Notes:How to write a medical record

Notes of *Degowin's Diagnostic Examination*

By rainoffallingstar,8th May 2020

The patient’s medical record is a document containing: (1) the medical history, (2) the findings from the PE, (3) the reports of laboratory tests, (4) the findings and conclusions from special examinations, (5) the findings and diagnoses of consultants, (6) the diagnoses of the responsible physician, (7) notes on treatment, including medication, surgical operations, radiation, physical therapy, and (8) progress notes by physicians, nurses, and others

**Outline**

The medical history is recorded in a standard sequence, differing minimally from one institution to another. The following sequence is suggested for adults. A different order giving prominence to the birth history is often preferred by pediatricians.

1. Identification
2. Informant
3. Chief complaints (CCs)
4. History of present illness (HPI)
5. Past medical and surgical history (PMH) A. General health B. Chronic illnesses and conditions C. Operations and injuries D. Hospitalizations
6. Family history (FH)
7. Social history (SH)
8. Review of systems (ROSs)
9. Medications
10. Allergies and medication intolerances
11. Preventive services, including immunizations
12. Physical examination (PE)
13. Laboratory and imaging studies
14. Assessment/ Problem list
15. Plan
16. Inpatient progress notes
17. Discharge summary
18. Physician’s signature

**Completion of the medical record**

It is the clinician’s responsibility to see that the medical record is complete and accurate. Your signature attests to the accuracy of the information and that you have verified it to your satisfaction. Once Entered and signed, the information in the medical Record cannot be altered, although addendums and corrections can be added.

**Identification**: These data are frequently provided or the clinician, but should be checked for accuracy.

**Patient’s name**. Record the complete name, including the family and given names, being careful to obtain correct spelling and birth date. When a married woman who has taken her husband’s name, place her husband’s given names in parentheses, as Brown, Mary Elizabeth (Mrs. Edward Charles), since she may sign her name as Mrs. Edward C. Brown in correspondence.

**Sex and gender.** Sex is determined by genetics, gender is the patient’s sexual identity. Usually, this is obvious, but specific questions asked sensitively may be required.

**Residence**. The address should be confirmed and recorded; occasionally, addresses may be needed to distinguish patients with the same name.

**Birth date and age**. Record the patient’s birth date and stated age. The birth date may be needed to distinguish between patients with the same name.

**Source of referral.** When referred, confirmed the reason for referral and the name, address, telephone, and FAX numbers of the referring clinician.

**The informant**

**Sources of the history.** The history is best obtained from the patient with supportive in formation from others. Record your impression of the historian’s accuracy and credibility.

**Interpreters**. Try to avoid untrained interpreters. The following is a frequent experience with a lay interpreter, especially a family member. You ask, “Do you have pain?” The interpreter and patient have an animated conversation or a minute or two after which the interpreter says, “No, she doesn’t have any pain.” It is reasonable to assume that there is uncertainty about the content of the discussion between interpreter and patient. You cannot evaluate the patient’s story or answers unless you know how the questions were asked. Your only recourse is to ask short concrete questions and insist that the resulting conversation be no longer than you judge necessary.

**Chief complaint**

Begin the record with CC, the symptom that precipitated the visit. Complaints should be listed as single words or short phrases with the approximate length of time they have been present: for example, nausea for 2 months; vomiting for 1 week. Use the patient’s own words free of interpretation. Do not accept a previous diagnosis as a CC; probing may be needed before the patient relates their symptoms rather than their diagnoses or those of previous providers and family members.

The CC is the starting place for making a differential diagnosis; the details of the symptoms should always be fully elucidated. Since these are the symptoms for which the patient sought care, they will require therapy or an explanation of why therapy is not given. The patient’s CC should be the 1st problem on your problem list. This would seem obvious, but occasionally the physician finds an interesting disease, unrelated to the CC; the medically attractive condition receives all the attention, and the CC is ignored.

**History of present illness.** The HPI is the patient’s story of their illness experience; it is the most important par t of the diagnostic examination. It should be recorded in complete sentences as a lucid, succinct, and chronologic narrative. Ideally, the HPI should be brief , so that it is easily read and digested, but this is only possible if the history is relatively straight forward. Some stories are complex and the diagnostic possibilities broad, requiring inclusion of more detail since you can’t be certain what is pertinent and what superfluous.

You must avoid premature interpretation such as replacing their words with medical terminology or failing to record seemingly irrelevant symptoms or events.

