

COMPLETED SOAP NOTE EXAMPLE

Educational example showing how S, O, A, and P connect in a complete note

Patient / Client: Emily R.	Date: May 13, 2026	Time: 09:30
Student: Alex M., Nursing Student	Course / Clinical: Medical-Surgical Clinical	Setting: Urgent Care

S

SUBJECTIVE | *What the patient reports*

Chief Complaint / Reason for Visit

"I've had a bad headache and feel nauseated."

History of Present Illness / Current Symptoms

Patient reports a headache that began last night and has progressively worsened this morning. Rates pain 7/10 and describes it as throbbing. Bright light increases the pain; resting in a quiet, dark room provides some relief.

Associated Symptoms / Pertinent Negatives

Reports nausea and sensitivity to light. Denies vomiting, fever, chest pain, shortness of breath, recent head injury, weakness, numbness, or confusion.

Relevant History / Patient Concern

Reports a history of migraines and states the current symptoms feel similar to previous episodes. Patient would like relief from pain and nausea.

O

OBJECTIVE | *What you observe, measure, or verify*

Vital Signs

Temp 98.6°F (37°C); HR 88 bpm; RR 18/min; BP 124/78 mmHg; SpO₂ 98% on room air.

Physical Assessment / Observable Findings

Patient appears uncomfortable and shields eyes from bright light. Alert and oriented ×4. Speech clear. Pupils equal, round, and reactive to light. No obvious facial asymmetry or focal neurological deficit observed. Ambulates without assistance.

Other Objective Data

No vomiting observed during assessment. Skin warm and dry. Patient able to tolerate small sips of water.

A

ASSESSMENT | *What the findings indicate*

Nursing Problem / Clinical Impression

Acute pain consistent with reported migraine symptoms, evidenced by throbbing headache rated 7/10, photophobia, nausea, and history of similar migraine episodes.

Supporting Findings / Current Status

Patient is hemodynamically stable with no observed acute neurological deficits. Nausea is present without vomiting; oral fluid intake is currently tolerated.

P

PLAN | *What happens next*

Interventions

Provide a quiet, dimly lit environment and encourage rest. Administer prescribed analgesic or anti-migraine medication as ordered. Encourage oral fluids as tolerated.

Monitoring / Reassessment

Monitor pain intensity, nausea, vital signs, and neurological status. Reassess pain and response to interventions within 30–60 minutes.

Patient Education

Teach patient to report worsening headache, persistent vomiting, visual changes, weakness, numbness, confusion, or other new symptoms. Reinforce medication and hydration instructions.

Follow-Up / Escalation

Follow provider instructions for ongoing management. Notify the appropriate provider if symptoms worsen, new neurological findings develop, or pain is not adequately relieved.

WHY THIS EXAMPLE WORKS

- S** The symptoms, pain description, history, and concerns are reported by the patient.
- O** Vital signs and assessment findings are observable or measurable.
- A** The assessment synthesizes S + O instead of simply repeating them.
- P** The plan responds directly to the identified problem and includes reassessment, education, and escalation.

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Educational example only. Follow your instructor, nursing program, or clinical site's documentation requirements.