Clinical Documentation Cheat Sheet

Documentation element	Description	Key points
Patient identification	Patient's personal information	Include name, date of birth, medical record number, and contact details
Medical history	Comprehensive medical background	Document past and current medical conditions, surgeries, and family history.
Medication list	Current and past medications	Include dosages, frequency, and any adverse reactions
Allergies	Documented allergies or reactions	Note specific allergens and type of reactions experienced.
Chief complaint	Primary reason for the visit	Record the patient's main concern or symptom.
History of present illness	Detailed account of the chief complaint	Describe the onset, duration, intensity, and associated symptoms
Physical examination	Findings from the physical assessment	Document vital signs, general appearance, and system-specific findings.
Assessment and plan	Clinical judgment and care plan	Summarize diagnoses and outline the treatment plan, including medications, therapies, and follow-up.
Progress notes	Ongoing documentation of care	Record changes in condition, response to treatment, and any modifications in the plan.
Discharge summary	Overview of the hospitalization or visit	Summarize the reason for admission, course of treatment, final diagnoses, and follow-up instructions.
Additional notes		