SOAP Note Example #2:

Date/Time: MSIII Progress Note - Medicine *(state which service)*

S: (*Subjective*) Patients noted no n/v (*nausea, vomiting*), no d/c (*diarrhea, constipation*) this am. +fever with shaking chills x 1 this am. Tolerated po (*oral intake*) well. No complaints of dysuria or abdominal pain. Last BM (*bowel movement)* 2 days ago. Patient continues to cough, productive of greenish-yellow sputum. No wheezing, hemoptysis, orthopnea or PND (*paroxysmal nocturnal dyspnea*), +SOB (*shortness of breath*), + pain on R side with deep inspiration. Slept poorly.

O: (*Objective*):
PE: (*physical examination)*
VS: *(vital signs)* T: 100.2, Tmax (*maximum temperature*) 102.6, BP 128/82 (115-130/72-84 (*range*)), RR: 20, HR: 98, regular, Pulse Ox 98% on 4L, I/O (*in's and out's*)=1.7/2.2 (*liters*).
Gen: A+O x 3 (*alert and oriented to person, place, and time*), flushed, moderate distress. MMM *(mucous membranes moist)*, fair skin turgor; WD/WN *(well-developed/well-nourished)*
HEENT: *(head, ears, eyes, nose, throat -- often combined into one description)*
Head: NC/AT *(normocephalic/atraumatic)*
Eyes: PERRLA *(pupils equal, round, and reactive to light and accommodation),* EOMI (*extraocular muscles intact*).
Ears: No erythema, no discharge, tympanic membrane intact.
Throat: No erythema or exudates. Tongue protrudes straight.
Neck: No nuchal rigidity, good ROM (*range of motion*); No masses/LAD *(lymphadenopathy)*
CV: RRR (*regular rate/rhythm*) S1/S2, no S3 or S4, no m/g/r (*murmurs, gallops, or rubs*)
Pulm: + R lower lobe dullness to percussion; increased tactile fremitis, increase BS *(breath sounds),* - bronchial BS, + whispered pectoriloquy; +fine crackles R lower third posteriorly. - w/r/r *(wheezes, rubs, or rhonchi).*
Abd: Soft, NT (*non-tender*) ND (*non-distended*), +BS (*bowel sounds*), no rebound, guarding, masses or HSM (*hepatosplenomegaly*); Heme + *(rectal exam positive for fecal occult blood)*
Ext: no c/c/e (*clubbing, cyanosis, edema*), 2+ DP/PT (*dorsalis pedis, posterior tibial*)
Neuro: CNI *(cranial nerves intact)*

Labs: None

A: (*Assessment*) 54 y/o white male PMH (*past medical history*) DK +Tob ppd x 20 years, with one day h/o CAP *(community-acquired pneumonia)*.

P: (*Plan*)
1. Pulm: Pneumonia Continue 02 4L, Day I Ceftriaxone I g q12 Codeine prn for pleuritic chest pain, Tylenol prn fever
2. Endocrine: DM Type II Continue Glipizide qd c (*with*) daily accu-checks
3. FEN: *(fluids/electrolytes/nutrition)* Full PO diet/liquids as tolerated. I/0's good, continue D51/2 NS @ 80 cc/hr
4. Dispo: Consult for Smoking Cessation Program

Jim Q. Student, MS III (*always sign notes*), *Pager #*