A. S. ALIAKSEYEVA, A. V. RYLATKA

FILLING IN PATIENT'S MEDICAL RECORD FOR OUTPATIENT CLINICS

МИНИСТЕРСТВО ЗДРАВООХРАНЕНИЯ РЕСПУБЛИКИ БЕЛАРУСЬ
БЕЛОРУССКИЙ ГОСУДАРСТВЕННЫЙ МЕДИЦИНСКИЙ УНИВЕРСИТЕТ
КАФЕДРА ПОЛИКЛИНИЧЕСКОЙ ТЕРАПИИ

Е. С. Алексеева, Е. В. Рылатко

ОФОРМЛЕНИЕ УЧЕБНОЙ МЕДИЦИНСКОЙ КАРТЫ ПАЦИЕНТА ДЛЯ АМБУЛАТОРНО-ПОЛИКЛИНИЧЕСКИХ ОРГАНИЗАЦИЙ

FILLING IN PATIENT'S MEDICAL RECORD FOR OUTPATIENT CLINICS

Электронные методические рекомендации

Минск БГМУ 2026

ISBN 978-985-21-2334-1

Об издании — 1, 2, 3

УДК 614.21:616-052(075.8)=111
ББК 51.1(2)я73
А47

Рекомендовано Научно-методическим советом университета в качестве методических рекомендаций от 15.04.2026 г., протокол № 8

Р е ц е н з е н т ы: канд. мед. наук, доц., доц. каф. внутренних болезней, кардиологии и ревматологии с курсом повышения квалификации и переподготовки Белорусского государственного медицинского университета О. А. Паторская; каф. общей врачебной практики Витебского государственного ордена Дружбы народов медицинского университета

Алексеева, Е. С.

Оформление учебной медицинской карты пациента для амбулаторно-поликлинических организаций = Filling in patient's medical record for outpatient clinics : электронные методические рекомендации / Е. С. Алексеева, Е. В. Рылатко. – Минск: БГМУ, 2026. – 17 с. ; 1 файл (0,44 Мбайт). – Режим доступа: свободный.

ISBN 978-985-21-2334-1.

Предназначено для студентов 4-го курса медицинского факультета иностранных учащихся, обучающихся на английском языке по учебной дисциплине «Поликлиническая терапия».

Издание реализовано в программной оболочке Adobe Acrobat и оснащено интерактивным оглавлением. Минимальные системные требования: программа для просмотра PDF-файлов (Adobe Acrobat Reader и др.), наличие сетевого доступа (интернет-браузер Google Chrome, Mozilla Firefox и др.).

УДК 614.21:616-052(075.8)=111
ББК 51.1(2)я73

CONTENTS

INTRODUCTION

High-quality and accessible medical care is the most important direction of development of the healthcare system of the Republic of Belarus, the key role in which belongs to primary health care, provided mainly in outpatient settings. The main figure in the primary health care system in the Republic of Belarus is the general practitioner (GP). Keeping medical records is an integral part of the practical activities of doctors of all specialties working in outpatient settings, allowing for monitoring the health of patients, ensuring continuity and quality control of the work of medical personnel, generating statistical data at all levels of the healthcare system, etc.

The development of information and communication technologies in healthcare and the level of computer equipment in healthcare institutions make it possible to switch to maintaining medical records in electronic form while maintaining medical confidentiality. In particular, a number of healthcare institutions have successfully implemented automated information systems such as «Electronic Prescription», «Electronic Medical Record», etc. However, the undeniable advantages of electronic document management compared to paper — saving the doctor's time, a unified and neat («readable») appearance of documents — require strict adherence to the rules for the execution of medical records by both doctors and mid-level medical personnel.

Practical skills in compiling medical documentation, its formation and consolidation are one of the main areas of the educational process at the Outpatient Therapy Department.

