The following suggestions may be helpful as you practice SOAP documentation of patient encounters in primary health care settings:

1. Always record height and weight and note percentage of ideal.
2. Be sure to record pertinent negatives and significant positives.
3. Be sure data is sufficient to warrant assessment conclusion.
4. Distinguish onset and course of presentation.
5. Always address sleep, appetite, mental status, development.
6. Be sure to address the “Do not miss” rule outs for the presenting symptom.
7. Use a targeted assessment approach for the symptom that presents.
8. Consider the related body systems to the presenting complaint.
9. Remember that problems like hepatitis can present as another system; e.g., URI.
10. For lungs, always note if there is wheezing, it can be clear and still wheeze.
11. Note that findings are “bilateral” whenever warranted; e.g., nares patent bil.
12. Always think foreign body in young children.
14. Use appropriate terminology, e.g., pharynx instead of “throat.”
15. Use a list of derm presentations; e.g., punctate means point.
16. With URI or HEENT, note if neck is nontender and supple.
17. Always document that client was warned about sedating effects of meds.
18. Document med. effects clearly; e.g., “instructed to avoid operating car or...”
19. Note follow-up directions given; e.g., RTC in 10 days or if symptoms increase.
20. With ABT treatment, note RTC with first sign of rash or SOB or if T or Sx incr.

This is just a start. Use this list to add your own “tips” and guidelines for SOAP documentation. Remember that the documentation is constructed of several major components:

- the presenting problem or chief complaint
- the patient profile, past medical history, family and social history
- the preventive health screening questions and baseline questions for everyone
- the developmentally appropriate concerns
- the review of systems
- the SOAP of the chief complaint or present illness