\*\*The chief purpose of the history is to help you form diagnostic hypotheses

**Past medical history**

The past history helps you understand the person you are evaluating and the preconditions that may substantially alter current and future risks or specific health conditions. When relevant, specific acts may be included in the HPI, but they must be recorded again in this section. The significance of past illnesses may only be appreciated after future developments in the patient’s condition or as newly recognized disease associations are reported.

**General health**. The patient’s lifetime health, before the present illness, is sometimes revealing. Factors to consider include body weight (present, maxi- mum, and minimum, with dates of each), previous PEs (dates and findings), and any periods of medical disability.

Chronic and episodic illnesses Chronic medical illness. List all illnesses, diseases, or conditions or which the patient receives, or has received, chronic medical treatment.

**Infectious diseases.** Infectious diseases have had an important history in medicine. Knowledge o past infections is important to understand current and future infection risk. List dates and complications of these illnesses with particular attention to hepatitis, rheumatic fever, tuberculosis, sexually transmitted diseases, and HIV. Give dates and duration of antibiotic treatment.

**Operations and injuries**. Give dates and nature of injuries, operations, operative diagnoses, and infection, hemorrhage, blood transfusions, or other complications.

Previous hospitalizations. Record each hospitalization, including the dates, names, and location of hospitals. If the hospital records are available, summarize the dates and diagnoses or each admission.

**Family history** : A FH is essential or all patients receiving more than the most cursory care. This should **include four generations, when available: grandparents, parents, aunts and uncles, siblings, and children**. For parents and grand- parents, record the birth year and current health or age at death and causes. For aunts, uncles, siblings, and children, record the birth year, 1st name, and cur- rent health or cause of death and age at death. Make note of any FH of hyper- tension, heart disease, diabetes, kidney disease, autoimmune diseases, gout, atopy, asthma, obesity, endocrine disorders, osteoporosis, cancer (particularly breast, colon, ovarian, and endocrine cancers), hemophilia or other bleeding diseases, venous thromboembolism, stroke, migraine, neurologic or muscular disorders, mental or emotional disturbances, substance abuse, and epilepsy.

**Social history**

**Place of birth,Nationality, ethnicity, and language,Marital status,Occupations.**

**Military history** : It is important to note military service by branch, geo graphic locations, discharge (honorable or dishonorable), and eligibility or veteran’s benefits

**Social and economic status.** Record the patient’s years of formal education, vocational training, current living arrangements, and any financial problems.

**Habits**. Determine the patient’s former and current use o tobacco, coffee, alcohol, sedatives, illicit drugs (especially injection drug use), tattoos, and body piercing.

**Violence and safety.** Record the patient’s use of vehicle restraints, bicycle and motorcycle helmets, and the presence of home smoke and carbon monoxide alarms

**Prostheses and in-home assistance.** Record the patient’s use of eyeglasses, dentures and dental appliances, hearing aides, ambulation assistance devices (cane, walker, scooter, wheelchair), braces, prosthetic footwear, and any aide or assistance received in the home (visiting nurse, physical therapy, home- maker services).

**Review of systems**

The following outline can help inquire or symptoms associated with each system or anatomic region. Symptoms related to the patient’s current problem, discovered during your ROS inquiry, should be recorded in the HPI. Become familiar with these symptoms and learn their diagnostic significance: record positive answers and negative responses when they are pertinent to the differential diagnosis. It is efficient to ask the questions while examining the body to which the questions pertain. Use of a standardized check in questionnaire will facilitate a thorough review and save time.

**Constitutional**. Weight Loss or Gain, Fatigue, Fevers, Chills, or Sweats

**Skin, hair, and nails**

**Skin**: Color, pigmentation, temperature, moisture, eruptions, pruritus, scaling, bruising, bleeding. **Hair**: Color, texture, abnormal loss or growth, distribution.

**Nails**: Color changes, brittleness, ridging, pitting, curvature

**Lymph nodes.** Enlargement, pain, tenderness, suppuration, draining sinuses, location.

**Bones, joints, and muscles**. Fractures, dislocations, sprains, arthritis, myositis, pain, swelling, stiffness, degree of disability, muscular weakness, wasting or atrophy, night cramps.

Hemopoietic system. Anemia (type, therapy, and response), lymphadenopathy, bleeding or clotting (spontaneous, traumatic, familial).

