Introduction
If you already know how to write a History and Physical (and we know you do!), you can write a SOAP note. (Please review the document entitled “Writing a History and Physical” if needed.) SOAP notes are used for follow-up visits after the initial H&P or for a focused visit. SOAP notes are used in both inpatient and outpatient settings. During years 3 and 4, in most inpatient rotations you will admit a patient and write a full H&P at that time. For all subsequent daily evaluations until the patient is discharged you will write a SOAP note. For outpatient evaluations in years 3 and 4, the patient will more than likely have already established care with a physician in the clinic and thus be presenting for a follow-up visit regarding one or more problems. A SOAP note is also used in this setting. Your clinic attending will let you know if you are expected to perform and document a full H&P for a patient in an outpatient setting.

S (subjective)
This section corresponds to the HPI in an H&P plus any of the following sections that have not been documented in a previous H&P, is new or needs updating, or is pertinent to the presenting complaint: Allergies/adverse drug reactions, past medical and surgical history, medications, social history, high risk behaviors, family history and review of systems.

For most SOAP notes, the subjective portion will usually be comprised only of the HPI with pertinent parts of the other sections (including ROS) being incorporated into the HPI. However, always pay attention to medications (as these change frequently), allergies/adverse drug reactions (to confirm what is documented) and tobacco use.

For patients who are presenting for follow-up of more than one problem, you may wish to organize your Subjective section by problem, including the appropriate information under each problem heading.

O (objective)
This section corresponds to the physical exam and objective data (labs, radiographs, etc.) sections in an H&P. Remember to include vitals signs. For most SOAP notes, the parts of the physical exam performed and documented should directly relate to the presenting problem(s).

A/P (Assessment and Plan)
This corresponds to the A/P section of an H&P and there is no difference between them. As a reminder, this section includes your assessment of the problem, a discussion of the assessment, and the plan. Just as in an H&P, there should be an A/P for each of the problems a patient is presenting with or following up for.