Fill-in SOAP note

Free template from soapnotes.xyz. Fill it in by hand or type over it.

S: SUBJECTIVE

The patient reports [symptom or concern] for [how long].

Severity is [0 to 10]. It is better with [what helps] and worse with [what makes it worse].

Relevant history: [history, medications, allergies as reported].

O: OBJECTIVE

Vitals: [measurements].

Examination: [findings].

Tests or scores: [results].

A: ASSESSMENT

Your impression]. Compared with the last visit, the problem is [better / the same / worse] because [reason].

P: PLAN

Treatment: [what you will do or order].

Advice: [what the patient was told].

Follow-up: [when and why].

Educational template, not medical or legal advice. Follow your employer and regulator rules.