EDUCATIONAL MATERIAL

«Patient's medical record for outpatient clinics» (hereinafter referred to as the medical record) (form No. 025/u-23) is the main medical document of a physician of an outpatient and polyclinic institution, reflecting the state and dynamics of a person's health over a long period of time. This allows physicians of various specialties, who treat a given patient throughout his or her life, to obtain a comprehensive picture of the patient and make adequate medical decisions. Responsibility for the correct execution and maintenance of this document rests with the physicians of the outpatient and polyclinic institution and, first of all, with the GP.

A medical record (Appendix 1) is completed for each patient upon the first request for medical care provided in an outpatient setting and is the property of the medical organization. All subsequent requests for medical care are noted in the relevant sections of this document. The medical record is kept at the registry, it is prohibited to hand it over to patients, and the information contained in it is confidential.

«**Patient's medical record for outpatient clinics**» has the following structure:

- passport section;
- sheet for recording doses of X-ray examinations;
- sheet for recording final diagnoses;
- sheet for recording temporary disability;
- sheet for recording preventive vaccinations;

– sheets for recording medical examinations by medical specialists and medical workers with specialized medical education;

– space for posting the results of laboratory, instrumental and other studies, conclusions of medical consultations (consultations), extracts from medical documents and other information about the patient's health.

The results of laboratory (general blood test, general urine test, biochemical blood test, etc.) and instrumental studies (electrocardiogram, spirogram, ultrasound, etc.), conclusions of specialists from outpatient clinics and diagnostic centers, medical reports from hospitals are pasted at the end of the medical record.

The passport section is filled in at the reception of the medical institution when the patient first seeks medical care. The patient's surname, first name, patronymic, gender, date of birth, identification number, and permanent residence address in the Republic of Belarus are filled in according to the identity document (passport). If the patient does not have a permanent residence in the Republic of Belarus, the address of registration at the place of stay is indicated based on the presented document. Telephone numbers (home, mobile, and work), place of work (study), and employee position are recorded from the patient's words. The medical records of elderly and senile persons living alone contain the coordinates of their closest relatives, acquaintances, or employees of the Department of Social Assistance to Citizens assigned to them.

This sheet contains notes that are important for doctors of all specialties: the presence of allergies to medications, the patient’s relation to the category of citizens entitled to benefits for medical care (disabled veterans of the Great Patriotic War, disabled persons of groups I and II, etc.) indicating the number of the document certifying the benefit.

The X-ray examination dose record sheet contains information on the radiation load received during all types of X-ray examinations performed on the patient (date and type of examination, effective dose per examination). This is necessary to resolve the issue of frequency and possibility of repeat X-ray examinations considering the radiation dose received by the patient; this section is filled in by a health worker in the X-ray room, as well as by a general practitioner's nurse from medical reports and other medical documentation.

The final diagnosis record sheet contains information on the date of the visit (date, month, year), the final diagnosis in accordance with the International Statistical Classification of Diseases and Related Health Problems (ICD), which is certified by the legible signature of the health worker. The information entered in this sheet allows the doctor to immediately learn about the pathology with which the patient visited.

The temporary disability record sheet is used to register all cases of temporary disability (TD) of the patient: the period of TD (date of issue and date of closure of the sick leave sheet (SLS)), the final diagnosis in accordance with the ICD, the total number of days of temporary disability for each case. Entering information on TD in a separate section, despite the fact that the issuance of the SLS is necessarily reflected in the medical examination record, allows the doctor to quickly navigate the frequency and duration of TD in the patient, facilitates the preparation of a referral for medical and social expertise (if necessary) and the preparation of periodic reports on TD.

The vaccination record sheet contains information on vaccinations against viral hepatitis A, B, diphtheria, whooping cough, tetanus, poliomyelitis, measles, mumps, tuberculosis, and other infectious diseases: date of vaccination and revaccination, name of the drug, its dose and series, as well as information on post-vaccination reactions and complications (local and general reaction to the drug (if any)). The entry in the outpatient card is made by the vaccination room nurse, and in the case of a reaction to the vaccination, by the attending physician.

