NURSING SOAP NOTE TEMPLATE

SUBJECTIVE

DETAILS:

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

EXAMPLE:

- Chief Complaint: "I've had a headache for the past [02] days." HPI: [45] yearold 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]
- 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:

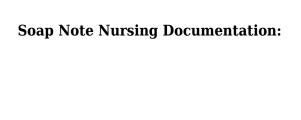
Vital signs and physical assessment findings and results from diagnostic tests

EXAMPLE:

- 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]
- HEENT: [PERRLA, EOMI, no nystagmus, no discharge or erythema in ears or nose, oropharynx clear]
- Cardiovascular: [S1, S2, regular rate and rhythm, no murmurs, rubs, or gallops]
- Respiratory: [Clear to auscultation bilaterally, no wheezing, rales, or rhonchi]
- Abdomen: [Soft, non-distended, no tenderness or guarding, bowel sounds present in all four quadrants]
- Extremities: [No cyanosis, clubbing, or edema; pulses equal bilaterally]
- Neurological: [Alert and oriented x3, cranial nerves II-XII grossly intact, normal gait, 5/5 strength bilaterally]

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