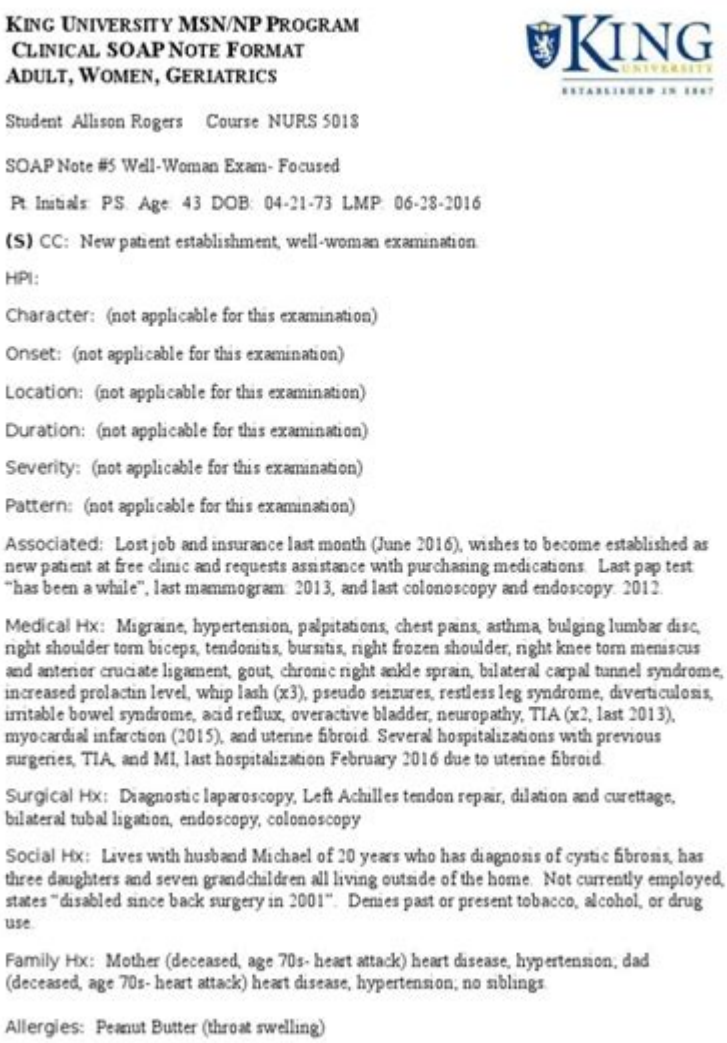
Well Woman Exam Soap Note Example



KING UNIVERSITY MSN/NP PROGRAM
CLINICAL SOAP NOTE FORMAT
ADULT, WOMEN, GERIATRICS

Student: Allison Rogers Course: NURS 5018

SOAP Note #5 Well-Woman Exam- Focused

Pt. Initials: PS. Age: 43 DOB: 04-21-73 LMP: 06-28-2016

(S) CC: New patient establishment, well-woman examination.

HPI:

Character: (not applicable for this examination)

Onset: (not applicable for this examination)

Location: (not applicable for this examination)

Duration: (not applicable for this examination)

Severity: (not applicable for this examination)

Pattern: (not applicable for this examination)

Associated: Lost job and insurance last month (June 2016), wishes to become established as new patient at free clinic and requests assistance with purchasing medications. Last pap test "has been a while", last mammogram: 2013, and last colonoscopy and endoscopy: 2012.

Medical Hx: Migraine, hypertension, palpitations, chest pains, asthma, bulging lumbar disc, right shoulder torn biceps, tendonitis, bursitis, right frozen shoulder, right knee torn meniscus and anterior cruciate ligament, gout, chronic right ankle sprain, bilateral carpal tunnel syndrome, increased prolactin level, whip lash (x3), pseudo seizures, restless leg syndrome, diverticulosis, irritable bowel syndrome, acid reflux, overactive bladder, neuropathy, TIA (x2, last 2013), myocardial infarction (2015), and uterine fibroid. Several hospitalizations with previous surgeries, TIA, and MI, last hospitalization February 2016 due to uterine fibroid.

