

Comprehensive Diagnosis Descriptions in Medical Record Patient Problem List Summaries

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ABSTRACT

The activities of medical care providers and their organizations are coordinated by medical records, increasingly electronic medical records (EMRs). The central issue in EMR use is the comprehensive recording of objective facts in organized and intuitively logical sections that promote better patient outcomes, practice efficiency, and positive practitioner experience. A critical component section of EMRs is the summary complete patient problem list.

The Global Burden of Diseases studies provide rich information on the major health conditions in populations demanding optimal diagnosis and management. Additionally, multiple credible sources provide evidence-based guidelines for diagnosis and interventions. A challenge is how to bring these data together in EMRs to address the central issue of providing high-quality care.

This communication proposes expanding the information provided with specific diagnoses in the patient problem list by itemizing with these their anatomic, pathologic and biochemical characteristics to provide staging and intervention targeting information. Example templates of key characteristics for hypertension, ischemic heart disease, diabetes, chronic obstructive pulmonary disease, and breast cancer illustrate how this procedure can describe these individual patient diagnoses in depth and identify appropriate diagnostic and management strategies to promote quality of care. The initial professional work time to create such information panels should be less than the work time expended during follow-up visits.

Keywords

Ambulatory care, Primary healthcare delivery, Medical record patient problem lists, Expanding diagnosis descriptions, Diagnostic staging, Clinical practice efficiency.

Introduction

The critical role of (electronic) medical records and their components in provision of high-quality medical care

Electronic medical records (EMRs) are an essential tool for sustainable high-quality medical care. They are the critical glue for comprehensive information gathering, management, integration, and coordination. EMR use is clearly associated with improved quality of care, better health outcomes, increased efficiency of care, reduced errors, and decreased utilization of health services [1].

The rational basis for a permanent, comprehensive, and sharable EMR lies in the reality that any health risk situation or condition can only be addressed impactfully if a full picture of patient-centered information is easily at hand. There needs to be a transformation of current widely used standard EMRs from a services coding and billing tool to an itemized patient health information-centered record. A restructured EMR should be characterized by four major functionality areas (Table 1).

Background rationale and data defining the key components of patient-centered EMRs

EMR work must be specifically grounded in the goals of health services which are to maximize human potential, improve population health and reduce capital costs [2]. Unfortunately, as I have written, this statement of the Institute for Health Improvement

Table 1: Dominant functionality areas for a patient-care-information centered EMR.

1.	Patient goals, determinants for health, and medical history.
2.	Visit records with detailed specific history and physical examination entries
3.	Links for definitions of common diagnoses, details of examinations, and diagnostic and treatment guidelines.
4.	Laboratory testing and imaging reports

completely ignores a central challenge in meeting these aims: the need to improve providers’ experience by better spelling out their time expenditure and tasks [3]. Two critical perspectives provide the background information for what those tasks should entail.

First, we need a broad view of the natural history of the adverse health conditions which we should be seeking to prevent delay or control. The dominant current model is one in which, majorly, inherited factors and personal behaviors lead to illness, first manifest as specific systemic or organ-related symptoms or as a medical/clinical event or crisis. Current health care systems and services target these health problem presentations. Unfortunately, under this approach, only 20% of achievable health is being attained [4,5]. Increasing biological evidence has been accumulating supporting a major role for inflammation as a common biological pathway for multiple interacting chronic conditions [6-8]. This evidence grounds the ecological determinants –the causes of poor health-- firmly in biology and broadens further the need to address these causative factors or stressors [9]. I suggest framing a new illness model or paradigm of health as described in Figure 1. As the figure and the cited population data suggest, we need to change

from endlessly engaging in repairing the damage from ecological factors (the stressors and determinants) that are hidden and silent, to putting greater effort into turning off the spigots of these leading causes and promoters of chronic illness. Our current focus in health care is dominantly on circumstances at the right side of this figure.

Broadly, what are these stressors? I list these in Table 2 and have written in detail about them in another communication [9]. What is to be emphasized here in the context of the purpose of this communication—expanding the details of major diagnoses in patient problem lists—is that as the major arrow linking chronic inflammation and body organ changes in Figure 1 suggests, and as the extensive and increasing published data demonstrate, stressors -through the central biological process of inflammation-- both cause and promote organ changes and clinical signs and symptoms. We have reduced our concepts of health to individualistic biomedical paradigms that overemphasize clinical perspectives, while normalizing existing social conditions and neglecting other key drivers of health [10]. Monitoring these organ and clinical changes carefully then is a critical part of the management of chronic conditions, which the proposal in this communication addresses.

