PRENATAL SOAP NOTE

Student Name
Date of Clinic Visit
Patient's Name
Preceptor's Name

S (SUBJECTIVE)
Information related to the physician from the patient directly. This would include the chief complaint with history and pertinent questions related to the complaint. For the prenatal visit this would include such things as symptoms that have occurred since the previous visit. Also, questions that the physician may want to know – Have you been having nausea/vomiting?-Have you had any vaginal bleeding?- Have you felt any movement from the baby?

Example: 25 year old Gravida I Para 0-0-0-0 female complains of nausea in the morning for the past 2 weeks. She has been able to tolerate the nausea because it usually subsides by 10 am. She is very active with a full-time legal aid position, but has noted more fatigue at the end of the day. She has not had any vaginal bleeding. She has not felt fetal movement as of this time.

O (OBJECTIVE)
Clinical data such as vital signs and physical findings (Uterine size, Fetal Heart Tones, Urinalysis –done at each visit). Laboratory results. Ultrasound findings.

Example: B.P. 120/80 P 72 Weight 130
Uterine Size about 2cm below the umbilicus FHT 120
Urinalysis – negative

A (ASSESSMENT)
Diagnosis/Opinion of the patient at this visit (may be more than one diagnosis)

Example: 12 weeks gestation with nausea

P (PLAN)
What actions you want the patient to do and what actions you will do in the future (further testing and visits)

Example: 1. Continue taking prenatal vitamins
2. Supportive care for nausea – to notify me if increased problems
3. Offer childbirth classes in the future.
4. Appointment in 4 weeks with UA