Surgical Hx: Diagnostic laparoscopy, Left Achilles tendon repair, dilation and curettage, bilateral tubal ligation, endoscopy, colonoscopy

Social Hx: Lives with husband Michael of 20 years who has diagnosis of cystic fibrosis, has three daughters and seven grandchildren all living outside of the home. Not currently employed, states "disabled since back surgery in 2001". Denies past or present tobacco, alcohol, or drug use.

Family Hx: Mother (deceased, age 70s- heart attack) heart disease, hypertension; dad (deceased, age 70s- heart attack) heart disease, hypertension; no siblings.

Allergies: Peanut Butter (throat swelling)

Well woman exam soap note example is a critical component of women's healthcare, providing healthcare providers with a structured method to document patient encounters. SOAP notes—an acronym for Subjective, Objective, Assessment, and Plan—are used in various medical settings to ensure comprehensive and effective communication among providers and with patients. In this article, we will discuss the elements of a well woman exam SOAP note, the importance of each section, and provide a practical example to illustrate how to document a well woman exam effectively.

Understanding the SOAP Format

The SOAP note format is a systematic way of documenting patient encounters. Each section has a specific purpose:

1. Subjective

This section captures the patient's self-reported symptoms, concerns, and history. It often includes:

- Chief complaint
- History of present illness (HPI)
- Past medical history (PMH)
- Family history (FH)
- Social history (SH)
- Review of systems (ROS)

2. Objective

This section contains observable, measurable data obtained during the examination. It includes:

- Vital signs (e.g., blood pressure, heart rate)
- Physical examination findings
- Laboratory and imaging results

3. Assessment

The assessment section summarizes the healthcare provider's clinical judgment based on the subjective and objective data. It may include:

- Diagnoses
- Differential diagnoses
- Any relevant medical conditions

4. Plan

The plan outlines the next steps in patient care. It typically includes:

- Diagnostic tests
- Referrals
- Treatments or interventions
- Patient education
- Follow-up appointments

Components of a Well Woman Exam

A well woman exam is a comprehensive evaluation tailored to the specific needs of women. It typically includes:

- A thorough history and physical examination
- Screening for potential health issues (e.g., cervical cancer, breast cancer)
- Counseling on reproductive health and family planning
- Assessment of mental health and lifestyle factors

Key Elements of a Well Woman Exam SOAP Note

When documenting a well woman exam, it's essential to include specific components for each section of the SOAP note:

Subjective

- Chief Complaint: "I am here for my annual well woman exam."
- History of Present Illness: Document any specific concerns the patient may have, such as menstrual irregularities, changes in weight, or symptoms of anxiety or depression.
- Past Medical History: Include relevant history such as previous surgeries, chronic conditions, and any gynecological issues (e.g., endometriosis).
- Family History: Note any family history of gynecological cancers, cardiovascular diseases, or other relevant conditions.
- Social History: Consider lifestyle factors such as smoking, alcohol use, exercise, and sexual activity.
- Review of Systems: Ask about any other symptoms the patient may be experiencing, such as fatigue, mood changes, or gastrointestinal issues.

Objective

- Vital Signs: Record the patient's blood pressure, heart rate, height, weight, and body mass index (BMI).
- Physical Examination Findings: Document the results of the breast examination, pelvic examination, and any other relevant findings (e.g., abdominal tenderness).
- Laboratory Tests: Include results of any recent Pap smears, mammograms, or STD screenings.

Assessment

- Provide a summary of the patient's health status based on the subjective and objective data. For example, "Patient is a 35-year-old female with a history of irregular menstrual cycles and no significant family history of gynecological cancers. Current assessment includes routine well woman exam with normal findings."

