What kind of information can I find in doctors' notes in MyChart?

Looking at doctors' notes from your recent visits can help you find:

- The names of the health problems you have
- The names of your medicines
- The names of the doctors who took care of you
- The dates of your visit to the hospital, clinic, or emergency department
- Test results
- Directions you can follow to improve your health

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How can the information from doctors' notes in MyChart help me?

The information you find in doctors' notes can help you:

- **Know what you need to do to take care of yourself.** For example, the notes can tell you:
    - What medicines to stop taking, start taking, or keep taking
    - What other visits have been scheduled for you
    - What other visits you need to schedule for yourself
- **Tell your other doctors about your recent visit.** If you are going to see one of your other doctors, you can print the doctors' notes from your recent visit and take them with you. This could:
    - Save you time since you might not need to call or visit UAMS to request your records
    - Help your doctor take the best care of you, since they will have more information about you when they treat you

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What kinds of doctors' notes can I see in MyChart?

Some common types of notes are:

History & Physical. Your doctor may write a History & Physical (or H&P Note) after a visit to the hospital, clinic, or emergency department. It has these main parts:

- Assessment/Plan: The main things the doctor plans to do to help your health problems
- Chief Complaint (CC): The main problem that made you come to the clinic or hospital
- History of Present Illness (HPI): More details about what made you come to the clinic or hospital
- Past Medical History (PMH): Health problems you have now or have had in the past, and how those have been treated Past and current medicines you take might be included too. May also include a Past Surgical History (PSH).
- Family History: Medical history that runs in your family which may be relevant to your health needs.
- Social History: Things you do, or things you are around, that may affect your health such as current or prior tobacco use, employment history that has known health risks, and any needs or wants affecting your Social Determinants of Health.
- Review of Systems: Information about your overall health and other symptoms you may have.
- Exam: What the doctor found when they looked at you.

Progress (SOAP) Note. Your doctor may write a progress note on some or all days when you are in the hospital. It is a daily summary. It is commonly described in medicine as a SOAP Note. The letters in SOAP stand for its main parts:

- S is for Subjective: The subjective components of how you are doing that day, often written in the form a narrative comprising conversations you have had with you healthcare providers since the last note was written.
- 0 is for Objective: Facts that describe your health. These are things like your physical exam, vital signs, your test results, and other data valuable to the course of your care. This section will commonly have medical acronyms, technical terms of the profession, and other language you may not be familiar with as a patient.
- A is for Assessment: This is a brief summary of your main health problem in the context of your other health problems. It is intended to provide a short, accurate, overview that anyone on your care team can read to be quickly brought up to speed on your current care.
- P is for Plan: What the team plans to do to learn about or treat your health problems

Discharge Summary: Your doctor will write this note as you leave the hospital. It is a summary of the main things that happened during your stay. The "patient instructions" section can help you know what to do to take care of yourself when you leave the hospital.

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What if I do not understand something in the doctors' notes?

Doctors may use abbreviations or words that you do not know. Use these to help you better understand their notes:

- **www.medlineplus.gov:** If you use the internet, this is a site with good health information. It is written for patients and families. Use the search box at the top of the site to look up a word.
- **List of common acronyms and abbreviations:**

Acronym or Abbreviation	What it stands for or means
CC	Chief complaint (the main problem)
HPI	History of present illness (details about your current health problem)
y.o.	Year-old (for example, if you are 64 years old, your note might say "64 y.o.")
RLQ, LLQ, RUQ, LUQ	Right lower quadrant, Left lower quadrant, Right upper quadrant, Left upper quadrant (doctors use these to talk about areas of your body)
BP	Blood pressure
Sig	What your medicine label should say
Resp	Respiratory rate (how fast you are breathing)
Sp02	How much oxygen is in your blood
HEENT	About your head, eyes, ears, nose, and throat
CV	About your heart
Abd	About your abdomen, or stomach area
MSK	About your muscles and bones
GU	About your male or female parts, bladder, or kidneys
Neuro	About your brain or spinal cord
Psych	How alert and aware you are about the things around you
Temp	Temperature
Wt	Weight
Ht	Height
LMP	Last menstrual period (the date of)
BMI	Body Mass Index (a measurement of your weight against your height)
LOS	Length of stay (how long you have been in the hospital)
I/O	Input/Output (what you have eaten and drank, and how much you have emptied your bowel and bladder)
ROM	Range of motion (how well you are moving)
IV	Intravenous (medicine or food given through your vein)
TPN	Total parenteral nutrition (all food given through a tube)
PT	Physical therapy
OT	Occupational therapy
ST or SLT	Speech therapy or speech-language therapy

- **Your doctor's office.** You can reach your doctor's office in 1 of 2 ways:
    - Send a message through MyChart.

1. Click the "Messaging" icon in mychart
    a. If you are on a mobile device, select **Send a Message**
    b. If you are on a computer, select **Ask a Question**
2. When asking your question you can select a subject of: **General Non-Urgent Medical Question, Prescription Question, Test Results Question, Visit Follow up Question**

    - Call on the phone. Dial 501-686-7000 to reach an operator.

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What if I see something in a doctors' note that I think is wrong?

UAMS patients have the right to request that UAMS amend their Protected Health Information or other records. The Health Information Management (HIM) office manages these requests. Requests must be made in writing and include the reason. You can get more information and the form by calling 501-526-6765 or by going to this webpage: https://uamshealth.com/patientsandguests/medicalrecords/patient-requests-to-amend-medical-records/.

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