**problem-oriented medical record (POMR),**

a method of recording data about the health status of a patient in a problem-solving system. The POMR preserves the data in an easily accessible way that encourages ongoing assessment and revision of the health care plan by all members of the health care team. The particular format of the system used varies from setting to setting, but the components of the method are similar. A data base is collected before beginning the process of identifying the patient's problems. The data base consists of all information available that contributes to this end, such as that collected in an interview with the patient and family or others, that from a health assessment or physical examination of the patient, and that from various laboratory and radiologic tests. It is recommended that the data base be as complete as possible, limited only by potential hazard, pain or discomfort to the patient, or excessive assumed expense of the diagnostic procedure. The interview, augmented by prior records, provides the patient's history, including the reason for contact; an identifying statement that is a descriptive profile of the person; a family illness history; a history of the current illness; a history of past illness; an account of the patient's current health practices; and a review of systems. The physical examination or health assessment makes up the second major part of the data base. The extent and depth of the examination vary from setting to setting and depend on the services offered and the condition of the patient. The next section of the POMR is the master problem list. The formulation of the problems on the list is similar to the assessment phase of the nursing process. Each problem as identified represents a conclusion or a decision resulting from examination, investigation, and analysis of the data base. A problem is defined as anything that causes concern to the patient or to the caregiver, including physical abnormalities, psychologic disturbance, and socioeconomic problems. The master problem list usually includes active, inactive, temporary, and potential problems. The list serves as an index to the rest of the record and is arranged in five columns: a chronologic list of problems, the date of each problem's onset, the action taken, the outcome (often its resolution), and the date of the outcome. Problems may be added, and intervention or plans for intervention may be changed; thus the status of each problem is available for the information of all members of the various professions involved in caring for the patient. The third major section of the POMR is the initial plan, in which each separate problem is named and described, usually on the progress note in a SOAP format: *S,*subjective data from the patient's point of view; *O,* the objective data acquired by inspection, percussion, auscultation, and palpation and from laboratory and radiologic tests; *A,* assessment of the problem that is an analysis of the subjective and objective data; and *P,* the plan, including further diagnostic work, therapy, and education or counseling. After an initial plan for each problem is formulated and recorded, the problems are followed in the progress notes by narrative notes in the SOAP format or by flow sheets showing the significant data in a tabular manner. A discharge summary is formulated and written, relating the overall assessment of progress during treatment and the plans for follow-up or referral. The summary allows a review of all the problems initially identified and encourages continuity of care for the patient.