Family & Community Medicine
UNIVERSITY OF TORONTO

SOAP Notes*

To document patient encounters, family doctors (and some other clinicians) use a "S.O.A.P." format. This is very similar to a "progress note" used when rounding on patients in the hospital but differs from the comprehensive Clinical Skills case report you have been learning to date.

This note provides the necessary information to reflect the history and relevant data to support the diagnosis or differential diagnosis for a particular patient encounter and documents the management plan for the patient including plans for follow-up.

The S.O.A.P. note is a stand-alone entry that should provide the reader enough information to understand the presenting problem and its subsequent management. This becomes particularly important as primary care is increasingly occurring in multidisciplinary/group settings. A good S.O.A.P. note provides all the necessary and relevant information, in a concise format and may be presented in sentences, point-form or a mixture of both formats.

During Family Medicine encounters, patients often present with more than one 'chief complaint' or 'problem'. In the S.O.A.P. note, each presenting problem (S.) should be numbered and then the corresponding information relating to each problem documented in the remaining sections (O.A.P.).

Please feel free to use this template to teach your FMLE student about how to format their SOAP note. You can also print this out or share this with your FMLE student.

What does SOAP mean?

S	Subjective *Your history.* • History of why they are here today. • Possibly relevant past history (TIP: most of the information is in patient's cumulative patient profile or CPP and that should be up to date).
O	Objective *Your exam. What you see/find?* • Choose exams relevant exam to visit. ○ For example: if upper respiratory illness will do head and neck, respiratory exam
A	Assessment *Your diagnosis/formulation/differential diagnoses.* • Your assessment/diagnosis of the situation. ○ For example: upper respiratory viral illness, ddx: pneumonia, postnasal drip.
P	Plan *What are you going to do? How will you manage the condition(s)?* • What you are doing with this visit? How do you want to manage the condition(s)? ○ For example: symptomatic management, reviewed with patient red flags and when to seek further assessments.

Source: Adapted from one of our own FMLE preceptors, Dr. Jeff Habert!

*For more details, please refer to the FMLE Student Handbook.