Plan

- Outline the recommendations for the patient, which may include:
- Referrals for any abnormal findings
- Recommendations for routine screenings (e.g., Pap smear, mammogram)
- Counseling on lifestyle changes (e.g., diet, exercise)
- Follow-up appointment in one year for the next well woman exam

Sample Well Woman Exam SOAP Note

Here is a practical example of a well woman exam documented using the SOAP note format:

Patient Name: Jane Doe
Date: 10/01/2023
Age: 30
Gender: Female

S: Subjective
- Chief Complaint: "I am here for my annual well woman exam."
- HPI: Jane reports no significant health concerns. Her menstrual cycles are regular, occurring every 28 days, lasting 5 days. She notes some mild cramping but denies any heavy bleeding or intermenstrual spotting.
- PMH: No significant medical history. No prior surgeries.
- FH: Mother with a history of breast cancer at age 50.
- SH: Non-smoker, occasional alcohol use. Active lifestyle, exercises 3-4 times a week. Sexually active with one partner, uses condoms for contraception.
- ROS: Denies fatigue, weight changes, mood issues, or gastrointestinal symptoms.

O: Objective
- Vital Signs: BP 120/80, HR 72, Height 5'6", Weight 140 lbs, BMI 22.5.
- Physical Exam:
- Breast Exam: No masses or tenderness noted.
- Pelvic Exam: Normal external examination, no lesions or abnormalities. Cervix appears normal, and bimanual exam shows no adnexal tenderness.
- Laboratory Tests: Pap smear performed today, results pending.

A: Assessment
- Routine well woman exam is unremarkable. Regular menstrual cycles, normal breast and pelvic exams. Family history of breast cancer noted, recommend earlier mammogram screening in 5 years.

P: Plan
- Schedule follow-up appointment in one year for next well woman exam.
- Refer Jane for a mammogram at age 35 due to family history.

- Discussed the importance of maintaining a healthy lifestyle and routine screenings.
- Provide educational materials on breast self-examination and cervical cancer prevention.

Conclusion

A well woman exam SOAP note is an essential tool for documenting women's health encounters. It provides a comprehensive overview of a patient's health status, facilitating communication among healthcare providers and ensuring that patients receive the appropriate care and education. By adhering to the SOAP format and including all relevant components, providers can enhance the quality of care delivered to women and support their overall health and well-being. By utilizing the sample provided, healthcare professionals can ensure they cover all necessary areas during a well woman exam, leading to effective patient management and follow-up.

Frequently Asked Questions

What is a well woman exam SOAP note?

A well woman exam SOAP note is a structured documentation format used by healthcare providers to record a woman's health assessment during an annual check-up. SOAP stands for Subjective, Objective, Assessment, and Plan.

What should be included in the Subjective section of a well woman exam SOAP note?

The Subjective section includes the patient's reported symptoms, medical history, menstrual history, sexual health, lifestyle factors, and any concerns or questions they may have regarding their health.

What type of information is documented in the Objective section of a well woman exam SOAP note?

The Objective section contains measurable data collected during the examination, such as vital signs, physical examination findings, laboratory results, and any imaging tests performed.

Why is the Assessment section important in a well woman exam SOAP note?

The Assessment section synthesizes the information gathered from the Subjective and Objective parts to provide a diagnosis or evaluation of the

patient's health status, identifying any potential health issues.

What typically goes into the Plan section of a well woman exam SOAP note?

The Plan section outlines the recommended next steps for the patient, which may include further testing, referrals, treatment options, lifestyle modifications, and follow-up appointments.

How can a well woman exam SOAP note improve patient care?

A well-structured SOAP note enhances communication among healthcare providers, ensures comprehensive patient assessments, and facilitates continuity of care by providing clear documentation of the patient's health status and treatment plans.

What is the significance of documenting preventive care in a well woman exam SOAP note?

Documenting preventive care, such as vaccinations, screenings (like Pap smears and mammograms), and counseling on healthy lifestyle choices, is crucial for tracking compliance, ensuring comprehensive care, and promoting long-term health outcomes.

Well Woman Exam Soap Note Example

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