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世界中医药学会联合会

World Federation of Chinese Medicine Societies

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国际中医门诊病历书写规范

Standard for medical records in the international clinic of Chinese Medicine

（征求意见草案，Committee draft）

世界中联国际组织标准

International Standard

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前　　言

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引　言

病历是医生在临床诊疗实践中，按规定的格式和要求书写的诊疗过程记录，也是对患者的病情、治疗方案和治疗效果综合分析整理而成的全面总结。病历在中医诊疗、教学、科研和管理等工作中具有重要价值。通过病历，医生可以更加全面地了解患者的病情演变和治疗过程，为进一步的诊断和治疗提供依据；可以作为教学案例，用于学术理论、诊断思路、治疗方法和临床思维的学习；可以提取信息，为相关疾病研究、治疗方法的评价提供支持；可以发现医疗过程中存在的问题，总结经验教训，提高医疗服务水平。

建立具有国际适用性的中医门诊病历规范，是国际中医诊疗能力提升和学术发展的内在需求，为提升全球范围内中医门诊诊疗工作质量，推动各国中医临床实践和学术交流提供了重要基础。

本文件中的内容基于国际中医临床诊疗发展的实际情况，参考了中国和其他国家政府与学术团体对中医门诊病历记录的要求，突出了中医诊疗和临床思维特色。本文件提出的要求在确保病历记录内容规范性的同时，也考虑了在门诊诊疗中应用的实用性，可供各国中医医疗机构和中医临床从业人员参考使用。

