# SOAP Note

*This document follows the SOAP note format (Subjective, Objective, Assessment, Plan), a widely used method for documenting clinical encounters between healthcare providers and patients. It helps in maintaining structured, accurate, and effective medical records.*

## Patient Information

* **Name:** {name}
* **Date of Birth:** {dob}
* **Gender:** {gender}
* **Date of Visit:** {dateOfVisit}
* **Provider:** {providerName}

## Subjective

**Chief Complaint:** {chiefComplaint}

**History of Present Illness:** {hpi}

**Past Medical History:** {pastMedicalHistory}

**Medications:** {medications}

**Allergies:** {allergies}

**Social History:** {socialHistory}

**Review of Systems:** {reviewOfSystems}

## Objective

**Vital Signs:**

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

**Physical Exam Findings:**

{physicalExam}

**Diagnostic Test Results:**

{diagnosticResults}

## Assessment

**Primary Diagnosis:** {primaryDiagnosis}

**Differential Diagnoses:**

{differentialDiagnoses}

## Plan

**Treatment Plan:**

{treatmentPlan}

**Medications Prescribed:**

{#medicationsPrescribed}

* **{medName}** — {dosage}, {frequency}, {duration}

{/medicationsPrescribed}

**Recommendations/Instructions:**

{recommendations}

**Follow-Up:**

* Next Appointment: {nextAppointment}
* Provider to Follow-Up: {followUpProvider}

**Additional Notes:** {additionalNotes}