**Endocrine system.** History of growth, body configuration, and weight; size of hands, feet, and head, especially changes during adulthood; hair distribution; skin pigmentation; goiter, exophthalmos, dryness of skin and hair, intolerance to heat or cold, tremor; polyphagia, polydipsia, polyuria; libido, secondary sex characteristics, impotence, sterility.

**Allergic and immunologic history.** Dermatitis, urticaria, angioedema, eczema, hay fever, rhinitis, asthma, conjunctivitis; known sensitivity to pollens, foods, danders, X-ray contrast agents, bee stings; previous skin tests and their results; results of tuberculin tests and others; desensitization, serum injections, vaccinations, and immunizations.

**Head**. Headaches, migraine, trauma, syncope, convulsive seizures.

**Eyes**. Loss of vision or color blindness, diplopia, hemianopsia, trauma, inflammation, glasses (date of refraction), discharge, excessive tearing.

**Ears**. Deafness, tinnitus, vertigo, discharge from the ears, pain, mastoiditis, operations.

**Nose**. Coryza, rhinitis, sinusitis, discharge, obstruction, epistaxis.

**Mouth**. Soreness of mouth or tongue, symptoms referable to teeth and gums.

**Throat**. Hoarseness, sore throats, tonsillitis, voice changes, dysphagia, odynophagia.

**Neck**. Swelling, suppurative lesions, enlargement of lymph nodes, goiter, stiffness, and limitation of motion.

**Breasts**. Development, lactation, trauma, lumps, pains, discharge rom nipples, gynecomastia, changes in nipples, skin changes.

**Respiratory system.** Pain, shortness of breath, wheezing, cough, sputum, hemoptysis, night sweats, pleurisy, bronchitis, tuberculosis (history of contacts), pneumonia, asthma, other respiratory infections.

**Cardiovascular system**. Palpitation, tachycardia, irregularities of rhythm, pain in the chest, exertional dyspnea, paroxysmal nocturnal dyspnea, orthopnea, cough, cyanosis, edema; intermittent claudication, cold extremities, postural or permanent changes in skin color; hypertension, rheumatic fever ,chorea, syphilis, diphtheria; drugs such as digitalis, quinidine, nitroglycerin, diuretics, anticoagulants, anti-platelet agents, and other medications.

**Gastrointestinal system.** Appetite, dysphagia, nausea, eructation, flatulence, abdominal pain or colic, vomiting, hematemesis, jaundice (pain, fever, intensity, duration, color o urine and stools), ascites, stools (color, frequency, in- continence, consistency, odor, gas, cathartics, pain or diffculty with passage, urge to stool), hemorrhoids, change in bowel habits.

**Genitourinary system**. Color of urine, polyuria, oliguria, nocturia, dysuria, hematuria, pyuria, urinary retention, urinary frequency, incontinence, pain or colic, passage of stones

**Gynecologic history**:Age of menarche, frequency of periods, regularity, duration, amount of f ow, leukorrhea, dysmenorrhea, date of last normal and preceding periods, date and character of menopause, postmenopausal bleeding; pregnancies (number, abortions, miscarriages, stillbirths, chronologic sequence), complications of pregnancy; birth control practices (oral contraceptive medications, barrier methods, etc.).

**Male history:**Erectile dysfunction, premature ejaculation, blood in the semen, contraceptive methods, and condom use

**Venereal disease history:**Sexual activity (sex of partners and practices), chancre, bubo, urethral discharge, treatment of venereal diseases

**Nervous system General.** Headache, loss of consciousness, unsteadiness, vertigo, falls, sleep disorders (insomnia, non-restful sleep, leg movements of sleep, sleep walking), restless legs.

**Cranial nerves (CNs).** Disturbances of smell (CN I), visual disturbances (CN II, III, IV, VI), orofacial paresthesias and difficulty in chewing (CN V), facial weakness and taste disturbances (CN VII), disturbances in hearing and equilibrium (CN VIII), difficulties in speech, swallowing, and taste (CN IX, X, XII), limitation in motion of neck (CN XII).

**Motor system.** Paralyses, weakness, muscle wasting, involuntary movements, convulsions, gait, incoordination.

**Sensory system**. Pain, lightning pain, girdle pain, paresthesia, hypesthesia, anesthesia, allodynia.

**Autonomic system.** Control of urination and defecation, sweating, erythema, cyanosis, pallor, reaction to heat and cold, postural faintness.