国际中医门诊病历规范

1 范围

本文件规定了中医门诊病历书写和的记录内容的基本要求。

本文件适用于中医门诊纸质和电子病历，用于指导各国家和地区中医门诊病历书写，也可用于跨国家和地区间的科学研究以及指导有关机构制定管理规章制度等。

2 规范性引用文件

本文件无规范性引用文件。

3 术语和定义

下列术语和定义适用于本标准。

3.1

病历

医务人员在医疗活动过程中形成的文字、符号、图表、影像、切片等资料的总和，包括门（急）诊病历和住院病历。

3.2

门诊病历书写

医务人员通过望、闻、问、切及查体、辅助检查、诊断、治疗、护理等医疗活动获得有关资料，并进行归纳、分析、整理形成医疗活动记录的行为。

3.3

首诊

患者在本医疗机构，因特定主诉的诊治需要首次就诊的过程。

注：首诊具有相对性，是否作为首诊可由接诊医师根据临床实际酌情确定。

3.4

复诊

患者首诊后，在较为集中时间阶段内，因首诊主诉相关病情的诊治需要，一次或多次前来本医疗机构就诊的过程。

3.5

随访

患者就诊期间，医师或医疗机构人员通过电话等通讯方式对患者进行跟踪访问，了解其病情变化和治疗情况，指导其调护康复的过程。

3.6

刻下症

患者就诊当时存在的主要症状、体征或其他临床表现。

3.7

临床评估

采用特定的临床评估标准、指数、量表等工具，对患者与疾病相关的临床指标进行的定性或定量评价。

3.8

患者依从性

患者执行医嘱，完成医师提出的与疾病诊断、治疗和预防相关要求事项的程度。

4 一般规范

4.1 记录要求

4.1.1 中医门诊病历的书写应当真实、准确、及时、完整、规范。

4.1.2 病历的书写应规范使用医学术语。中医术语的使用依照相关标准、规范执行。记录要求文字工整、字迹清晰、表述准确、语句通顺、标点正确。

4.1.3 纸质病历书写过程中出现错字时，应当用双线划在错字上，保留原记录清楚、可辨，并注明修改时间，修改人签名。

4.1.4 门诊病历一般应当由接诊医师在接诊当日及时完成，并记录接诊医师姓名和时间。

4.1.5 病历中包含了患者个人和病情的隐私信息，应严格保密管理。

4.1.6 对病历记录信息和文件的管理，应符合医疗机构所在国家和地区相关法规要求。

4.2 病历内容要求

4.2.1 门诊病历首页

首页应包括患者姓名、性别、出生年月、民族或种族、国别、婚姻状况、职业、出生地、常住地址、过敏史、患者诊断及诊次记录等相关信息。

4.2.2 首诊记录项目

首诊记录应当包括如下项目信息：

a) 病史信息，包括：主诉、现病史、既往史、个人史、婚育月经史、家族史等；

b) 诊查情况，包括：一般情况、望闻切诊等体格检查、专科检查、临床评估、辅助检查（包括阳性和有鉴别诊断价值的阴性信息）、辨证分析，记录中医疾病、证候诊断等；

c) 治疗方案，包括：治则治法、处置的中成药、汤药、针刺、其他治疗以及针对调护的医嘱等。

4.2.3 复诊记录项目

复诊记录应当包括如下项目信息：

a) 上次就诊或随访后至本次复诊期间患者的情况。包括：依从治疗情况、治疗后反应、患者刻下症，以及患者在随访中补充报告的病史信息等；

b) 诊查情况，包括：一般情况、望闻切诊等体格检查、专科检查、临床评估、（包括阳性和有鉴别诊断价值的阴性信息）、辨证分析，记录中医疾病、证候诊断等；

c) 治疗方案，包括：治则治法、处置的中成药、汤药、针刺、其他治疗以及针对调护的医嘱等。

4.2.4 随访记录项目

随访记录项目应当包括如下信息：

a) 患者上次就诊后至本次随访期间的情况，包括：依从治疗的情况、治疗后的反应、患者刻下症，以及患者在随访中补充报告的病史信息等；
b) 针对患者反馈信息，对治疗方案的调整；
c) 对患者依从治疗和疾病调护的医嘱信息等。

5 首诊记录

5.1 病史信息

5.1.1 主诉

促使患者就诊的主要症状、体征或临床发现及其持续时间。

5.1.2 现病史

患者本次疾病的发生、演变、诊疗等方面的详细情况，应当按时间顺序书写，并结合中医问诊，记录目前情况。内容包括发病情况、主要症状特点及其发展变化情况、伴随症状、发病后诊疗经过及结果、睡眠和饮食等一般情况的变化，以及与鉴别诊断有关的阳性或阴性资料等。

a) 发病情况：记录发病的时间、地点、起病缓急、前驱症状、可能的原因或诱因。
b) 主要症状特点及其发展变化情况：按发生的先后顺序描述主要症状的部位、性质、持续时间、程度、缓解或加剧因素，演变发展情况等。
c) 伴随症状：记录伴随症状，描述伴随症状与主要症状之间的相互关系。
d) 发病以来诊治经过及结果：记录患者发病后到就诊前，在院内、外接受检查与治疗的详细经过及效果，包括患者自行采用的调护干预措施等。对患者提供的药物（含保健品）、诊断和手术名称需加引号（“”）以示区别。
e) 发病以来一般情况：简要记录患者发病后的寒热、饮食、睡眠、情志、二便、体重等情况。
f) 患者当前存在的刻下症。
g) 患者本次求诊的主要目的。

