Standard Operating Procedure (SOP): Collection and Documentation of Patient Medical History

1. Purpose

This SOP details the process for the **collection and documentation of patient medical history**, including patient interview techniques, accurate recording of past medical conditions, allergies, medications, family history, and lifestyle factors. The SOP ensures consistent and comprehensive gathering of critical health information to support diagnosis, treatment planning, and continuity of care, while maintaining patient confidentiality and data security.

2. Scope

This SOP applies to all healthcare staff responsible for obtaining and documenting patient medical history in [Facility Name].

3. Responsibilities

- **Healthcare Providers:** Conduct patient interviews and document medical history accurately.
- **Administrative Staff:** Ensure documentation forms are available and properly maintained.
- **All Staff:** Adhere to confidentiality and data security protocols.

4. Procedure

1. **Preparation**
    - Verify patient identity using at least two identifiers (e.g., name, birthdate).
    - Ensure privacy and a comfortable environment for the interview.
    - Have required documentation forms or electronic devices ready.
2. **Patient Interview Techniques**
    - Use open-ended and closed-ended questions as appropriate.
    - Establish rapport to encourage honest and complete responses.
    - Practice active listening and follow up on vague or incomplete answers.
3. **Information to be Collected**

Category	Details
Personal Information	Full name, DOB, contact details, gender, and other identifiers.
Chief Complaint	Primary reason for visit or consultation.
History of Present Illness	Onset, duration, symptoms, associated factors, previous interventions.
Past Medical History	Chronic illnesses, surgeries, hospitalizations, injuries.
Medications	Current and past medications, dosages, adherence, over-the-counter drugs, supplements.
Allergies	Drug, food, environmental, and reaction types.
Family History	Genetic or hereditary conditions, major illnesses in immediate family.
Social & Lifestyle Factors	Smoking, alcohol, substance use, diet, exercise, occupational exposures, living situation.

4. **Documentation**
    - Record information clearly, objectively, and legibly (paper or electronic forms).
    - Include date, time, and provider's signature or electronic authentication.
    - Use standard medical abbreviations and terminology.
5. **Review and Confirmation**
    - Review documented history with the patient for accuracy.
    - Address any discrepancies or uncertainties.
6. **Confidentiality and Data Security**
    - Store medical records securely according to facility policy and legal requirements.
    - Only authorized personnel may access patient medical histories.

5. Documentation Retention

Maintain medical history documentation as per [Facility/Regulatory] retention policies.

6. References

- [Institutional Policy on Medical Documentation & Record Keeping]
- [Local/National Laws on Health Information Privacy (HIPAA, etc.)]
- [Best Practice Guidelines for Patient Medical History Taking]

7. Revision History

Date	Revision	Description	Author
[YYYY-MM-DD]	1.0	Initial release	[Name/Title]