SOAP Note Details by Specialty.

A quick reference for each specialty: reminders of what to dictate in every SOAP section so your notes come out complete the first time. Glance at your specialty before or during the visit and cover the details that matter for Subjective, Objective, Assessment, and Plan. Copy-and-paste versions are in the accompanying **.md** file.

Allergy & Immunology · SOAP

Subjective	Allergy/immunologic complaint with timeline and seasonality; suspected triggers and exposures; prior reactions and severity; current medications (antihistamines, steroids, biologics); environmental and occupational history
Objective	Vitals; focused exam of skin, nasal mucosa, conjunctiva, and chest; in-office testing (skin-prick/intradermal, spirometry, peak flow); prior IgE and lab results
Assessment	Diagnosis and reasoning (allergic rhinitis, asthma, urticaria, anaphylaxis risk); control status; ICD-10 per problem
Plan	Avoidance guidance; pharmacotherapy; immunotherapy plan; anaphylaxis action plan and epinephrine; testing ordered; follow-up interval

Cardiology · SOAP

Subjective	Cardiac complaint (chest pain, dyspnea, palpitations, syncope) with onset and character; exertional tolerance; cardiac risk factors; current cardiac medications and adherence
Objective	Vitals including BP in both arms; cardiac, pulmonary, and vascular exam; edema; ECG; echo, stress, and lab results reviewed
Assessment	Diagnosis and reasoning (CAD, heart failure, arrhythmia, hypertension); risk stratification; ICD-10 per problem
Plan	Medication changes; diagnostics ordered (echo, stress test, monitor); procedures or referrals; risk-factor modification; follow-up

Chiropractic · SOAP

Subjective	Chief complaint and mechanism; pain scale and quality; aggravating and relieving factors; activities of daily living affected
Objective	Posture and gait; palpation findings; ranges of motion; orthopedic and neurologic tests; segmental levels addressed
Assessment	Diagnosis; subluxation/segmental findings; clinical rationale; response to prior care
Plan	Adjustments/manipulation by region; modalities; home care; visit frequency and re-exam interval

Dermatology · SOAP

Subjective	Skin complaint with lesion timeline and evolution; symptoms (itch, pain); prior treatments; sun-exposure and skin-cancer history; relevant medications
Objective	Full or regional skin exam; lesion morphology (type, size, color, distribution, borders); dermoscopy; body-site diagram; procedures (biopsy) with site
Assessment	Diagnosis and differential; benign versus concerning features; pathology pending; ICD-10
Plan	Topical or systemic therapy; procedure plan; biopsy/pathology follow-up; sun-protection counseling; recheck interval

Emergency Medicine · SOAP

Subjective	Chief complaint and HPI; symptom onset and severity; pertinent ROS; PMH, medications, allergies; mode of arrival; code status
Objective	Vitals and trends; focused exam by system; ECG; point-of-care, lab, and imaging results; reassessments
Assessment	Working diagnosis and differential; risk stratification; clinical course; medical decision-making complexity
Plan	Interventions and response; consults; disposition (admit, discharge, transfer); return precautions; follow-up

Endocrinology · SOAP

Subjective	Endocrine complaint; symptom review (weight, energy, thirst, menstrual changes); glucose and BP logs; current medications and insulin; adherence and hypoglycemia episodes
Objective	Vitals and BMI; focused exam (thyroid, skin, feet, neuro); labs (A1c, TSH, lipids, hormone panels); CGM or glucose data
Assessment	Diagnosis and control status (diabetes, thyroid, adrenal, bone); complication screening; ICD-10 per problem
Plan	Medication titration and targets; labs ordered; lifestyle counseling; screening; follow-up interval

ENT / Otolaryngology · SOAP

Subjective	ENT complaint (hearing, ear pain, nasal, throat, voice, dizziness); duration; prior treatments; relevant history
Objective	Head and neck exam; otoscopy; nasal endoscopy/rhinoscopy; oropharynx; neck and lymph-node exam; audiogram or scope findings
Assessment	Diagnosis and differential with laterality; ICD-10
Plan	Medical therapy; procedures (cerumen removal, scope, biopsy); imaging or audiology ordered; surgical planning; follow-up

Family Medicine · SOAP

Subjective	HPI in the patient's words; ROS; current medications; allergies; social and family history; preventive-care concerns
Objective	Vitals; focused exam by system; in-visit results; screening measures
Assessment	Problem list with clinical reasoning; chronic-disease control; ICD-10 per problem
Plan	Orders, prescriptions, referrals; patient education; preventive care due; follow-up interval

Gastroenterology · SOAP

Subjective	GI complaint (abdominal pain, bowel changes, reflux, bleeding); diet and weight change; medications; prior scopes and imaging; family GI/cancer history
Objective	Vitals; abdominal exam; rectal exam if indicated; labs (LFTs, CBC); imaging or endoscopy findings
Assessment	Diagnosis and differential; severity and risk; ICD-10
Plan	Medications; dietary guidance; endoscopy or imaging ordered; labs; follow-up and screening intervals

Internal Medicine · SOAP

Subjective	HPI; comprehensive ROS; chronic-problem updates; current medications and adherence; allergies; social history
Objective	Vitals; complete or focused exam by system; in-visit and recent results
Assessment	Problem list with reasoning across comorbidities; control status; ICD-10 per problem
Plan	Medication management; diagnostics; referrals; preventive care; follow-up

