THE SOAP OR FOCUSED PROGRESS NOTE

Content and Format

The format for recording a patient's focused clinic evaluation or daily inpatient progress takes the form of the *SOAP note* or *progress note*. These terms are sometimes used interchangeably. As this is a more focused record than the complete history and physical documentation, what is recorded is often limited to what is pertinent to the current problem or problems.

If you have completed a fairly thorough assessment of the patient with a great deal of detailed history, it is usually better to use the complete documentation format. Reserve the SOAP note format for abbreviated evaluations.

The four components of the note include:

(S) Subjective. This is usually recorded in two paragraphs. The first paragraph addresses the chief concern and complete history of present illness and includes pertinent positive and negative ROS. The second paragraph includes pertinent or significant portions of the past medical history, including medications, family history and social history. If the patient has several presenting problems, then include each problem in a separate paragraph followed by a paragraph describing past medical history, etc.

(O) Objective. Describe the physical exam findings in the first paragraph. In the second paragraph, list any diagnostic tests (x-rays or lab tests) either performed for the visit, or pertinent to the current visit.

(A) Assessment/Impression. Begin your assessment with a one-sentence summary of the problem. Enumerate each problem in one of two ways: either list the most acute or newest problem first, or list the most important problem first. In either case, follow the order of your subjective paragraphs.

For each problem include:
- statement of the problem
- differential diagnosis (acute problem) or status (chronic problem)
- clinical reasoning

(P) Plan. The plan should separate problems by number and will often have 4 components:
- Diagnostic testing
- Treatment plan
- Patient education
- Planned follow-up