

## ***SOAP Note Example #2:***

Date/Time: MSIII Progress Note - Medicine *(state which service)*

**S:** *(Subjective)* Patients noted no n/v *(nausea, vomiting)*, no d/c *(diarrhea, constipation)* this am. +fever with shaking chills x 1 this am. Tolerated po *(oral intake)* well. No complaints of dysuria or abdominal pain. Last BM *(bowel movement)* 2 days ago. Patient continues to cough, productive of greenish-yellow sputum. No wheezing, hemoptysis, orthopnea or PND *(paroxysmal nocturnal dyspnea)*, +SOB *(shortness of breath)*, + pain on R side with deep inspiration. Slept poorly.

**O:** *(Objective):*

PE: *(physical examination)*

VS: *(vital signs)* T: 100.2, Tmax *(maximum temperature)* 102.6, BP 128/82 (115-130/72-84 *(range)*), RR: 20, HR: 98, regular, Pulse Ox 98% on 4L, I/O *(in's and out's)*=1.7/2.2 *(liters)*.

Gen: A+O x 3 *(alert and oriented to person, place, and time)*, flushed, moderate distress. MMM *(mucous membranes moist)*, fair skin turgor; WD/WN *(well-developed/well-nourished)*

HEENT: *(head, ears, eyes, nose, throat -- often combined into one description)*

Head: NC/AT *(normocephalic/atraumatic)*

Eyes: PERRLA *(pupils equal, round, and reactive to light and accommodation)*, EOMI *(extraocular muscles intact)*.

Ears: No erythema, no discharge, tympanic membrane intact.

Throat: No erythema or exudates. Tongue protrudes straight.

Neck: No nuchal rigidity, good ROM *(range of motion)*; No masses/LAD *(lymphadenopathy)*

CV: RRR *(regular rate/rhythm)* S1/S2, no S3 or S4, no m/g/r *(murmurs, gallops, or rubs)*

Pulm: + R lower lobe dullness to percussion; increased tactile fremitis, increase BS *(breath sounds)*, - bronchial BS, + whispered pectoriloquy; +fine crackles R lower third posteriorly. - w/r/r *(wheezes, rubs, or rhonchi)*.

Abd: Soft, NT *(non-tender)* ND *(non-distended)*, +BS *(bowel sounds)*, no rebound, guarding, masses or HSM *(hepatosplenomegaly)*; Heme + *(rectal exam positive for fecal occult blood)*

Ext: no c/c/e *(clubbing, cyanosis, edema)*, 2+ DP/PT *(dorsalis pedis, posterior tibial)*

Neuro: CNI *(cranial nerves intact)*

Labs: None

**A:** *(Assessment)* 54 y/o white male PMH *(past medical history)* DK +Tob ppd x 20 years, with one day h/o CAP *(community-acquired pneumonia)*.

**P:** *(Plan)*

1. Pulm: Pneumonia Continue O2 4L, Day I Ceftriaxone I g q12 Codeine prn for pleuritic chest pain, Tylenol prn fever
2. Endocrine: DM Type II Continue Glipizide qd c *(with)* daily accu-checks
3. FEN: *(fluids/electrolytes/nutrition)* Full PO diet/liquids as tolerated. I/O's good, continue D51/2 NS @ 80 cc/hr
4. Dispo: Consult for Smoking Cessation Program

Jim Q. Student, MS III *(always sign notes)*, Pager #