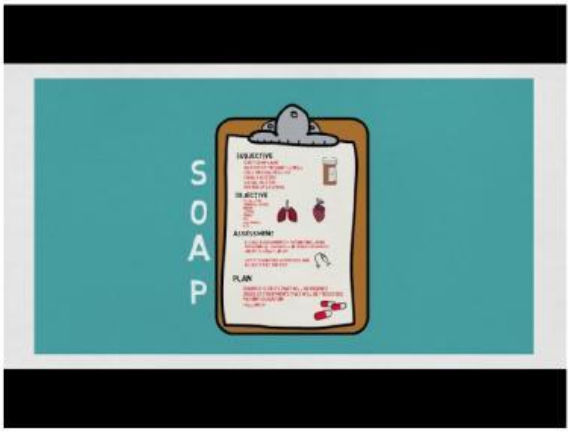
Listening Comprehension – SOAP notes

Listen to the video and choose the correct option in each statement. Use this activity as a guide to understand and structure SOAP notes.
https://www.youtube.com/watch?v=9TZqTtbBVXc&t=76s



🔹 Understanding the SOAP Note Structure

1. The SOAP note is mainly used for **communication / billing** between healthcare providers.
2. The acronym SOAP stands for **Subjective, Objective, Assessment, Plan / Symptoms, Observations, Advice, Prescription**.
3. The **Subjective / Objective** section includes what the patient tells you about their condition.
4. The **Subjective / Objective** section includes facts like vital signs and physical exam findings.
5. In the assessment, you state **what the patient feels / what you think is going on**.
6. The plan may include things like prescriptions, follow-up, and **social history / patient education**.

🔹 Case Example: Mr. Fred K. Aloha

7. Mr. Aloha came to the clinic complaining of **sore throat / chest pain**.
8. He described the sore throat as constant and **worse at night / worse in the morning**.
9. His symptoms included fever and inflamed tonsils, but he **denied / reported** headache, sinus pain, and cough.
10. On examination, his throat showed red inflammation and **white exudate / nasal congestion** on the tonsils.
11. The diagnosis was streptococcal pharyngitis based on **4 / 5** Centor criteria points.
12. For treatment, the plan included penicillin, pain relief, and **referral to ENT / supportive care at home**.
13. For hypertension, his medication dose was **increased / stopped** because it was not yet at goal.
14. The patient was advised to follow up in **3 days / 7 days** if symptoms did not improve.

🔚 Wrap-Up

15. The SOAP note structure helps clinicians organize their notes by focusing on

what the patient wants / what is observed, concluded, and planned.