5.1.3 既往史

患者过去的健康和疾病情况。内容包括既往一般健康状况、疾病史、传染病史、预防接种史、手术外伤史、输血史、食物或药物过敏史等。

5.1.4 个人史

患者出生地及长期居留地、生活习惯，烟、酒、药物等嗜好，职业与工作环境，工业毒物、粉尘、放射性物质接触史和冶游史等。

5.1.5 婚育史、月经史

患者婚姻状况、结婚年龄、配偶健康状况、有无子女等。女性患者记录月经、白带分泌情

况以及孕产情况等。

5.1.6 家族史

患者父母、兄弟、姐妹健康状况，以及家族内有无与患者类似疾病、家族遗传性疾病情况。

5.2 诊查情况

5.2.1 一般情况

患者体温、呼吸、心率、血压、身高、体重等。

5.2.2 望诊

5.2.2.1 一般望诊

患者整体及局部神、色、形、态的变化，比如形体、胖瘦、面色、唇色、精神状况等相关情况。

5.2.2.2 舌诊

包括舌质、舌色、舌苔和舌下脉络等舌诊相关信息。

5.2.3 闻诊

包括听声音和闻气味，应当记录有诊断意义的患者言语、咳嗽、喘息等声音特征、心肺等重要部位听诊，以及呼吸、排泄物等气味等。

5.2.4 切诊

5.2.4.1 一般切诊

一般切诊应包括体表、腹部、经络、穴位及全身多部位切诊相关情况。

5.2.4.2 脉诊

脉诊应包括脉位、脉率、脉体、脉力等整体及分部描述等脉诊相关信息。

5.2.5 专科情况

根据患者疾病特征记录专科体格检查中发现的有诊断意义的特殊信息。

5.2.6 临床评估

临床评估应包括重要临床症状、证候表现、生活能力、社会心理状况等定量评估结果。

5.2.7 辅助检查

记录就诊前和就诊期间所作的与本次疾病相关的主要检验检查结果。

应分类按检查时间顺序记录检查结果，如在其他医疗机构所作检查，应当写明该机构名称和检查时间。

5.2.8 辨证分析

简要描述对患者诊查信息进行的分析推理过程、对病机和病证的初步认识等。

5.2.9 诊断结果

诊断结果是经治医师根据患者本次就诊时情况，综合分析所做出的诊断，包括中医疾病、证候诊断。如诊断为多项时，应当主次分明，根据临床重要性进行合理排序。

5.3 治疗方案

5.3.1 治则治法

概括描述医师所依据的治疗原则、计划采取的治疗方法。

5.3.2 处方

医师在治则治法指导下采用的具体治疗处置方案，包括：计划实施的中成药、汤药等药物处方、针刺处方、其他非药物疗法干预方案。

a) 中成药处方，应包括药物名称、规格、剂量和服法；
b) 中药汤药处方，应包括方剂名称、组方药物的名称、用量、处置方法，药物剂数和服法；
c) 针刺处方，应包括穴位名称和针刺操作手法等。

5.3.3 调护医嘱

医师依据患者病情和治疗处置方案实施、依从需要，给出的需要患者配合的具体建议，比如对患者生活方式、日常饮食、家庭护理等方面的指导性意见，以及必要时给出的其他检查治疗意见等。

6 复诊记录

6.1 依从治疗的情况

应记录患者上次就诊或随访后至本次复诊期间，对医师开具的处方用药服用情况，以及对相关医嘱的执行情况等。

6.2 治疗后的反应

应记录患者上次就诊或随访后至本次复诊期间，服用医师开具的处方用药或执行医嘱后的感受、病情和症状变化情况等。

6.3 刻下症和补充病史

应记录患者复诊当时存在的主要症状、体征或其他临床表现。必要时，记录需要补充的病史信息。

6.4 诊查情况

同“5.2 诊查情况”。

6.5 治疗方案

参照“5.3 治疗方案”。

7 随访记录

7.1 依从治疗的情况

同“6.1 依从治疗的情况”。

7.2 治疗后的反应

同“6.2 治疗后的反应”。

7.3 刻下症和补充病史

参照“6.3 刻下症和补充病史”部分要求。

7.4 治疗方案调整

记录医师根据随访情况，针对治则治法、处方和调护医嘱等治疗方案内容的调整情况。

7.5 随访医嘱

记录医师根据随访情况，针对患者对依从治疗方案，以及针对生活方式、日常饮食、家庭护理等调护医嘱的内容。

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Foreword

Please note that some content in this document may involve patents. The issuing organization of this document does not assume responsibility for identifying patents.
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Introduction

A medical record is a comprehensive summary of the diagnosis and treatment process written by doctors in clinical practice according to prescribed formats and requirements. It also reflects a comprehensive analysis and organization of the patient's condition, treatment plan, and treatment outcomes. Medical records hold significant value in Chinese medicine diagnosis and treatment, teaching, scientific research, and management. Through medical records, doctors can gain a more comprehensive understanding of the patient's disease progression and treatment process, providing a basis for further diagnosis and treatment. They can serve as teaching cases for learning academic theories, diagnostic approaches, treatment methods, and clinical thinking. Information can be extracted to support research on related diseases and the evaluation of treatment methods. Furthermore, medical records can identify issues in the medical process, summarize experiences and lessons learned, and enhance the level of medical services.

