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]

What Is Soap In Nursing Documentation

Patricia W. lyer, Nancy Hand Camp

What Is Soap In Nursing Documentation:

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

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