



ReasonNotes

FREE CLINICAL RESOURCE

SOAP Note Template

A fill-in template for Subjective, Objective, Assessment and Plan notes.

Free to use and share in your practice.

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SUBJECTIVE

- Chief Complaint: [Patient's main concern in their own words]
- History of Present Illness: [Detailed description of current symptoms]
- Review of Systems: [Relevant positive/negative findings]
- Past Medical History: [Relevant medical history]
- Medications: [Current medications and dosages]
- Allergies: [Known allergies and reactions]
- Social History: [Relevant social factors]

OBJECTIVE

- Vital Signs: BP ____ HR ____ RR ____ Temp ____ O2 Sat ____
- General Appearance: [Overall patient presentation]
- Physical Examination:
 - HEENT: [Head, eyes, ears, nose, throat findings]
 - Cardiovascular: [Heart examination findings]
 - Respiratory: [Lung examination findings]
 - Abdomen: [Abdominal examination findings]
 - Neurological: [Neurological examination findings]
- Diagnostic Results: [Lab results, imaging, etc.]

ASSESSMENT

- Primary Diagnosis: [Main diagnosis with ICD-10 code]
- Differential Diagnosis: [Alternative diagnoses considered]
- Secondary Diagnoses: [Additional relevant diagnoses]
- Clinical Impression: [Overall clinical assessment]

PLAN

- Medications: [Prescribed medications with dosages]
- Diagnostic Tests: [Ordered tests or procedures]
- Patient Education: [Information provided to patient]
- Follow-up: [Next appointment or monitoring plan]
- Referrals: [Specialist referrals if needed]
- Return Precautions: [When to seek immediate care]