Clinical documents follow standardized formats. This guide explains the structure of the four most common record types you will encounter, with annotated examples.

The SOAP Note

SOAP notes are used for every patient encounter. Each section has a specific purpose:

Section	What It Contains	Key Terms to Know
S — Subjective	Patient's own words: chief complaint, history of present illness (HPI), review of systems (ROS), past medical history (PMHx), r	c/o, HPI, ROS, PMH, NKDA (no known drug allergies), Hx, r
O — Objective	Clinician's observations: vital signs, physical exam findings, lab/imaging results	BP, HR, RR, T, SpO2, WNL, NAD, A&O×3, CBC, BMP, CXR
A — Assessment	Clinical judgment: diagnosis or differential diagnoses, problem list	Dx, DDx, R/O (rule out), r/t (related to), ICD-10 codes
P — Plan	Treatment plan: medications, referrals, follow-up, patient education, orders	Rx, PRN, BID, IV, PO, F/U, consult, D/C, patient ed

Sample SOAP Note Excerpt (annotated):

S:	68 y/o M c/o chest pain ×2 days, 7/10, radiating to left arm. PMHx: HTN, DM type 2, hyperlipidemia. Meds: metoprolol, metformin, atorvastatin
O:	BP 158/96, HR 98, RR 18, T 37.0°C, SpO2 97% on RA. Exam: NAD, mild diaphoresis. Cardiac: regular rate, no murmurs. EKG: ST depressio
A:	1. Acute coronary syndrome (ACS) — R/O NSTEMI 2. Uncontrolled HTN 3. DM type 2, uncontrolled (HbA1c pending)
P:	Admit to CCU. Aspirin 325 mg PO STAT. Heparin drip per protocol. Cardiology consult. Serial troponins q6h. NPO pending cath.

The H&P; (History & Physical)

The H&P; is a comprehensive document completed upon hospital admission. It is more detailed than a SOAP note.

Section	Contents
Chief Complaint (CC)	Primary reason for the visit, in patient's words (1–2 sentences)
History of Present Illness (HPI)	OLDCARTS: Onset, Location, Duration, Character, Aggravating factors, Relieving factors, Timing, Severity
Past Medical History (PMH)	Prior diagnoses, surgeries, hospitalizations, immunizations
Medications	Current prescriptions, OTC drugs, supplements (name, dose, frequency, route)
Allergies	Drug, food, and environmental allergies + reaction type
Family History (FH)	First-degree relatives' significant diagnoses
Social History (SH)	Tobacco, alcohol, drugs; occupation; living situation; sexual history
Review of Systems (ROS)	Systematic head-to-toe symptom review by body system
Physical Exam (PE)	Objective findings: general appearance, HEENT, cardiac, pulmonary, abdominal, MSK, neuro, skin
Assessment & Plan	Same as SOAP note A and P sections

Discharge Summary

Completed when a patient leaves the hospital. Provides continuity of care for outpatient providers.

Field	What It Includes
Admission date / Discharge date	Length of stay

Field	What It Includes
Attending physician	Responsible clinician
Admitting diagnosis	Why patient was admitted
Discharge diagnosis	Final confirmed diagnosis (may differ from admission Dx)
Hospital course	Chronological summary of events, treatments, procedures, response to therapy
Procedures performed	Surgeries, imaging, biopsies, procedures with dates
Condition at discharge	Stable, improved, guarded, critical, deceased
Discharge medications	Complete med list with doses and instructions
Follow-up instructions	Appointments, wound care, activity restrictions, diet
Pending results	Labs or studies not yet resulted at time of discharge

Operative Report

Created after every surgical procedure. Legal document describing exactly what was done in the OR.

Field	Meaning
Preoperative diagnosis	Reason for surgery before the procedure
Postoperative diagnosis	Confirmed diagnosis after procedure (may change)
Procedure performed	Name of the surgery (e.g., laparoscopic cholecystectomy)
Surgeon / Assistants	Names and roles
Anesthesia type	GA, regional, local, MAC
Estimated blood loss (EBL)	Blood lost during surgery (mL)
Specimens	Tissue sent to pathology
Findings	What was observed intraoperatively
Complications	Any intraoperative issues
Disposition	Where patient went after surgery (PACU, ICU, floor)

Common Documentation Terms

Term	Meaning
Attending	Supervising/responsible physician
Consult	Request for specialty opinion
Interval history	Changes since last visit
Pertinent positives/negatives	Relevant present/absent findings
OLDCARTS	Mnemonic for HPI: Onset, Location, Duration, Character, Aggravating, Relieving, Timing, Severity
Chief complaint (CC)	Primary reason for the encounter
Working diagnosis	Best current diagnosis pending confirmation
Differential diagnosis (DDx)	List of possible diagnoses being considered
Impression	Clinician's overall assessment