Establishing standardized outpatient medical records for Chinese medicine with international applicability is an inherent requirement for enhancing Chinese medicine diagnostic and treatment capabilities and academic development worldwide. It provides a crucial foundation for improving the quality of Chinese medicine outpatient diagnosis and treatment globally, and promoting clinical practice and academic exchanges of Chinese medicine among various countries.

The content of this document is based on the actual development of international clinical diagnosis and treatment of Chinese medicine, referencing the requirements of Chinese and other countries' governments and academic organizations for Chinese medicine outpatient medical records, highlighting the characteristics of Chinese medicine diagnosis and clinical thinking. The requirements proposed in this document, while ensuring the standardization of medical record content, also consider the practicality of application in outpatient diagnosis and treatment, and can be used as a reference for Chinese medicine medical institutions and clinical practitioners around the world.

Standard for medical records in the international clinic of Chinese medicine

1 Scope

This document specifies the basic requirements for the writing and contents of Chinese medicine outpatient medical records in various countries.

This document is applicable to both paper-based and electronic Chinese medicine outpatient medical records. It can be used as guide for Chinese medicine outpatient medical records in various countries, and also as references to formulate relevant management rules and regulations for relevant organs.

2 Normative references

This document contains no normative references.

3 Terms and definitions

The following terms and definitions are applicable to this standard.

3.1
medical record
the sum of words, symbols, charts, images, slices and other information formed by medical personnel during the course of medical activities, which includes medical records of outpatient, emergency and Inpatient.

3.2
outpatient medical records writing
an action refers to that the medical personnel collect the relevant information by looking, listening & smelling, asking, pulse feeling & palpation, and physical examination, auxiliary examination, diagnosis, treatment, nursing, and so on; then write medical record by inducing, analyzing and summarizing.

3.3
first visit
The process of first visit to the medical institution by patient who has specific complaints and medical needs.
Note: The first diagnosis is relative, whether it is the first diagnosis should be determined by the doctor according to the clinical practice.

3.4
return visit
After the first visit, the patient visits the medical institution one or more times in a centralized time period, due to the necessity of further diagnosis and treatment according to

the first diagnosis .

3.5

follow-up

during the treat period, doctor or medical personnel follow up with the patients by telephone and other means of communication, to keep informed of their condition and treatment development, and to guide the process of nursing and recovery.

3.6

present symptoms

main symptoms, signs, or other clinical manifestations of the patient at the time of the visit.

3.7

clinical assessment

a semi-quantitative or quantitative evaluation of patients' disease-related clinical indicators by using specific clinical evaluation criteria, indices, and scales.

3.8

patient compliance

level of the patient implements the doctor's prescription related to the diagnosis, treatment, and prevention of the disease.

4 General specifications

4.1 Requirements for writing

4.1.1 The writing of TCM outpatient medical records should be true, accurate, timely, complete and standardized.

4.1.2 The writer of medical records should use medical terms correctly. The use of TCM terms should be in accordance with relevant standards and specifications. The records should be write with neat script, clear handwriting, precise sentences, smooth statements and correct punctuation.

4.1.3 For handwriting, the wrong words should be marked with two lines, the wrong words should be clear and recognizable, and a sign with time is asked.

4.1.4 Out-patient medical records generally should be written by the on-duty doctor on the day of receipt, and the doctor's name and time should be recorded.

4.1.5 As the medical records contain private information of personal and healthy, the documents should be managed confidentially.

4.1.6 The management of medical records, information and documents should comply with the relevant laws and regulations of the countries and regions in which the medical institutions are located.

