

Introduction to Medical Records

Introduction to Medical Records

(A concise guide for students, new healthcare staff, and anyone interested in health?information management)

1. What Is a Medical Record?

Aspect	Description
Definition	A systematic collection of information about a patient’s health, diagnoses, treatment, and care over time.
Purpose	• Supports clinical decision?making • Documents legal and regulatory compliance • Enables billing and reimbursement • Facilitates research, quality improvement, and public health reporting
Types	1. Paper (paper?based) – traditional charts, folders, and forms. 2. Electronic (EMR/EHR) – digital versions that can be shared across systems.

2. Core Components of a Medical Record

Section	Typical Content	Key Elements
1. Patient Identification	Name, DOB, gender, medical record number, contact info, emergency contacts.	Unique identifier (MRN), photo (optional).
2. Administrative Data	Admission/discharge dates, insurance details, consent forms.	Admission type (inpatient, outpatient), payer information.

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Section	Typical Content	Key Elements
3. History	• Chief Complaint (CC) – primary reason for visit. • History of Present Illness (HPI) – timeline, symptoms, modifiers. • Past Medical History (PMH) – chronic diseases, surgeries. • Family History (FH) – hereditary conditions. • Social History (SH) – occupation, tobacco/alcohol/drug use, living situation.	Structured narrative or check? boxes; use of standardized abbreviations.
4. Review of Systems (ROS)	System?by?system checklist of symptoms (e.g., cardiovascular, respiratory).	Positive findings highlighted.
5. Physical Examination	Objective findings (vitals, inspection, palpation, auscultation, special tests).	Date, examiner, measurement units.
6. Diagnostic Data	Laboratory results, imaging reports, pathology, ECGs, microbiology.	Test name, specimen, method, reference ranges, interpretation.
7. Assessment/Problem List	Clinician's synthesis of findings; prioritized diagnoses.	Use of ICD?10 or SNOMED codes when possible.
8. Plan	• Orders (medications, labs, imaging). • Therapeutic interventions. • Follow?up instructions. • Patient education.	Clear, actionable items; responsible provider noted.
9. Progress Notes	Daily or encounter?specific narrative (SOAP, DAR, or other format).	Time?stamped, signed, and dated.
10. Consent & Legal Documents	Informed consent forms, advance directives, Do?Not?Resuscitate (DNR) orders.	Signed by patient or surrogate.
11. Billing & Coding	CPT/HCPCS procedure codes, ICD?10 diagnosis codes, modifiers.	Linked to clinical documentation for audit.

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Section	Typical Content	Key Elements
12. Discharge Summary	Summary of stay, final diagnoses, discharge meds, follow-up plan, patient education.	Sent to primary care provider and patient.

3. Documentation Standards & Best Practices

1. Accuracy & Completeness

- Record facts, not opinions (unless labeled as assessment).
- Include all relevant data; avoid omissions.

2. Timeliness

- Document as soon as possible after patient interaction.