



PATIENT NAME

MR / ID NO.

AGE / SEX

DATE

CLINICIAN

S

Subjective

What the patient reports — chief complaint and history, in their own words

CHIEF COMPLAINT

in the patient's own words

HISTORY OF PRESENTING ILLNESS

Onset · Location · Duration · Character · Aggravating/alleviating · Radiation · Timing · Symptoms

PMH · MEDICATIONS · ALLERGIES

SOCIAL · FAMILY · PERTINENT NEGATIVES

O

Objective

What you observe and measure — findings, not interpretation

BP

mmHg

Pulse

bpm

Temp

°C

Resp. rate

/min

SpO2

%

Weight

kg

EXAMINATION FINDINGS

system by system · include relevant normals

RESULTS AVAILABLE

labs · imaging · ECG · point-of-care tests

A

Assessment

Your interpretation — synthesise the findings, don't repeat the history

WORKING DIAGNOSIS + REASONING

DIFFERENTIAL DIAGNOSIS

ranked, most → least likely

P

Plan

Next steps — every item traced back to a problem in the assessment

INVESTIGATIONS

TREATMENT · PRESCRIPTIONS · REFERRALS

EDUCATION · FOLLOW-UP · SAFETY-NETTING

SIGNATURE & DATE



A SOAP note does two jobs: it records the encounter, and it structures your clinical reasoning so the next clinician can follow it. Use this guide alongside the template — four sections, one job each.

S Subjective — take the history with OLD CARTS**O Onset**

When and how it started — sudden or gradual.

L Location

Where it is, and whether it moves.

D Duration

How long; constant or intermittent.

C Character

Sharp, dull, burning, crushing, aching.

A Aggravating / alleviating

What makes it better or worse.

R Radiation

Where the symptom spreads to.

T Timing

Pattern over the day; triggers.

S Symptoms

Associated symptoms + pertinent negatives.

O Objective — record, don't interpret

- ✓ Vital signs, and trends where relevant
- ✓ Examination findings — include relevant normals
- ✓ Mental-state observations where appropriate
- ✓ Results already available: labs, imaging, ECG

“Crackles at the right base” goes here; “pneumonia” goes in A.

A Assessment — interpret, don't repeat

- ✓ Name the working diagnosis
- ✓ Rank a differential when there's uncertainty
- ✓ Say briefly why — show the reasoning
- ✓ Number each problem in complex patients

The commonest failing in any note: an assessment that just restates the history.

P Plan — the five components of a complete plan**01****Investigations**

Tests ordered, and why.

02**Treatment**

Drug, dose, route, duration; referrals.

03**Education**

What you explained and agreed.

04**Follow-up**

When, and with whom.

05**Safety-netting**

What should prompt an earlier return.

Every item in the plan should trace back to a problem you named in the assessment.

! Common mistakes to avoid

- ✗ Presenting reported symptoms as established fact
- ✗ A plan disconnected from the documented problems
- ✗ Missing safety-netting advice
- ✗ An assessment that only repeats the history
- ✗ Ambiguous or non-approved abbreviations
- ✗ Copy-forward bloat from earlier notes

COMING SOON · PRIVATE BETA

Talk to your patient. Let Shifaa AI write the note.

Shifaa AI drafts your SOAP note from the consultation — you review, edit and sign.

Join the beta →

Sources: StatPearls, “SOAP Notes”, NCBI Bookshelf (NBK482263). The SOAP structure originates from Dr Lawrence Weed's problem-oriented medical record. This guide is a documentation aid for qualified clinicians, not medical advice.