

EXAMPLES OF SOAP NOTES FOR ACUTE PROBLEMS

EXAMPLE #1

Complete HPI → S: MS is a 77 y/o woman who presents with a rash. The rash began one week ago and first appeared on her back and extended to her abdomen on the left side. She first noticed the rash after working in her garden. For the first 3 days she had no associated symptoms, however on the 4th day, she began to experience severe pain "like being stung by a bee". The pain is worse in the evenings and she is having difficulty sleeping. She has been taking Tylenol every 4-6 hours and using Vitamin E lotion with minimal relief. She is worried she may have poison ivy.

One paragraph summary of medical history & medications → She has a history of hypertension. Her medications include: Nifedipine XL 30mg daily and Metoprolol 30mg BID.

One sentence summary of the problem → O: MS is an elderly woman who appears energetic and is in no distress. VS: BP 130/80, P 60, RR 12, T 37°. Skin exam reveals an erythematous rash of grouped vesicles with clear fluid, approximately half of which are crusted over. The rash extends from the midline of the back anterior to the left side of the T12-L1 dermatome region.

Differential diagnosis and critical thinking for acute problem → A: A new onset painful rash in a dermatomal distribution. This is most likely secondary to herpes zoster because of the location, distribution and associated pain. A less likely possibility is contact dermatitis, given her recent gardening. She may also have a cellulitis, but the lack of temperature doesn't support this.

P: #1 MS will continue to use Tylenol for pain relief.
#2 MS was informed that she may continue to experience pain after the rash resolves.
#3 MS should return to clinic if the pain becomes more severe or if she develops warm, redness or a fever.

EXAMPLE #2

HPI with pertinent Hx → S: Ms. Z is a 58 y/o woman who comes into clinic with a 10-day h/o a cough. It seemed to start as a "chest cold" but has not gotten any better. The cough is productive of clear sputum and seems to be worse at night when lying down. She has tried cough medicine without relief. She has also noticed some wheezing and that her chest feels tight. She has had a low-grade fever to 100°, with no chills. She is worried she has pneumonia. She denies PHN and LE edema, but does report shortness of breath with exertion after walking 1 block on level ground. She has had no hemoptysis.

One sentence summary of problem → She has an h/o pulmonary problems. She has type 2 diabetes controlled on metformin 500mg BID. She smokes 1 ppd and has done so for 40 years.

O: Ms. Z looks tired and her breathing is somewhat labored.
VS: T 99.8, P 92 reg, R 28, BP 110/70
Lungs: Diffuse wheezes are present bilaterally with expiration. No crackles or rhonchi.
CV: JVP is 6cm above the right atrium, PMI non-displaced. RRR, no murmurs, normal S1 and S2.
EXT: No edema.
CXR: No pneumonia or effusion. No cardiomegaly.

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