DATE (MO./DAY/YR.)	SUBJECTIVE (SYMPTOMS/ PATIENT COMPLAINTS)	OBJECTIVE (VITAL SIGNS /OBSERVATIONS PAST HISTORY)	ASSESSMENT (WHAT THE PROVIDER FEELS MAY BE THE PROBLEM)	PLAN (WHAT WAS DONE FOR THE PATIENT: MEDS GIVEN, DRESSINGS APPLIED, PT. ED)	NAME OF HEALTH WORKER (SIGN NAME LEGIBLY, NOTING CREDENTIALS, ETC. RN/NP/PA/MD/DO/DDS)