**Psychiatric history.** Describe difficulties with interpersonal relationships (with parents, siblings, spouse, children, friends and associates), sexual adjustments, school and employment success and difficulties, impulse control, sleep disorders, mood swings, difficulty with concentration, thought, or the presence of hallucinations

**Medication** : Keep a list of current medications by name, dose, effect, indication, and duration of use. Ask the patient to bring the original containers with the labels. If the labels are absent, call the pharmacy where they were dispensed. Be sure to list all nonprescription drugs, herbal remedies, supplements, and vitamins.

A**llergies And Medication Intolerances** : Untoward drug reactions should be as explicit as possible. Ask for the type of reaction or intolerance experienced.

Common side effects may be incorrectly identified as allergies: for example, stomach upset with codeine or erythromycin. Identify known or suspected causes o anaphylaxis (drugs, stings, and foods, e.g., peanuts). This summary of allergies and medication intolerances must be consulted when drugs are being prescribed

**physical examination:** Record the observations from your PE in the follow- ing sequence:

1. Vital signs
2. General appearance
3. Head, eyes, ears, nose, and throat
4. Neck and spine
5. Chest: breasts
6. Chest: chest wall and lungs
7. Chest: heart, major arteries, and neck veins
8. Abdomen
9. Genitourinary examination, including inguinal hernias
10. Rectal examination
11. Extremities
12. Lymph nodes
13. Neurologic examination, including the mental status examination
14. Skin

**Laboratory**: Record the results of the laboratory results used in developing your differential diagnosis

**Assessment**

**Case summary**. It is sometimes useful to write a brief abstract of the history and significant observations

**The problem list and assessment**. A working problem list should be maintained with notes and dates indicating their status. The problem list records each of the diagnostic and management problems that need to be addressed.

A problem may be a symptom, a sign, a laboratory finding, or a cluster of several associated items. A previously confirmed disease may be listed as a problem. By constantly reviewing the problem list, you assure that every problem is being evaluated and managed. It is important to update and revise the problem list.

Generate a differential diagnosis for each medical problem, the differential diagnosis can be pathophysiologic, diagnostic, or both. It is a good practice to keep the patient’s CC as the 1st problem.Beyond that, we do not feel that attempts to number the problem list in a prioritized or numerically consistent fashion is useful; priorities change as the evaluation and treatment proceed and problems disappear or consolidate as more information is acquired.

Diagnostic problem solving is much like putting together a jigsaw puzzle without the picture and with only a few pieces provided at a time. To eventually solve the puzzle, you place the pieces on the table and, as new pieces appear, keep trying different arrangements until the pattern emerges.

The problem list is your table full of pieces; your hypotheses are attempts to explain the pattern. It is often the odd piece that does not seem to fit anywhere that is the key to the puzzle. When the diagnosis is obscure, beware of lumping problems together prematurely; this may serve to obscure rather than to clarify the diagnosis.

**The plan**:For each problem, and the patient as a whole, you need to develop a management plan. The plan or each problem has three parts: (1) plans or testing your hypothesis, (2) therapy to be considered or given, and (3) education or the patient and family.

a plan is only as good as the diagnostic hypotheses that generated it. Our emphasis in this text is to help you think about the information acquired in the history and physical exam so that you can generate sound, testable hypotheses. Once you have generated a concise differential diagnosis, you can consult textbooks and/or search the medical literature to find an efficient method for testing your hypotheses.

**Inpatient progress notes**:Progress notes are made daily and additionally whenever necessary. Each note should be dated and the time of day recorded.

Each note has our subheads. Use the mnemonic SOAP to remember them: Subjective data (symptoms and changes in symptoms, their appearance and disappearance, and their response to therapy); Objective data (changes in or new physical signs and laboratory findings and response to therapy); assessments (updates to your problem list and hypotheses); and Plans (diagnostic tests, therapeutic interventions and instructions to the patient and nursing staff ). When a problem is resolved by inclusion in another diagnosis, or by cure or disappearance, it should be so noted in the progress note and in the working problem list.

The full and legible name of the writer is appended to each progress note. The name should be followed by a slash mark and an abbreviation indicating hospital role, that is, MD (resident), RN (student nurse or graduate), S (staff ), etc.

