



## Medicine Progress Note Template

Subjective:

Patient [denies/ admits] [worsening/ stable/ improving] [pertinent symptoms]. Pain [is/ is not] well-controlled, the patient rates it as a [1-10/10]. [ROS for hospital-related sx: nausea/ vomiting, BM, appetite, sleep, ambulation]

Objective:

- Vital signs
- I/O's (calculate urine output in cc/hr over the last 24 hours)
- Physical exam: General, heart, lungs, abdominal, any other pertinent systems
- Labs, imaging (with reads), and other data

Assessment:

This is a \_\_\_-year-old [man/ woman] with a history of [significant PMH] who presented with [admitting diagnosis], currently [status of patient].

- The above is just a general outline and will often have to be modified to fit your patient!
- Your assessment must be updated every day!

Plan:

- List problems by severity, with a plan after each problem
- All abnormalities should be addressed, even if benign or chronic

Prophylaxis (DVT, GI, other as needed)

Disposition (what conditions must be met for discharge, where will the patient go after discharge)