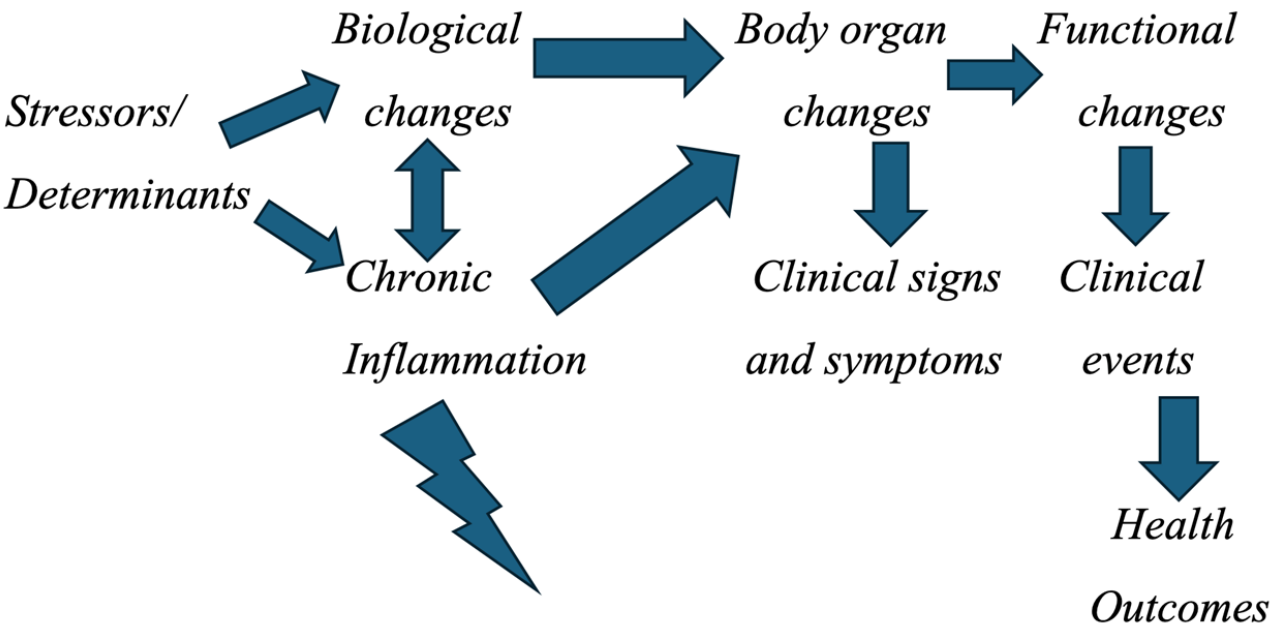


Figure 1: The development of poor health conditions.

Table 2: Categories of stressors or determinants of health.

* Genetic or epigenetic	* Communicable disease
* Psychosocial and economic	* Nutritional
* Environmental/chemical	* Oral

Table 3: The top 12 causes of disability adjusted life years* globally in 2023 [11].

1.	Ischemic heart disease
2.	Neonatal disorders
3.	Stroke
4.	Lower respiratory infections
5.	Diabetes
6.	Road injuries
7.	Chronic obstructive pulmonary disease (C.O.P.D.)
8.	Falls
9.	Low back pain
10.	Diarrheal diseases
11.	Depressive disorders
12.	Anxiety disorders

*Disability adjusted life year (DALY). One DALY represents one year of healthy life lost. It is calculated as the sum of two components: Years of Life Lost due to premature death and Years Lived with Disability due to illness or injury.

The second key background issue concerns what our foci should be in defining optimally the tasks of medical care providers. The Global Burden of Diseases (GBD) studies have highlighted the most burdensome and changing regional diseases and injuries internationally (Table 3) [11]. All of these conditions are often chronic and demand long-term management.

In considering the etiologic factors of the major causes of DALYS, hypertension with high systolic blood pressure was the leader in the most recent GBD report. Hypertension is also the primary risk factor for ischemic heart disease (the number one cause of DALYS globally in 2023) and stroke (the number 3 cause of DALYS globally in 2023) (Table 3). These GBD data suggest where our chronic disease foci in clinical practice need to be: hypertension (beyond heart disease, the major cause of stroke), ischemic heart disease, diabetes, and chronic obstructive pulmonary disease.

Key sections of an EMR (Table 4)
Briefly, to frame the argument of this communication, comments about critical sections of an EMR are appropriate.

Determinants of Health

To rigorously consider the underlying causes of poor health and redefine broadly the mission of clinical practice implied by Figure 1, in particular, by targeting the major causes of DALYS noted in Table 3, we need to be doing *stress load phenotyping* [9]. By this term I mean acquiring data on the breadth of life-long detailed biological and ecological factors whose categories are indicated in Table 2. The referenced paper provides details of how this activity can be pursued. Identified determinants, along with general medical history items should be entered on the patient problem list.

