Writing Effective SOAP notes

Before you write your notes, organize your thoughts. For example, you do not need to write everything in the same order the patient reported it. Take a few minutes and think about what you need to include and in what order you want to write.
Remember: the note serves as a logical and concise document of all data directly relevant to the patient condition. It serves as a source of communication to all subsequent providers. It provides insight into your ability to identify the crucial information in both history and physical exam and to utilize that information to develop a logical approach to the management of the patient. Finally, it also serves as a medical legal document.

Subjective: The "history" section
HPI: include symptom dimensions, chronological narrative of patient's complaints, information obtained from other sources (always identify source if not the patient). Pertinent past medical history. Pertinent review of system. Current medications (list with daily dosages).
Experienced doctors obtain the clinical history in a problem-solving manner which is based on testing a hypothesis. It is still necessary to ask all the usual questions about a symptom (e.g. onset, course, severity, associated symptom, previous episodes etc.) but the format of the history of the presenting problem should be problem based. In order to perform the problem-solving method competently, it is necessary to have knowledge of the causes of each symptom and the symptoms of each disease.

Objective:
Exam findings including vitals, observations even if the patient is not examined (eg pacing the floor) as well as lab tests or diagnostic imaging results

Assessment: A description of the patient and major problem
Problem list: A numerical list of problems identified. All listed problems need to be supported by findings in subjective and objective areas above. Include important positives & negatives that inform the differential diagnosis & identify most likely diagnoses. Try to take the assessment of the major problem to the highest level of diagnosis that you can, for example, "low back sprain caused by radiculitis involving left 5th LS nerve root." Provide at least 2 differential diagnoses for the major new problem identified in your note

Plan: Your plan for the patient based on the problems you've identified-what to do, when to return and why, and if appropriate, any preventative care that may be required
Develop a diagnostic and treatment plan for each differential diagnosis. Your diagnostic plan may include tests, procedures, other laboratory studies, consultations, etc. Your treatment plan should include: a rational for their inclusion in the plan, patient education, pharmacotherapy if any, other therapeutic procedures. You must also address plans for follow-up (next scheduled visit, etc.). Document discussions of new medication or procedures including side effects, complications, & potential outcomes. Include patient education & any handouts provided.

Other issues to consider when writing SOAP notes:

1. Update the patient profile. How do you develop and maintain your patient profile?
2. Update medications at each visit, removing those no longer used by patient. Include over-the-counter medications in the medication list.
3. Update allergies during Periodic Health Exams or when prescribing a new medication.
4. How does your clinic track lab results, diagnostic imaging reports, consult letters and so to ensure the patient has completed the requested interventions? How do you ensure that results are signed off by you?
5. How to you integrate new information on a patient into your chart/EMR? Is that information in a consistent readily accessible location eg all labs are organized chronologically in a specific location; all consults are in a separate location and so on.
6. If a patient is admitted to hospital and their medications are changed, how do you address this in your medical record?