4.2 Requirements for medical record content

4.2.1 The first page of the outpatient medical records

The first page of the outpatient medical records should include information on the patient's name, sex, year of birth, nationality or race, nation, marital status, occupation, place of birth,

residence address, history of allergies, diagnosis and visit time.

4.2.2 Items for first visit

The first visit record should include the items listed:

a) Medical history, including: complaint, history of present illness, history of past illness, personal history, history of marriage, childbearing and menstrual , family history, etc.
b) Diagnosis and examination, including: general situation, looking, listening & smelling, asking, pulse feeling & palpation, physical examination, speciality check-up, clinical evaluation, auxiliary examination (including positive and negative information of differential diagnosis), syndrome differentiation analysis, the TCM diseases, syndrome diagnosis, etc.
c) Treatment, including: therapeutic principle,therapeutic method, prescription of Chinese patent medicine, soup medicine, acupuncture, other treatments and advice for adjusting and nursing.

4.2.3 Items for return visit

The record of return visit should include the items listed:

a) Patient status since the last visit or follow-up. Including: compliance, response, present symptoms, more medical history reported by the patient in the follow-up.
b) Diagnosis and examination, including: general situation, looking, listening & smelling, asking, pulse feeling & palpation, physical examination, speciality check-up, clinical evaluation, auxiliary examination (including positive and negative information of differential diagnosis), syndrome differentiation analysis, the TCM diseases, syndrome diagnosis, etc.
c) Treatment, including:therapeutic principle,therapeutic method, prescription of Chinese patent medicine, soup medicine, acupuncture, other treatments and advice for adjusting and nursing.

4.2.4 Items for follow-up

The record of follow-up should include the items listed:

a) Patient status since the last visit or follow-up. Including: compliance, response, present symptoms, more medical history reported by the patient in the follow-up.
b) The adjustment of the treatment according to the feedback of the patient.
c) Advice for compliance, adjusting and nursing.

5 Records of first visit

5.1 Medical history

5.1.1 Complaint

The main symptoms, signs, or clinical findings which drives the patient to doctor and their duration.

5.1.2 History of present illness

The details of present illness, including occurrence, evolution, diagnosis and treatment, which should be written in chronological order, and the current situation with TCM inquiry, Including: the occurrence, the main symptoms and development, the accompanying symptoms, The course of diagnosis and treatment since the occurrence, therapeutic effect, and general situation of sleep and diet, the positive and negative information of differential diagnosis.

a) Occurrence: time, location, urgency, prodrome, possible causes or induced factors.
b) The main symptoms and development: location, nature, duration, degree, remission or exacerbation factors and development of the main symptoms, which should be written in chronological order.
c) Accompanying symptoms: record the accompanying symptoms and describe the relationship between accompanying symptoms and main symptoms.
d) The course of diagnosis and treatment since the occurrence: record the process and effect since the occurrence until this visit, including: the examination,diagnosis and treatment given to the patient in the hospital or other medical institutions, and also intervention measures applied by the patient. The names of drugs (including health products), the diagnoses and surgeries should be marked with quotation marks("").
e) General situation since the occurrence: briefly record the heat or cold, diet, sleep, mood, urine and stool,weight and so on.
f) Present symptoms of the patient.
g) The main purpose of the patient for the visit.

5.1.3 History of past illness

The patient's past health and illness, including general health status, history of disease, history of infectious diseases, history of vaccination, history of surgical trauma, history of blood transfusion, history of food or medicine allergy, etc.

5.1.4 Personal history

Place of birth , long-term residence and habits; hobbies as smoking, alcohol, drugs; occupation and working environment, industrial poison, dust, history of exposure to radioactive substances and sexual history.

5.1.5 History of marriage, childbearing and menstrual

Marital status, age of marriage, health status of spouse, children, etc; menstruation, leucorrhea secretion and pregnancy of female patients.

5.1.6 Family history

The health status of parents, brothers and sisters;and if there are diseases similar to the patient or family genetic diseases.

5.2 Diagnosis and examination

5.2.1 General situation

Body temperature, respiration, heart rate, blood pressure, height, weight, etc.