Table 4: The key components of an EMR.

1.	Determinants of health, medical history including current active medical conditions
2.	Patient’s chief complaint
3.	Targeted visit problem history
4.	Comprehensive vital signs and functional status panel [12]
5.	Targeted visit problem physical examination
6.	Summary and complete patient problem list

Comprehensive vital signs and functional status panel

Vital signs are indicators of the body’s critical functions. I have proposed an expanded 24 test vital signs and 9 organ functional assessments panel grounded in the GBD populations data [11,12]. Any panel item abnormal findings warrant addition to the patient problem list.

The process of creating the summary complete patient problem list

The problem list should present a whole person and integrated health story as an itemized, chronologically ordered, entry-time-stamped document. This list should include a full spectrum of data about determinants of health, medical history, and current medical conditions. Continual revising and updating are critical activities. What has not been focused on is the important role in providing high- quality care of synthesizing and analyzing and then recording the detailed data about major diagnoses in this list.

A clinical practice efficiency procedure: Expanded diagnostic descriptions in patient problem list summaries

The purpose of this communication is to propose and illustrate the use of comprehensive summaries of common diagnoses in medical record patient problem lists with details that define and highlight the specific parameters of the condition that demand attention. These items/details are anatomic, pathologic, and biochemical staging which are intervention-targeting measures.

Problem list summary example # 1. Hypertension

Diagnosis: On more than three separate assessments over a span of at least 3-4 weeks, properly measured blood pressure is: >130 mmHg systolic, and/or >80 mmHg diastolic [13]

(with time stamping of each item)

Date of onset:

Stage:

Value:

Left ventricular hypertrophy (by EKG changes) [14]:

Left ventricular hypertrophy (by echocardiographic changes):

Left ventricular hypertrophy (by cardiac-thoracic [CT] width ratio):

Retinopathy stage:

Kidney volume (by ultrasound) [15]: Right cm³ Left cm³

Kidney cortical thickness (by ultrasound): Right cm Left cm

Renal artery patency (by ultrasound): Right Left

Weight:

Height:

Body Mass Index (BMI):

BSA:

Waist circumference [16]:

Hemoglobin A1c:

Creatinine:

Glomerular filtration rate:

Moderate or > (causing increased heart or respiratory rates) exercise hours/week:

Number of occasions in last year consuming 4 or more alcoholic drinks [17]:

Dietary sodium intake: > or < 1 teaspoon per day

LDL cholesterol:

HDL cholesterol:

Lipoprotein(a):

ASCVD risk estimate (cvriskcalculator.com):

(Women) personal history of eclampsia

Patient representations and beliefs about this condition [18,19]:

Problem list summary example #2: Ischemic heart disease (I.H.D.) or Coronary Artery Disease (C.A.D.)

Diagnosis: Chest pain, particularly on exertion; fatigue; and shortness of breath; with laboratory evidence of cardiac dysfunction by electrocardiogram, echocardiogram, cardiac angiography, stress testing, or elevated troponin levels in the blood indicating cardiac muscle damage.

(with time stamping of each item)

Date of onset:

Clinical symptoms, signs, or event at onset:

Other clinical symptoms, signs, or events:

Current symptoms or signs:

Family history in first degree relative(s) of heart attack, sudden death, stroke or heart failure before age 50 (male), 60 (female):

Pack/years of smoking:

Blood pressure

Pulse at rest

Weight

Height

B.M.I.

BSA:

Waist circumference

LDL cholesterol:

HDL cholesterol:

Lipoprotein(a):

HDL cholesterol:

Hemoglobin A1(c):

Microalbuminuria:

Creatinine:

GFR:

Chest X ray: C/T ratio

Vascular calcification

Abnormalities

Electrocardiographic abnormalities: BBB, ST waves changes, Q waves, LVH [14]

Echocardiographic abnormalities:

Moderate (causing increased heart or respiratory rates) hours of exercise per week:

Daily aspirin adherence:

ASCVD risk estimate (cvriskcalculator.com):

Patient representations and beliefs about this condition

Problem list summary Example #3: Diabetes mellitus, Type 2

Diagnosis: Hemoglobin A1c blood test more than 6.5%; or Random blood glucose more than 200 mg/dL; or Fasting blood glucose more than 125 mg/dL. In the presence of weight loss, increased hunger, polyuria and polydipsia.

