

Internal medicine SOAP note example

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A fictional internal medicine SOAP note example that keeps multiple active problems, data review, uncertainty, and follow-up linked in a problem-oriented structure.

Clinical boundary

This example is educational and omits many encounter-specific details. It does not establish medical necessity, coding level, diagnosis, medication safety, or a complete internal medicine assessment.

Fictional SOAP example

Subjective

Fictional adult patient returns after a recent outside-care visit. The patient reports improved exertional tolerance compared with last week but continues to notice mild fatigue.

They report taking the current medication list as recorded, but one discharge medication name is uncertain. No new chest pressure, syncope, fever, or resting shortness of breath is reported in this example.

Objective

Vital signs and focused examination findings are entered from today's encounter. An outside discharge summary is available, while the most recent laboratory result referenced by the patient has not yet been received.

The medication list contains one item marked for reconciliation rather than silently copied forward as confirmed.

Assessment

1. Post-discharge fatigue and reduced exercise tolerance, improving by patient report. The cause remains uncertain because the outside result and final medication reconciliation are not yet available.
2. Previously documented hypertension, with today's status interpreted in the context of current readings and the unresolved discharge medication list.
3. Information gap: outside laboratory data and one medication require confirmation before the record can support a complete longitudinal assessment.

Plan

Request and review the outstanding outside record and laboratory result. Reconcile the medication list with the patient and dispensing record as appropriate.

The treating clinician determines problem-specific testing, medication, follow-up interval, and escalation instructions after integrating the full history, examination, and verified data.

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Information source and reliability

Problem-oriented interval history

Medication and allergy reconciliation

Relevant review of systems

Focused examination and vital signs

Data dates, trends, and pending items

Numbered problem representation

Problem-linked plan, contingencies, and follow-up

Review checklist

- Historian and unresolved information gaps
- Medication reconciliation after transitions of care
- Dates and sources for outside data
- A separate Assessment and Plan link for each active problem

Sources consulted

NCBI Bookshelf, SOAP Notes: <https://www.ncbi.nlm.nih.gov/books/NBK482263/>

AAFP, Writing Clinical Notes: Have We Made Progress?: <https://www.aafp.org/fpm/2022/0700/writing-clinical-notes>

ACP, State of the Note Summit: Primary Care: <https://www.acponline.org/sites/default/files/documents/practice-resources/business-resources/coding/state-of-the-note-summit-2021/sotn21-primarycare.pdf>