

FOR DOCTORS, CARE TEAMS AND PATIENT RECORD STAFF

Patient History Management

**Earlier visits. Better context.
Connected patient records.**

Keep previous consultations, prescriptions, reports, hospital records and visit documents connected to the patient for authorised review.



Patient history illustration from the Medoho product page.

DOCTORS

Earlier consultations, prescriptions and reports in context.

CARE TEAMS

OPD and IPD records and documents connected by visit.

PATIENTS

Information and documents shared by their care provider.

UNDERSTAND THE MODULE

What is Patient History?

Patient History Management brings recorded visits and related documents together, helping authorised staff review earlier care information alongside the current patient record.

One patient record across visits

Medoho connects previous consultations, diagnoses, prescriptions, reports and treatment records with the patient journey, including relevant OPD and IPD documents.

WHAT YOUR TEAM CAN REVIEW

Dated visits and consultations

Review earlier visits, consultation entries, diagnoses and recorded treatment information in the patient history.

Reports and documents

Keep laboratory reports and healthcare documents with the patient record for relevant authorised review.

Discharge and follow-up information

Review discharge summaries and recorded follow-up instructions when the patient returns for continued care.

Authorised staff access

Give doctors and staff access according to responsibility and the permissions configured for your organisation.

Prescription history

Find previous prescriptions with medicine details, dosage, duration and instructions retained with the visit.

OPD and IPD records

Connect outpatient visits and inpatient records to the same patient history, retaining the relevant visit context.

Bills and visit documents

Find relevant bills and documents alongside the visit or hospital stay they belong to in the patient history.

Shared records in the Patient App

Help patients access prescriptions, reports, bills and other information shared by their clinic or hospital.

Available history depends on records maintained in Medoho, shared documents, enabled modules and configured access.

EARLIER VISITS AND PRESCRIPTIONS

Bring earlier visits into view.

Give the doctor a dated reference for previous care and the prescriptions already recorded.

SCENARIO 01 / VISIT CHRONOLOGY

The order of earlier visits is hard to reconstruct.

THE PROBLEM

The patient brings papers from several visits, but the dates and consultation notes are mixed. The doctor spends time working out which information belongs to each earlier consultation.

HOW MEDOHO HELPS

Review the patient history as a dated record of visits and associated documents. Keep earlier consultation, diagnosis and treatment entries connected to the relevant visit so the doctor can review the recorded sequence.

What your team gains: A dated history helps the doctor place earlier consultations and documents in the relevant visit context.

SCENARIO 02 / PREVIOUS PRESCRIPTIONS

The patient cannot remember the earlier prescription.

THE PROBLEM

At a return visit, the patient cannot recall the medicines, dosage or instructions from the previous consultation. The earlier prescription is missing from the paper folder.

HOW MEDOHO HELPS

Keep digital prescriptions with the visit record. Authorised doctors can review the recorded medicine details, dosage, duration and instructions when considering the patient history during the next consultation.

What your team gains: The previous prescription remains available as recorded information for the doctor to review.

Doctors get: dated visit information and previous prescriptions connected to the patient record.

REPORTS AND HOSPITAL RECORDS

Keep care documents connected.

Retain the diagnostic and hospital information needed when reviewing the next patient visit.

SCENARIO 03 / REPORTS AND DOCUMENTS

A report is filed separately from the visit it belongs to.

THE PROBLEM

The patient has laboratory reports in one folder and consultation papers in another. Staff have to search both places to understand the report date and the relevant patient visit.

HOW MEDOHO HELPS

Keep laboratory reports and healthcare documents with patient history. Review the relevant reports alongside the recorded visits, with interpretation and clinical decisions remaining with the qualified healthcare professional.

What your team gains: Reports stay connected to the patient record for relevant review without searching separate document folders.

SCENARIO 04 / IPD AND DISCHARGE HISTORY

Hospital discharge information is missing at the next OPD visit.

THE PROBLEM

After a hospital stay, the patient attends an outpatient review without the discharge papers. The doctor has to ask for details of the admission, treatment and discharge instructions again.

HOW MEDOHO HELPS

Bring relevant inpatient records, treatment documents and the discharge summary into patient history. Authorised staff can review the recorded hospital stay alongside later outpatient visits when the relevant modules are enabled.

What your team gains: Recorded inpatient and discharge information provides context when the patient returns for outpatient care.

Care teams get: connected reports, OPD and IPD records, and relevant discharge documents.

VISIT DOCUMENTS AND FOLLOW-UP ADVICE

Retain the context of each visit.

Keep visit documents and recorded follow-up advice with the patient journey.

SCENARIO 05 / BILLS AND VISIT DOCUMENTS

A bill or document is hard to match to the correct visit.

