Veterinary SOAP note form

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VETERINARY SOAP NOTE

Patient _____

Patient ID or record number _____

Owner or caregiver _____

Date and time _____

Clinician _____

Reason for visit _____

Weight today _____

S: SUBJECTIVE (history from the owner)

Presenting complaint, in the owner's words:

When it started and how it has changed:

Appetite and water intake:

Vomiting, diarrhea, coughing, sneezing or other signs:

Urination and defecation:

Energy, activity and behavior:

Diet, treats and access to anything unusual (toxins, bones, plants, other animals):

Vaccination, parasite prevention and current medication (as reported):

Previous illness, surgery or allergies:

Home, environment and other pets:

Owner's main concern and goals for treatment:

O: OBJECTIVE (your findings)

Temperature, pulse and respiratory rate

Body condition score

Hydration, mucous membrane color and capillary refill time:

Demeanor and pain score (scale used):

Eyes, ears, nose and throat, mouth and teeth:

Heart and lungs:

Abdomen (palpation findings):

Skin, coat and lymph nodes:

Musculoskeletal, gait and neurological findings:

Urogenital and anal region:

Diagnostics performed and results (bloodwork, urinalysis, imaging, fecal, other):

Treatments given in the clinic (as ordered):

A: ASSESSMENT

Problem list, in order of importance:

Differential diagnoses for each problem, most likely first:

Working diagnosis, if there is one:

Prognosis and urgency:

P: PLAN

Further diagnostics (and why):

Treatment and medications prescribed (as ordered by the veterinarian):

Nursing care and home care (diet, rest, wound care):

What the owner was told, including options and costs discussed:

Owner consent or declined options:

Warning signs that should bring the patient back sooner:

Recheck date and who will contact the owner:

Signature and credentials:

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