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• 中文摘要

病歷氾指記載醫護人員和病患之間的互動關係、所有醫療照護的過程與結果、和病患的健康狀況的追蹤相關資訊。然而，實際上並無明確的結構標示(mark up)定義，一般病歷就是轉換成電子化，電腦仍難以瞭解其結構，因此也難以有效的加以運用或分析，更阻礙病歷的有效流通與傳輸，無法真正達到持續性醫療照護的功能。本計畫研究針對病歷相關文件，著重於建立疾病語彙資料庫以及藥品語彙知識庫爲主，並以門診之診斷、用藥處方等病歷結構探討在網際網路作業環境下發展病歷流通及調閱的系統架構，透過 HL7 標準傳遞電子病歷，並以 XML／HTML 爲病歷描述及顯示架構，使用 web browser 方便調閱病歷，也使病歷相關文件的流通和傳輸變得更有效。本研究成果不僅提供醫療專業人員從不同的醫療機構或取適當的病歷，同時也提供病患本身對於疾病與用藥知識，達到病患自我教育，提昇自我照顧的能力。

• 英文摘要

Patient records can be defined as a set of clinical documents in which describe health care services and the interactions between patients and doctors. In practice patient records are usually poorly structured. Some simply were transformed into electronic ones with plan text. Thus, those patient records can hardly be communicated among computer systems. And hence this makes the continuing healthcare very difficult. This project focused on establishing disease knowledge base and drug knowledge base for outpatient medical care, on investigating the structures of disease diagnosis, prescription and drug related knowledge, and on developing a prototype of web based system for exchange, query and presentation of patient records on web browsers. This framework can facilitate the exchange of patient records for medical professionals. It also can allow patients to acquire their medical records with their understandable presentation format. Thus, with the provided medical knowledge patients can be more informed to their health conditions, and may be able to take care themselves better.