What is the source of the diagnoses and procedures history in your hospital?

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Do you puzzle it together by copy/pasting info from previous letters? Or do you have one shared, jointly managed source of truth? If one common source: is it free text, or structured? If structured: do you use Snomed CT concepts? If so: do you search in all relevant hierarchies or in a managed clinical vocabulary? do you manage this in a problem list subset? do you manage your terminology inside our outside your Electronic Medical Record?
(I know, it's a lot of questions, but I'm really curious where we are with this in practice)

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