SOAP Note

Office of:	
For office use only:	

Patient's Name _____ **Date**_____ **Age**_____

HISTORY

S (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale: ☐ Not done

NO PAIN WORST

Section I

CC

History of Present Illness **Level: HPI**

Elements		
☐	Location	
☐	Quality	
☐	Severity	
☐	Duration	
☐	Timing	
☐	Context	
☐	Modifying factors	
☐	Assoc. Signs and Sx	

OR Status of ≥ 3 chronic or inactive conditions

_____

_____

_____

☐	II III	
☐	IV V	

Review of Systems (Only ask / record those systems pertinent for this encounter.) ☐ **Not done** **Level: ROS**

☐	Constitutional (Wt loss, etc.)
☐	Eyes
☐	Ears, nose, mouth, throat
☐	Cardiovascular
☐	Respiratory
☐	Gastrointestinal
☐	Genitourinary
☐	Musculoskeletal
☐	Integumentary (skin, breast)
☐	Neurological
☐	Psychiatric
☐	Endocrine
☐	Hematologic/lymphatic
☐	Allergic/immunologic

Section II

☐	II	N
☐	III	1 to
☐	IV	2-
☐	V	≥