Sheets for recording medical examinations (by medical specialists and medical workers with special medical education). The number of sheets for recording medical examinations, the so-called diaries, depends on the frequency of visits, the duration of each case of illness, etc., and therefore varies among patients. Doctors of all specialties make entries in this section of the medical record; therefore, the structure of the medical entry assumes, first of all, an indication of the place of the medical examination (at the clinic or at home), the date (day, month, mandatory — year) and time of visit (hours and minutes), the name of the specialty of the doctor conducting the examination, the type of examination (primary, repeated, active). Then a description of the patient's complaints, first the main ones, then the secondary ones. Complaints stated by the patient in any order and often unsystematically, are recorded by the doctor in a logical sequence of symptoms. Particularly significant symptoms are detailed, i. e. first the doctor must listen to the patient and clarify the details and only then write them down. Information is provided about the history of the disease, its duration, connection with any factors, the treatment carried out (medicines, «folk» remedies, etc. are indicated) and its effectiveness.

A medical examination, i. e. an objective study of the patient, is carried out in accordance with the scheme provided for by the propaedeutic of internal diseases, but in outpatient settings it is presented briefly. The results of the objective study are indicated with a detailed description of pathological changes and the state of those organs and systems that are related to the diagnosis. Temperature, heart rate, blood pressure, respiratory rate, height and body weight are measured, and the body mass index is determined. Based on the history of the disease and examination data, a diagnosis is formulated (preliminary or final clinical and functional) in accordance with current classifications. Prescribed treatment measures are noted: recommendations for regimen, nutrition, drug treatment (drugs with indication of dose and frequency of administration) and non-drug methods (herbal medicine, physiotherapy, exercises therapy, etc.). If necessary, a plan for laboratory and instrumental studies is indicated. Simple medical interventions are prescribed with the patient's consent, which he certifies in writing at the end of the medical examination record.

An examination of temporary disability involves a conclusion on the patient's ability to work or disability. If it is necessary to issue a temporary disability certificate, its number, date of issue and date of the follow-up medical examination (during which the temporary disability certificate may be closed or extended, which is also recorded) are indicated at the end of the record. The record of the medical examination is confirmed by the personal signature of the doctor. The approved form of the medical record also contains a template for recording the medical examination by a medical professional. There is part with notes of a medical worker with secondary specialized medical education.

Appendix 1
Outpatient medical record

MINISTRY OF HEALTH OF THE REPUBLIC OF BELARUS
BELARUSSIAN STATE MEDICAL UNIVERSITY
OUTPATIENT THERAPY DEPARTMENT

Head of Department
Rylatka Elena Viktorovna

PATIENT'S MEDICAL RECORD FOR OUTPATIENT CLINICS
(academic)

Patient’s name:

Supervisor: name, group number, year, faculty:

Teacher: position, name:

to the Resolution of the Ministry of Health of the Republic of Belarus
dated 05.12.2023 No. 188

_____

Name of healthcare organization

Form 025/u-23

OUTPATIENT MEDICAL RECORD

Patient's name _____

Date of Birth _____

Patient' ID _____

Sex: M / F

Place of residence (place of stay): region _____ district_____street_____ house # _____ apt.#_____
Actual residential address: region _____ district_____street_____ house # _____ apt.#_____

Place of service or work, Occupation _____

Phone: Home _____ Mobile _____

Category of citizens entitled to medical care benefits (specify benefit) _____

Date of issue of medical card: _____

X-RAY EXAMINATIONS RECORD

Surname, first name, patronymic (if any) of the patient: _____

Examination date	Type of research, number and type of procedures	Dose, mZv	Notes

FINAL (VERIFIED) DIAGNOSIS LIST

Date, month, year of final diagnosis	Final (verified) diagnosis based on ICD	Physician's name	Physician's signature

TEMPORARY DISABILITY RECORD

Period of TD	Diagnosis (reason) of temporary disability based on ICD	Disability with this diagnosis. Number of days