THE PROBLEM

The patient has several consultations and a hospital stay. Bills and other documents sit in separate files, making it harder for staff to identify which record belongs to which visit.

HOW MEDOHO HELPS

Keep relevant bills and documents with patient history and the associated visit or inpatient record. Authorised staff can use the visit context when finding documents from an earlier consultation or hospital stay.

What your team gains: Staff have a clearer reference for retrieving the document that belongs to the relevant patient visit.

SCENARIO 06 / FOLLOW-UP INSTRUCTIONS

Earlier follow-up advice is left in a separate note.

THE PROBLEM

Follow-up instructions are written on a loose paper or kept outside the patient record. During the next review, the doctor or care team has to ask what was previously advised.

HOW MEDOHO HELPS

Keep recorded follow-up advice and instructions connected to the visit, prescription or discharge information. Review the relevant earlier guidance with the patient history when organising continued care.

What your team gains: Recorded follow-up instructions remain connected to the earlier visit for authorised review.

Staff get: relevant bills, visit documents and recorded follow-up information in the patient history.

DOCTOR HANDOVER AND PATIENT ACCESS

Support the next conversation.

Help authorised care teams review earlier context and patients access the records shared with them.

SCENARIO 07 / AUTHORISED DOCTOR HANDOVER

A different doctor starts without the earlier treatment context.

THE PROBLEM

The patient sees another doctor in the practice. Earlier consultation and treatment information is held in separate notes, so the doctor relies on the patient to repeat the previous care history.

HOW MEDOHO HELPS

Use configured staff access to review the connected patient history. The authorised doctor can refer to earlier consultation, diagnosis, prescription and treatment records when reviewing the patient at the new visit.

What your team gains: The next authorised doctor has an organised reference for the earlier information recorded by the care team.

SCENARIO 08 / SHARED PATIENT RECORDS

The patient keeps requesting copies of shared records.

THE PROBLEM

The patient needs a prescription, report or bill after leaving the clinic. When papers are lost or files are scattered across messages, reception receives repeated requests for another copy.

HOW MEDOHO HELPS

Use the Medoho Patient App and configured sharing workflow to make the information shared by the clinic or hospital available to the patient. Keep relevant prescriptions, reports, bills and documents connected to their record.

What your team gains: Patients get an organised place to access the records their care provider shares with them.

Doctors and patients get: authorised history review and access to the records shared through the patient workflow.

SEE THE PATIENT HISTORY IN CONTEXT

One patient. A dated history.

Illustrative timeline only: the dates, stay length and document groups below are examples.

FROM THE PATIENT RECORD TO EARLIER VISITS

Open the patient history to review the dated visits and the relevant documents connected to each consultation or hospital stay.

01

10 Aug 2026 | OPD visit

Consultation and diagnosis entries, the digital prescription, relevant reports and the visit bill.

02

10 Oct 2026 | IPD stay, 5 days

Admission and stay details, treatment and nursing records, reports, service bills and the discharge summary.

03

20 Oct 2026 | OPD follow-up

New consultation, prescription and visit documents, with earlier visits and hospital records available for authorised review.

Keep each visit in its place

OPD visits, hospital stays and their relevant documents belong to one connected patient history.

FOR YOUR PATIENT RECORD WORKFLOW

Connect your patient records.

For clinics, multi-doctor practices and hospitals reviewing patient information across visits.

YOUR PATIENT HISTORY TOOLKIT

Dated visits and consultations; diagnosis and treatment entries; prescription history; reports and documents; OPD and IPD records; discharge summaries; relevant bills; recorded follow-up advice; authorised staff access; and records shared through the Patient App.

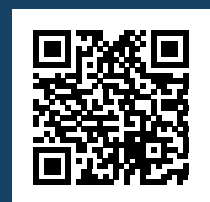
PLAN YOUR SETUP

- 01 Map the records you need** - Identify consultations, prescriptions, reports, bills, hospital stays and discharge documents.
- 02 Define staff access** - Confirm what doctors, care teams and record staff need to review according to responsibility.
- 03 Agree visit links and document sharing** - Confirm how records are associated with visits and shared with patients.
- 04 Review your existing records** - Discuss legacy documents, formats and any migration support needed for the selected setup.
- 05 Walk through one patient history** - Review an OPD visit, hospital stay, discharge, follow-up and the associated documents.

See Medoho in your patient workflow.

Book a 30-minute demonstration.

+91 63582 92566 | enquiry@medoho.com | www.medoho.com



Scan to book

History depends on records maintained and shared through the configured workflow. Module availability, migration, training and support are agreed for the selected setup; this guide does not define commercial package inclusions.