowel sounds present. No hepatosplenomegaly. No masses palpated.

Abnormal: [Tender/distended] in [location]. [Hypoactive/hyperactive] bowel sounds. [Hepatomegaly/splenomegaly]. Mass palpated in [location].

Neurologic:

Normal: Alert and oriented x3. Cranial nerves II-XII intact. Motor strength 5/5 throughout. Reflexes

2+ and symmetric. Sensation intact.

Abnormal: [Confused/disoriented]. CN [number] deficit: [description]. Motor strength [grade] in [location]. Reflexes [hyperactive/diminished]. Sensory deficit in [distribution].

PREVENTIVE CARE SCREENING GUIDELINES

- Hypertension: Adults 40+ or at increased risk, annually; ages 18-39 with normal BP, every 3-5 years (confirm outside the office)
- Diabetes: Adults 35-70 with overweight or obesity (BMI ≥ 25), every 3 years if normal
- Cholesterol: Adults 40-75, or earlier with risk factors, every 4-6 years if normal
- Colorectal Cancer: Adults 45-75, colonoscopy every 10 years or FIT annually
- Mammography: Women 40-74, every 2 years