**Discharge summary** : When the patient leaves the hospital, a discharge summary is created containing the principle diagnosis and all problems addressed during the hospitalization, an abstract of the history and hospital course, future plans, and each medication by dose and schedule, noting new, discontinued, or changed medications. Note the patient’s condition and functional status at discharge and any information or instructions given to the patient and attendants for home and follow-up care.

**physician’s signature** : Every physician note and order should be signed and dated as proof of authorship. Dates should include the month, day of the month, year, and time of day. In teaching hospitals, where many persons contribute to the record, the entries of medical students and nurses should be dated and accompanied by their signatures with suitable abbreviations indicating their status

**Example case 1**

**Union Hospital affiliated to Huazhong University of Science and Technology**

**Admission Record**  0000337023

**Department:**  Respiratory Medicine **Area:** J17 Respiratory Medicine **Bed No.** 109031 **Case No.** 1565825

**Name:** Hou Deguang **Gender:** Male  **Date of Birth:** 15/9/ 1936 **Age:** 78  **Nationality:** China  
**ID No.** 420102193609150819  **Ethnicity:** Han  **Occupation:** other  **Marital status:** Married   
**Address:** Nanchong，Sichuan  **Tel No.** 13871426922   
**Source of History:** Patient herself  **Reliability:** Reliable   
**Admission Date & Time:** 4/11/2014 14:36

**Chief Complaint:** Found pleural effusion for about 2 months.

**Present Illness:** The patient received the chest CT scan in the Wuhan Traditional Medicine Hospital two months ago and found right-side pleural effusion, right-side pulmonary atelectasis. After that, he was hospitalized in the Endocrinology Dept of our hospital for poor management of blood glucose level. On this admission, He received the thoracocentesis, and the laboratory examination results indicated the large possibility of tuberculous pleural effusion. No special treatment was given at that time. The patient was aware of a sense of polypnea after long walk, without cough, expectoration, night sweats, chest distress, thoracalgia, wheeze, dyspnea and can lie down to sleep at night. The return-visit in the clinic at October 13th showed that there were a few pleural effusion on the right side and is hard to be localized. Now the patient came to our hospital for further treatment and was admitted as “Pleural effusion origin unknown”.  
Since the onset of the disease, the patient’s spirit, appetite and sleep are normal. Nocturia for 1 time per night. Stool are as usual. No obvious weight and physical strength change.

**Past History:**   **General Health Status:** Relatively bad; **Respiratory Syste**m: Chronic bronchitis for about 10 years; **Circulatory System:** Hypertension for about 20 years, highest reached 180/95mmHg, took Amlodipine orally 5mg qd, BP management is good. Diagnosed of coronary heart disease in 2007, underwent intracoronary stent implantation in 2008, 3 stents were implanted; **Digestive Systems:** None; **Urinary System**: Benign prostatic hyperplasiafor about 5 years**,** Diabetic nephropathy for 3 years; **Hematologic System**: Thrombocytopenia for 2 years; **Endocrine System:** None. **Nervous System:**  Lacunar infarction in 2011; **Motor System:** None; **Infection History:** No infection of hepatitis and TB. **Others:** None special; **Preventive Inoculation**: In accordance with the stateplan; **Operation History:** underwent intracoronary stent implantation in 2008, 3 stents was implantated; **Blood Transfusion History:** None; **Traumatic History**: None; **Allergic History:** None;

**Personal History: Habitual Residence:** Hubei; **Residential Environment:** No exposure history to toxic substances and infected water; **Travelling History:** None; **Smoking History:** Smoking for about 40 years, 3 cigarettes per day. Quit smoking in 2008; **Drinking History:** Drinking for 40 years, 150g-350g per day, Quit drinking in 2008;

**Marital History:** Married,

**Menstrual History:** Male

**Family History:** Father is deceased, mother is deceased. No other infective and hereditary diseases.

**Physical Examination**

**Vital Signs:** T:36.5℃. P:86 bpm, regular. R: 20min, regular. BP: 132/74 mmHg. Height: 164cm. Weight: 64kg. Expression: Normal. Development: Well. Nutritional status: Fairly. Consciousness: Conscious. Spirit: Well. Gait: Normal. Position: Active. Coordination with Examination: Cooperative.

**Skin and Lymph Nodes:** No jaundice. Some scattered scratch in hands and abdomen, No subcutaneous bleeding, edema, nodules or unusual pigmentation. Liver palm(-). Spider angioma(-). No swelling of general superficial lymph nodes.

