EXAMPLES OF SOAP NOTES FOR CHRONIC PROBLEMS

EXAMPLE #1

S: Mr. O is a 63 y/o man seen today for follow-up 4 weeks after undergoing cardiac bypass surgery and for his hypertension. He has had no episodes of chest pain consistent with previous angina. He has had only minimal "stretching" chest discomfort at the site of his surgical incision on his chest wall. Mr. O describes no DOE and is able to take a brisk 2-3 mile walk daily without symptoms. He describes no PND or orthopnea. He reports no edema or any pain in his calves when exercising.

2nd paragraph for 2nd problem →

Mr. O has been checking his blood pressure twice a week. His values are usually 130-140/80-85. He has not experienced side effects from his medications.

3rd paragraph for past history, social history →

His past history is significant for CAD, MI in 1992 and hypercholesterolemia. He also has hypertension. His medications include lisinopril 20 mg daily, atenolol 50 mg daily, simvastatin 80 mg daily and ASA 325 mg daily. He and his wife have been adhering to a low-fat Mediterranean diet.

O: Generally, Mr. O is an elderly male, appearing younger than his stated age.
P 60 reg, BP 132/78, HT – 5'10", WT-200 lbs, BMI – 28.7
Neck: No JVD, 2+ carotids, no bruits
Lungs: Clear to auscultation
Chest wall: healing midline scar without erythema or discharge.
CV: RRR, NL S1 and S2, no murmurs
Extremities: Incision from vein harvest on R medial calf is healing without erythema or discharge.
Posterior tibial and dorsalis pedis pulses are 2+ bilaterally. No edema.

Status of the problems and clinical reasoning for chronic problems →

A: 63 y/o man seen for follow-up after surgery and for hypertension.
#1. Coronary artery disease, 12 weeks s/p bypass surgery. Doing well without angina or shortness of breath. Good exercise tolerance.
#2. Hypertension, well controlled on atenolol, since BP less than 140/90.

P: #1. CAD
Continue current medications.
Fasting lipid panel will be drawn today.
Follow-up appointment in 3 months.

#2. HTN
Check electrolytes today.
Encourage Mr. O to continue to monitor his blood pressure.

EXAMPLE #2

S: Ms. G is 64 y/o woman who comes in for follow-up of her HTN. She feels well. She does not have dizziness, headache or fatigue.

She has no past history other than hypertension. Her only medication is HCTZ at 25mg per day. She has lost 5lbs in the past 2 months, following a low-fat diet and walking 15 minutes a day. She drinks 1-2 glasses of wine each evening. She uses no OTC medications such as cold remedies or herbal remedies.

Status of the problem and clinical reasoning for a chronic problem

O: Generally, Ms. G is well appearing. Weight 160lbs, Height 65 inches, BMI ~27, Pulse 76 reg, BP 150/70. She has no lower extremity edema.

A: Ms. G is here for follow up of her hypertension. It is not well-controlled since blood pressure above goal of 140/90. A possible trigger to her poor control of HTN may be her alcohol use or presence of obesity.

P: #1 Continue low-fat diet and exercise. Consider increasing walking time to 20-30 minutes to assist with weight loss.
#2 Discussed alcohol use and relationship to HTN. Patient agrees to a trial of drinking wine only on weekend evenings.
#3 Check home BPs.
#4 Check potassium, since she is taking a diuretic.
#5 Follow-up in clinic in 1 month. Bring blood pressure diary to that visit. Consider adding ACE inhibitor at next visit if BP still elevated.

EXAMPLE #3

S: Ms. G is a 56 y/o female who comes in for follow-up of her diabetes. She has been checking her BS regularly and her fasting BS are all between 90-135. She does not have polyuria, polydipsia, or polyphagia. She has had no episodes or symptoms of hypoglycemia.

She has a past history of diabetes Type 2 for 5years. Medications include metformin 500 mg BID and atorvastatin 10 mg daily.

O: Generally healthy appearing, no acute distress. Weight 151lbs, Height 64 in., BMI 26 kg/m2. Sensory function of lower extremities intact to light touch.

HbA1C = 6.2 (2 weeks ago).

Status of the chronic problem and clinical reasoning

A: A 56 y/o female here for follow-up of diabetes. It is well-controlled with diet and weight loss. There are no symptoms of hyperglycemia or hypoglycemia and blood work confirms good glucose control.

P: #1 Continue to follow diabetic diet.
#2 Return to clinic in 3 months for follow-up.
#3 Check HbA1C and fasting lipids 1 week prior to next visit.

EXAMPLE OF A SOAP NOTE FOR AN ACUTE AND CHRONIC PROBLEM

S: Mrs. S. is a 45 y/o who comes in today for follow-up of her chronic obstructive pulmonary disease and for new onset of chest pain.

1st paragraph is the HPI for the acute problem

She has had 2-3 episodes of chest pain over the past week. Each episode of "compression"-like pain occurred at night and woke her up from her sleep. It has not occurred in the last 2 nights. She has never had pain like this before. She runs 2-3 miles every other day and has not had any accompanying chest pain or discomfort. These recent episodes of pain improved with positioning as propping herself up on 2 pillows seemed to relieve some of the discomfort. Lately, she has been eating larger meals, later at night than usual and that seems to coincide with the onset of her symptoms. She has no SOB, palpitations, nausea or diaphoresis.

2nd paragraph is the HPI for the chronic problem

Regarding her COPD, she has been experiencing less shortness of breath with activity since her last visit where her inhalers were changed. She is able to walk up a flight of stairs without shortness of breath. She is coughing only rarely.

3rd paragraph is medical history and medications

She has a past history of COPD. She has no history of high cholesterol or hypertension. Her medications include Aspirin 81 mg daily, Calcium Carbonate/Vitamin D 600 mg BID, combivent inhaler 2 puffs four times a day, albuterol inhaler as needed.

O: Generally thin, slightly anxious appearing. Weight 126 lbs (with shoes), Height 62 in., BMI 23 kg/m2, Pulse 70 reg., BP (sitting) 116/64.
Lungs: distinct breath sounds without wheezes.
CV: RRR, NL S1 and S2, no S3 or S4. No murmurs.
Abdomen: normal bowel sounds, no tenderness to palpation

A: A 45 y/o patient for chest pain and COPD.

Differential diagnosis and clinical reasoning for an acute problem

#1. Recent onset nocturnal chest pain. The chest pain is most likely is from GERD, given that it is only when recumbent and not present with exertion. Also, the change in her diet to eating larger meals at night is supportive. The chest pain could also be from heart disease though this seems less likely given no chest pain with exertion. The chest pain could also be due to chest wall strain as the pain improves with position.

Status of the problem and clinical reasoning for a chronic problem

#2. COPD doing well with recent changes in medications. Improved shortness of breath and no cough.

P: #1 Chest pain
She is advised to refrain from eating 2-3 hours prior to sleeping in order to prevent episodes of heartburn.
If her chest pain continues despite a change in eating habits, she will call the clinic for further advice.
Follow-up in 3-4 weeks to reassess chest pain.
Seek care immediate if pain begins occurring with activity.

#2 COPD
Continue medications for COPD.
Follow up in 3-4 weeks.