

NURSING SOAP NOTE TEMPLATE

SUBJECTIVE

DETAILS:

Patient's complaints, concerns, or symptoms in their own words. Include relevant medical, social, and family history

EXAMPLE:

1. **Chief Complaint:** "I've had a headache for the past [02] days." HPI: [45] year-old female patient reports experiencing a constant, throbbing headache for the past [02] days. Pain is localized to the right temple and rates it as a [7/10] on the pain scale. Reports no relief with over-the-counter pain medication. Denies any recent trauma or fever.
2. **Past Medical History:** [Hypertension, migraines, seasonal allergies]
3. **Family History:** [Mother with hypertension, father with diabetes, sister with migraines]
4. **Social History:** [Non-smoker, occasional alcohol use, no illicit drug use]

OBJECTIVE

DETAILS:

Vital signs and physical assessment findings and results from diagnostic tests

EXAMPLE:

1. **Vital Signs:** BP: [135/85] mmHg, HR: [78] bpm, RR: [16] breaths/min, Temp: [98.6°]F (37°C), SpO2: [98%]
2. **General Appearance:** [Alert, oriented, appears uncomfortable due to headache]
3. **HEENT:** [PERRLA, EOMI, no nystagmus, no discharge or erythema in ears or nose, oropharynx clear]
4. **Cardiovascular:** [S1, S2, regular rate and rhythm, no murmurs, rubs, or gallops]
5. **Respiratory:** [Clear to auscultation bilaterally, no wheezing, rales, or rhonchi]
6. **Abdomen:** [Soft, non-distended, no tenderness or guarding, bowel sounds present in all four quadrants]
7. **Extremities:** [No cyanosis, clubbing, or edema; pulses equal bilaterally]
8. **Neurological:** [Alert and oriented x3, cranial nerves II-XII grossly intact, normal gait, 5/5 strength bilaterally]

Soap Note Nursing Documentation

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