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Medical records are the collection of data of characters, symbols, tables, images, sections, etc., including outpatient, emergency and inpatient medical records. They record medical activities by summarizing, analyzing, and sorting relative data obtained from inquiries, physical examinations, auxiliary examinations, diagnoses, treatments, nursing, etc. They are the comprehensive records of clinical practices, reflecting onsets, progresses, outcomes, diagnoses, and treatments of the patient's illness. Clinical physicians use medical records as scientific evidences to diagnose, treat, and prevent diseases. Medical records can reflect hospital management, medical quality, and professional skill. They are basic data of clinical teaching, scientific research, and information management, as well as important basis for

qualification evaluation of medical service. They are medical files of legal effects and important basis for medical disputes and litigation. Recently, medical records have been required to be in accordance with strict standards and requirements by the (National Health and Family Planning Commission). They are forbidden to be forged, hidden, destroyed, or seized. The patient has the right to cope some part of medical records, including some medical notes, body temperature sheets, medical order sheets, test reports, medical imaging data, special examination consent forms, surgery consent forms, surgery and anesthesia records, pathological data, nursing records, etc. So, it is a basic clinical skill for each physician to write medical records correctly and carefully.

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