Standard Operating Procedure (SOP)
Medical History and Current Medication Recording Process

1. Purpose

This SOP details the **medical history and current medication recording process**, including systematic collection, documentation, and verification of patient medical histories and active medications. It emphasizes accurate data entry, patient confidentiality, and regular updates to ensure effective healthcare management and informed clinical decision-making. The purpose is to maintain comprehensive and up-to-date medical records to support patient safety and treatment accuracy.

2. Scope

This procedure applies to all healthcare staff involved in patient intake, assessment, and record keeping within the facility.

3. Responsibilities

- **Clinical Staff:** Collect, document, and verify medical history and current medications.
- **Medical Records Personnel:** Ensure data accuracy, privacy, and timely updates in the medical record system.
- **Supervising Clinician:** Review completed records for compliance and completeness.

4. Procedure

1. **Patient Identification:** Confirm patient identity using at least two identifiers (e.g., full name, date of birth).
2. **Information Gathering:**
    - Collect comprehensive medical history, including past illnesses, surgeries, allergies, familial diseases, and immunizations.
    - Document all current medications, including prescribed, over-the-counter, herbal supplements, and vitamins.
    - Note details for each medication: name, dosage, frequency, route, and prescribing clinician.
3. **Data Entry:**
    - Enter collected information accurately into the Electronic Medical Record (EMR) or physical record as appropriate.
    - Use standard medical terminology and avoid abbreviations unless widely recognized.
4. **Verification:**
    - Confirm accuracy by cross-referencing with previous records and verifying with the patient or legally authorized representative.
5. **Confidentiality:**
    - Adhere to all relevant privacy laws and regulations (e.g., HIPAA) when handling patient information.
6. **Updates:**
    - Review and update medical history and current medications at every patient visit or when new information emerges.
7. **Documentation:**
    - Document date and time of each entry and the staff member responsible for the documentation.

5. Documentation Format Example

Date	Staff	Medical History Summary	Allergies	Current Medications

2024-06-10	Dr. Smith	HTN, T2DM, Appendectomy (2015)	Penicillin	Metformin 500 mg BID; Lisinopril 10 mg QD; Aspirin 81 mg QD

6. Review and Audit

- Supervisors must randomly audit patient records monthly for accuracy and completeness.
- Non-compliance or errors must be addressed with corrective training.

7. References

- Facility Policy on Patient Record Management
- Health Insurance Portability and Accountability Act (HIPAA)
- Clinical Documentation Standards

Version: 1.0 | Effective Date: 2024-06-10