(with time stamping of each item)

Date of onset:

Family history of diabetes in first degree relative(s):

(Women) Personal history of gestational diabetes:

Hemoglobin A1c:

Weight:

Height:

Waist circumference:

Hip circumference:

Waist/hip circumference ratio:

Body Mass Index (BMI):

BSA:

Dorsalis pedis pulses:

Retinopathy stage:

Nephropathy with microalbuminuria

Creatinine:

Glomerular filtration rate:

Kidney volume (by ultrasound) [14]: Right cm³ /Left cm³

Kidney cortical thickness (by ultrasound) [14]: Right cm³ Left cm³

Peripheral neuropathy status: Top and side of foot vibratory sensation:

Top and side of foot pinprick sensation

Achilles deep tendon reflexes R

L

Skin feet callus formation:

Moderate or > (causing increased heart or respiratory rates)

hours of exercise per week:

ASCVD risk estimate (cvriskcalculator.com):

Patient representations and beliefs about this condition:

Problem list summary example #4: Chronic obstructive pulmonary disease (C.O.P.D.)

Diagnosis: an incompletely reversible (post bronchodilator) ratio of FEV₁: FVC of less than 70%, in presence of exposure history, dyspnea, chronic cough and chronic sputum production [20] (with time stamping of each item)

Date of onset:

Phenotype [21]
mMRC dyspnea score [22]
Bode Index [23]
Exposure to smoke in home
Pack/years smoking:
Allergies:
History of COPD in first degree relatives:
Symptoms/signs Dyspnea
Cough
Chronic sputum production
Moderate or > (causing increased heart or respiratory rates)
hours of exercise/week:
Interference with activities of daily living
Chest X ray abnormalities:
Hemoglobin level:
Oximetry at rest:
Spirometry: FVC:
FEV₁
Weight
Height
BMI:
Waist circumference:
Blood pressure:
Nasal polyps:
Immunization status:
Use of masking:
Patient representations and beliefs about this condition

Problem list summary example # 5. Woman with breast cancer

(with time stamping of each item)

Onset/date of pathological diagnosis:
Site: Breast L/R Quadrant
Menopausal status at diagnosis
Menopausal status currently
Clinical Stage: T N M
Primary surgical procedure and date:
Pathological stage: T N M
Family history of breast cancer in mother:
If yes, age of onset:
Primary tumor size by ultrasound:
Pathology, Core needle biopsy type
Excision type
Histologic grade:
Lympho-vascular invasion:
Estrogen receptor status: Allred score:
Progesterone receptor status: Allred score:
Her-2/neu Test type: Status

Weight
Height
BMI:
Waist circumference:
Hip circumference:
Waist/hip circumference ratio:
Staging studies:
Right axillary, infraclavicular, and supraclavicular node status
by ultrasound:
Chest X-ray:
Liver function tests:
Left breast ultrasound:
Patient representations and beliefs about this condition [24]:

These example comprehensive summaries of common multi-system diseases illustrate why they are so important. The details define and highlight the specific and critical parameters of the condition and those that demand periodic attention. Some details repeat items which may already be in the patient's problem list because they have been identified as vital sign or functional status abnormalities [22]. I propose that clinicians should modify these example templates as their patient populations and circumstances suggest, and then when a diagnosis is confirmed put the entire template into the patient summary problem list. As for vital signs and functional status panels, paraprofessionals can be charged with completing the detailed item entries in these templates [12]. At every ambulatory care visit, the entire patient problem list should be read together with the patient. The EKG, retinopathic, echocardiographic, and ultrasound images can be useful in showing patients direct evidence and consequences of their specific health conditions. Optimally, the patient's entire problem list can be transferred to an electronic application and given to the patient on their cell phone. At any health care visit, the information on the app can be updated.

The creation of such diagnostic problem summary lists and their insertion into the patient's problem list renders the details easily accessible and organized for a doctor's rapid assessment of their conditions. In usual practice to pull together this information is often a frustrating search and time-consuming exercise for practitioners, and critical parameters are easily missed. As foretasted, a full picture of patients' history and conditions, with additionally such details for major diagnoses, is the foundation for high-quality care. Further I suggest that the issue of adopting this record keeping approach is not a research question, but a quality assurance measure.

Advantages and disadvantages or costs of creation of major diagnosis anatomic, pathologic, and biochemical parameter panels I suggest that the advantages of creation of the proposed diagnosis detail panels significantly outweigh the costs (Table 5)

Table 5

Advantages	Costs
Promotes comprehensiveness and rigor	Initial work and time required for creation
Increases accessibility of critical data	Time and effort required for updating
Improves overall system efficiency	—
Provides data transparency	—
Patient problem-centered	—

Discussion

A major challenge in clinical practice is organizing work activities to promote provision of high quality of care, practice efficiency, practitioner satisfaction, and targeted practitioner work. The organizational procedure of creating detailed specific diagnosis characteristic panels for patient summary problem lists is a procedure to meet this challenge.

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