Army soap note

The SOAP note is the accepted method of medical record entries for the military. S: (subjective) - What the patient tells you. O: (objective) - Physical findings of the exam. A: (assessment) - Your interpretation of the patients condition. P: (plan) - Includes the following: 1. Medical treatment: includes use of meds, use of bandages, etc. 2. Additional diagnostics: which if any test which still might be needed. X-ray MRI ect.. 3. Special instructions, handouts, use of medications, side effects, etc. 4. Return to clinic: when and under what circumstances to return. Components of the SOAP note. . Medical History – Which gives you an idea of the patients problem before you start the physical exam of the patient. a. Patient data b. chief complaint 1. This is the reason for the patients visit. 2. Use direct quotes from patient. 3. Avoid using medical terms. c. Observations begin as soon as the patient walks through the door. d. Open ended questions will help you to get more complete and accurate information. e. Provider obstacles which are your attitude towards the individual or pre diagnosis of sick call ranger may prevent you from making an accurate judgment. . History of present illness/injury (HPI) f. Duration: when the illness/injury started. g. Type of pain: use the patients words to describe the type of pain. h. Location: have the patient explain, then have them point it out. i. : what makes it better or worse and is it constant or does it vary in intensity. j. Pain in different positions: does the pain vary with the change of the patients position. k. Medications/allergies: note any medications whether over the counter or not. Do the medications relate to the problem?

Take note of the patients allergies. l. Supplements: note any supplements the patient is taking along with vitamins so you are aware of the possible

interactions with the medication that may be given to the patient. m. Pertinent facts: facts which lead you to your diagnosis. Usually consist of classical signs and/or symptoms. I have found that the best way to get a person’s medical history is to using the SAMPLE and OPQRST. It’s a fast and easy way to recall the information that you need to provide to the PA or NCOIC.

S: Symptoms A: Allergies M: Medicine taken P: Past history of similar events L: Last meal E: Events leading up to illness or injury O: Onset – What caused the illness or injury, or what were you doing at the time P: Provocation/Position - what brought symptoms on, where is pain located. Q: Quality - sharp, dull, crushing etc... R: Radiation - does pain travel S: Severity/Symptoms Associated with or on a scale of 1 to 10, what other symptoms occur T: Timing/Triggers - occasional, constant, intermittent, only when I do this.

Lastly you need to provide a name(first, last and middle initial) phone number, date of birth, FULL social security number, sex, and rank/grade. All this information is provided in order to file the note into the patients medical records. It can also be used to contact the patient regarding an appointment or information we may further need to assist the patient in his medical needs. All notes must be signed by the individual that screened the patient. There are 2 reason for this one is to insure that nothing is added to the note, this protects both yourself and the patient.

It also allows the PA or NCOIC to speak with the individual that screened the patient for additional information regarding the patient or having them correct a deficiency with the note itself before being placed in the patients

medical history. Signing under the last portion of the note lets people know that the note has ended however do not mark any open space out, the PA may want to add additional information which he will then stamp verifying that he was the one who in fact added the information. Spc Singleton 68W10