5.2.2 Looking

5.2.2.1 General looking

The changes of whole body and parts as look, color, shape and posture, such as shape, fat and thin, facial color, lip color, mental condition and so on.

5.2.2.2 Tongue inspection

Information related to tongue inspection including corpora linguae, tongue color, tongue coating and sublingual choroid.

5.2.3 Listening and smelling

Both listening and smelling: information of diagnostic significance should be recorded,including sound features as speak, cough and wheeze, auscultation of heart and lung, smells of breath and excreta.

5.2.4 Pulse feeling and palpation

5.2.4.1 General palpation

Information related to general palpation including palpation on the body surface, abdomen, meridian, acupoints and other parts of the body.

5.2.4.2 Pulse feeling

Information related to pulse feeling including position, pulse rate, vein material, pulse force and so on.

5.2.5 Speciality situation

Record the diagnostic information found in the speciality check-up according to the patient's disease characteristics.

5.2.6 Clinical assessment

Including the important clinical symptoms, syndromes, life ability, social psychological status and so on.

5.2.7 Auxiliary examination

Record the results of major examinations related to the disease before and during the visit. The results should be categorized and recorded in chronological order. Results from other medical institutions should be marked with time and name of the institutions.

5.2.8 Syndrome differentiation analysis

Briefly describes the process of analysis, the preliminary understanding of pathogenesis and syndrome based on information of diagnosis and examination.

5.2.9 Diagnostic results

The diagnostic results shoud be made by the doctor based on a comprehensive analysis of the patient's condition at the current visit, including Chinese medicine disease and syndrome diagnosis. The multiple diagnosis should be listed with proper priority according

to the clinical importance.

5.3 Treatment programmes

5.3.1 Therapeutic principle and therapeutic method

A general description of therapeutic principle and therapeutic method to apply.

5.3.2 Prescriptions

The specific treatment plans adopted by doctors under the guidance of therapeutic method, including: drug prescription of Chinese patent medicine and soup medicine, acupuncture prescriptions, and other non-drug therapy intervention methods.

a) Prescriptions for Chinese patentdrugs should include the name of the drug, specification, dosage, and method of administration.
b) Chinese medicine decoction prescriptions should include the name of the prescription, the names of the constituent herbs, dosage, preparation method, number of doses, and administration method.
c) Acupuncture prescription should include the names of acupoints and the acupuncture manipulation techniques.

5.3.3 Advice for adjusting and nursing

According to the patient's condition and treatment plans, medical advice for patients to cooperate with, such as guiding opinions on the patient's lifestyle, daily diet, home nursing, etc; and advice for further examination and treatment if it is necessary.

6 Record of return visit

6.1 Compliance with treatment

The use of prescriptions and cooperation of the advice should be recorded since last visit or follow-up until this time.

6.2 Response to treatment

The patient's perceptions, change of the disease condition and symptom after taken the drugs and advice, which should be recorded since last visit or follow-up until this time.

6.3 Present symptoms and supplementary medical history

The main symptoms, signs, or other clinical manifestations present at the patient's follow-up visit should be recorded. If necessary, additional medical history information that needs to be supplemented should be recorded.

6.4 Diagnosis and examination

See requirements in "5.2 Diagnosis and examination".

6.5 Treatment programmes

Refer to requirements in "5.3 Treatment programmes".

7 Records of follow-up

7.1 Compliance with treatment

See requirements in “6.1 Compliance with treatment”.

7.2 Response to treatment

See requirements in “6.2 Response to treatment”.

7.3 Present symptoms and supplementary medical history

See some of the requirements in "6.3 Present symptoms and supplementary medical history".

7.4 Adjustment of treatment plan

The adjustment of treatment plan for therapeutic principle, therapeutic method, prescription and advice should be recorded, which is based on information of follow-up.

7.5 Advice of follow-up

The advice on the patient's lifestyle, daily diet and home nursing should be recorded, which is based on compliance and information of follow-up.

Bibliography

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