Neurology · SOAP

Subjective	Neurologic complaint (headache, weakness, numbness, seizure, memory) with onset and course; triggers; current neuro medications; functional impact
Objective	Mental status; cranial nerves; motor and sensory exam; reflexes; coordination and gait; imaging, EEG, or EMG results
Assessment	Localization and diagnosis/differential with clinical reasoning; ICD-10
Plan	Medications; diagnostics (MRI, EEG, EMG, LP); referrals; safety counseling; follow-up

OB/GYN · SOAP

Subjective	Reproductive/gynecologic complaint or prenatal update; LMP and gestational age; menstrual and obstetric history; contraception; symptoms; current medications
Objective	Vitals (BP, weight); abdominal and pelvic exam; fundal height and fetal heart rate if prenatal; Pap, lab, and ultrasound results
Assessment	Diagnosis or pregnancy status and dating; risk factors; ICD-10
Plan	Management and prescriptions; screening (Pap, labs, ultrasound); prenatal schedule; counseling; follow-up

Oncology · SOAP

Subjective	Cancer history and current treatment phase; symptom and toxicity review; performance status; pain; current regimen and tolerance
Objective	Vitals and weight; focused exam; labs (CBC, CMP, tumor markers); imaging or restaging results; ECOG status
Assessment	Diagnosis with stage; treatment response; toxicity grading; ICD-10
Plan	Treatment plan and cycle; supportive care; labs and imaging; dose adjustments; goals-of-care discussion; follow-up

Ophthalmology · SOAP

Subjective	Eye complaint (vision change, pain, redness, floaters) with onset and laterality; prior eye history and surgery; current drops and medications
Objective	Visual acuity; intraocular pressure; pupils; external and slit-lamp exam; dilated fundus exam; OCT or visual fields
Assessment	Diagnosis by eye (OD/OS/OU) and differential; ICD-10
Plan	Drops or medications; procedures or laser; imaging; referral; follow-up interval

Orthopedics · SOAP

Subjective	Musculoskeletal complaint with mechanism or injury; pain (location, NPRS); functional limits; prior treatment and imaging
Objective	Inspection and palpation; ROM and strength; special tests by joint; neurovascular status; imaging findings
Assessment	Diagnosis with laterality; operative versus nonoperative reasoning; ICD-10
Plan	Conservative care (bracing, PT, injections); surgical planning and consent; imaging; activity restrictions; follow-up

Pediatrics · SOAP

Subjective	Caregiver/patient concern with symptom timeline; feeding, sleep, and behavior; immunization status; developmental concerns; medications and allergies
Objective	Growth parameters and percentiles; vitals; age-appropriate exam; developmental screening
Assessment	Diagnosis and differential; growth and development assessment; ICD-10
Plan	Treatment with weight-based dosing; immunizations; anticipatory guidance; screening; follow-up

Physical Therapy · SOAP

Subjective	Patient-reported status and change since last visit; pain (NPRS) with location and laterality; functional limitations; home-exercise-program compliance; new complaints
Objective	ROM (degrees by joint/side); manual muscle testing grades; special tests; standardized outcomes (LEFS/ODI/DASH) with change from baseline; interventions with CPT code and exact timed minutes
Assessment	Skilled clinical reasoning; progress toward goals; medical necessity for continued skilled care; response and barriers
Plan	Frequency and duration; planned progression; next-visit focus; plan-of-care certification/recertification status; progress-report due date

Psychiatry & Mental Health · SOAP

Subjective	Presenting concerns; mood, anxiety, sleep, and appetite; safety (suicidal/homicidal ideation); stressors; substance use; current psychiatric medications and adherence; therapy
Objective	Mental status exam (appearance, behavior, speech, mood/affect, thought, cognition, insight); screening scores (PHQ-9, GAD-7)
Assessment	Diagnosis and differential (DSM-5); risk assessment; ICD-10
Plan	Medication management; therapy or referral; safety plan; labs and monitoring; follow-up interval

Pulmonology · SOAP

Subjective	Respiratory complaint (dyspnea, cough, wheeze, sputum); triggers; smoking and exposure history; inhaler use and adherence; oxygen use
Objective	Vitals including SpO2; respiratory and cardiac exam; spirometry or PFTs; imaging; ABG if relevant
Assessment	Diagnosis (asthma, COPD, ILD, infection); severity and control; ICD-10
Plan	Inhaler and medication plan; oxygen; diagnostics (PFT, imaging); pulmonary rehabilitation; action plan; follow-up

Rheumatology · SOAP

Subjective	Joint or systemic complaint; pattern and duration of pain and stiffness; functional impact; systemic symptoms; current DMARDs/biologics and tolerance
Objective	Joint exam (swelling, tenderness, ROM); skin and nail findings; extra-articular findings; labs (ESR/CRP, autoantibodies); imaging
Assessment	Diagnosis and differential; disease activity; ICD-10
Plan	DMARD or biologic management; monitoring labs; imaging; injections; patient education; follow-up

Urgent Care · SOAP

Subjective	Chief complaint and HPI with onset and severity; pertinent ROS; PMH, medications, allergies; tetanus status if injury
Objective	Vitals; focused exam; point-of-care testing (rapid strep, flu, urinalysis, glucose); in-visit imaging or results
Assessment	Working diagnosis and differential; severity and red-flag assessment; ICD-10
Plan	Treatment given; prescriptions; procedures (laceration repair, splint); work/school note; ED referral criteria; return precautions; follow-up

Make them yours. These are neutral starting points. Eluve's custom templates adapt to how each clinician actually writes (your sections, your headings, your level of detail) and keep growing as new specialties are added.