**HEENT(Head, Eye, Ear, Nose, Throat):** Normal skull. No baldness, no scars. Eyes: No ptosis. Conjuctiva normal. The pupils are round, symmetric and responsive to light and accommodation is normal. Ears: Externally normal. Canals clear. Drums normal. Noses: No abnormalities noted. Month and Throat: lips red, tongue red, no swelling of tonsils.

**Neck:** Motion free. Thyroid is not enlarged. No abnormal pulsations. Trachea in middle. Carotid: Pulse is normal. Hepatojugular reflux sign(-). Vascular bruit: None.

**Chest and Lung:** Normal contour. Breast normal. Inspection: respiratory movement symmetric and regular. Palpation: Normal and symmetric. No pleural friction fremitus. Percussion: both sides resonance. Auscultation: right-side breath sounds weaken, left-side is normal. No moist or dry rales. No pleural friction rubs.

**Heart:** No protrusion of precordium. Normal apical impulse. No thrill. No enlarged cardiac dullness border. Heart rate: 88bpm, rhythm normal. No abnormal and extra cardiac sounds or cardiac murmurs. No peripheral vascular signs.

**Abdomen:** Flat abdomen. No gastric or intestinal pattern. No visible peristalsis. Normal bowel sound. No rigidity. No mass palpable. No tenderness and rebound tenderness. Liver and spleen are not palpable. Kidneys are not palpable. No percussion tenderness over kidney regions. No shifting dullness.

**Rectum:** Normal anus and perineum.

**Genitourinary System:** Normal.

**Neural System:** Normal.

**Extremities:** No joint disease. Muscle strength normal. Pathological reflex (-).

**Specialty Examination:** Right-side breath sounds weaken, left side normal. No moist or dry rales, No swelling of general superficial lymph nodes. No edema in neither lower extremities.

**Accessory Examination:** Discharge record of Endocrinology Dept. of our hospital at September 2014; Clinic examination at October 13th: a few pleural effusion on the right side and is hard to be localized.

**History summary:** 1. Hou Deguang, male, 78 yr.  
 2. Admitted for ”Found plaural effusion for about 2 months”.  
 3. T:36.5℃. P:86 bpm, regular. R: 20min, regular. BP: 132/74 mmHg. Expression: Normal. Spirit clear. Cardiac sounds normal, HR: 72 bpm, rhythm normal, No abnormal and extra cardiac sounds or cardiac murmurs. Right-side breath sounds weaken, left side normal. No moist or dry rales, no pleural friction rubs. Flat abdomen. No rigidity.   
 4. Special examination: Trachea in middle. Contour symmetric. Respiratory movement regular. Right-side breath sounds weaken, left side normal. No moist or dry rales, no pleural friction rubs.  
 5. Accessory Examination: Discharge record of Endocrinology Dept of our hospital at September 2014; Clinic examination at October 13th: a few pleural effusion on the right side and is hard to be localized.   
 6. Past history: **Respiratory Syste**m: Chronic bronchitis for about 10 years; **Circulatory System:** Hypertension for about 20 years, highest reached 180/95mmHg, took Amlodipine orally 5mg qd, BP management is good. Diagnosed of coronary heart disease in 2007, underwent intracoronary stent implantation in 2008, 3 stents was implantated; **Digestive Systems:** None; **Urinary System**: Benign prostatic hyperplasiafor about 5 years**,** Diabetic nephropathy for 3 years; **Hematologic System**: Thrombocytopenia for 2 years; **Endocrine System:** None. **Nervous System:**  Lacunar infarction in 2011; **Motor System:** None; **Infection History:** No infection of hepatitis and TB. **Others:** None special; **Preventive Inoculation**: In accordance with the stateplan; **Operation History:** underwent intracoronary stent implantation in 2008, 3 stents was implantated; **Blood Transfusion History:** None; **Traumatic History**: None; **Allergic History:** None;

**Impression:** 1. Right-side pleural effusion origin unknown: TB? Tumor?  
 2. II diabetes mellitus, Diabetic nephropathy  
 3. Hypertension III, high risk  
 4. Coronary heart disease, post-intracoronary stent implantation  
 5. Lacunar infarction  
 6. Thrombocytopenia  
 7. Benign prostatic hyperplasia

**Recorder:** Cheng Long **Date & Time:** 4/11/2014 16:14  
**Checker:** Xu Juanjuan  
**Date & Time:** 5/11/2014 10:22