# Clinical Progress Notes

**Purpose:** These SOAP-format (Subjective, Objective, Assessment, Plan) notes are used to document a patient's clinical status, treatment progress, and plan of care across multiple visits. This format ensures consistency and clarity in medical records.

## Patient Information

**Name:** {name}
**Date of Birth:** {dob}
**Patient ID:** {patientId}
**Visit Date:** {visitDate}
**Clinician:** {clinicianName}, {clinicianTitle}

## Subjective

**Chief Complaint:** {chiefComplaint}
**History of Present Illness:** {presentIllness}
**Patient Reported Symptoms:** {symptoms}
**Current Medications:** {currentMedications}
**Allergies:** {allergies}

## Objective

**Vital Signs:**

* Blood Pressure: {bloodPressure}
* Heart Rate: {heartRate}
* Respiratory Rate: {respiratoryRate}
* Temperature: {temperature}
* Oxygen Saturation: {oxygenSaturation}

**Physical Examination Findings:**

 {physicalExam}

## Assessment

{clinicalAssessment}

## Plan

**Treatment Plan:** {treatmentPlan}
**Medications Prescribed:** {medicationsPrescribed}
**Follow-up Instructions:** {followUp}
**Referrals:** {referrals}

## Additional Notes

{additionalNotes}

{#diagnoses}

### Diagnoses

* **{code}:** {description}

{/diagnoses}

{#procedures}

### Procedures Performed This Visit

* **{name}:** {details}

{/procedures}

## Signature

**Provider:** {clinicianName}, {clinicianTitle}
**Date Signed:** {signatureDate}