CARD OF VACCINATIONS DONE

Vaccination against	Date	Name of medication	Dose	Batch	Information of postvaccination' reactions
Viral hepatitis B					
Vaccination # 1					
Vaccination # 2					
Vaccination # 3					
Diphtheria, Whooping cough, tetanus					
Vaccination # 1					
Vaccination # 2					
Vaccination # 3					
Revaccination # 1					
Revaccination # 2					
Revaccination # 3					
Revaccination # 4					
Diphtheria, tetanus					
Vaccination # 1					
Vaccination # 2					
Revaccination # 1					
Revaccination # 2					
Revaccination # 3					
Revaccination # 4					
Revaccination # 5					
Poliomyelitis					
Vaccination # 1					
Vaccination # 2					
Vaccination # 3					

End of the table

Vaccination against	Date	Name of medication	Dose	Batch	Information of postvaccination' reactions
Revaccination # 1					
Revaccination # 2					
Revaccination # 3					
Measles					
Vaccination					
Revaccination					
Epidemic mumps					
Vaccination # 1					
Revaccination # 1					
Vaccination # 2					
Revaccination # 2					
Viral hepatitis A					
Vaccination					
Revaccination					
Tuberculosis					
Vaccination # 1					
Vaccination # 2					
Revaccination # 1					
Revaccination # 2					
Other infectious diseases					

PHYSICIAN'S RECORDS

Primary, repeated, active (underline what is needed)

1. Place of examenation: _____
2. Date and time of examenation: 20__ , __ hour __ min.
3. Patient'complaints_____
_____
_____
_____
_____
4. Medical history:
_____
_____
5. Data of medical examination results:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

6. Diagnosis: primary, final (underline what is needed)

_____
_____
_____
_____

7. Treatment:

_____
_____
_____
_____
_____
_____
_____

8. Recomendations:

_____
_____
_____
_____

9. Temporary disability examination:

_____
_____

10. Sick leave certificate № _____from _____ till_____regime _____
11. Date of the next consultation: _____ 20__ .

Physician _____ _____
(signature) (Doctor' name)

Consent for simple medical interventions obtained

_____ _____
(signature) (Patient'name)

MEDICAL EXAMINATION BY A MEDICAL PROFESSIONAL WITH SECONDARY SPECIALIZED MEDICAL EDUCATION

Primary, repeated, active (underline what is needed)

1. Place of examenation: _____
2. Date and time of examenation: 20__ , _ _ hour __ min.
3. Patient'complaints_____
_____
_____
4. Medical history:
_____
5. Data of medical examination results:
_____
_____
6. Diagnosis: primary, final (underline what is needed)
_____
_____
7. Treatment:
_____
_____
8. Recomendations:
_____
_____
9. Temporary disability examination:
10. Sick leave certificate № _____from _____ till_____regime _____
11. Date of the next consultation: _____ 20__ .

A medical worker with secondary specialized medical education _____ _____
(signature) (Name)

Consent for simple medical interventions obtained _____ _____
(signature) (Patient'name)

Учебное издание

Алексеева Елена Сергеевна
Рылатко Елена Викторовна

ОФОРМЛЕНИЕ УЧЕБНОЙ МЕДИЦИНСКОЙ КАРТЫ ПАЦИЕНТА ДЛЯ АМБУЛАТОРНО-ПОЛИКЛИНИЧЕСКИХ ОРГАНИЗАЦИЙ

FILLING IN PATIENT'S MEDICAL RECORD FOR OUTPATIENT CLINICS

Электронные методические рекомендации

На английском языке

Ответственная за выпуск Е. В. Рылатко
Переводчик Е. С. Алексеева
Компьютерная верстка А. В. Янушкевич

Издание разработано с помощью программного обеспечения Microsoft Office Word, Adobe Acrobat Pro.
Подписано к использованию 11.09.2026.
Объем издания: 0,44 Мб.

Издатель: учреждение образования
«Белорусский государственный медицинский университет».
Ул. Ленинградская, 6, 220006, Минск

ISBN 978-985-21-2334-1