


This Quick Reference Guide (QRG) reviews the steps for documenting a patient history.

Common Buttons & Icons

	Add icon
	Search icon

Document Historical Procedure

➤ **From the Ambulatory View in the patient's chart:**

STEP 1: Click the **Histories** component from the Ambulatory workflow menu.

STEP 2: Click the **Procedure** tab in the Histories component.

NOTE: It is expected that all staff will review procedures each time they meet with a patient. If you do not need to make any updates, click Mark as Reviewed.

STEP 3: Click the **Histories** component header above the tabs.

STEP 4: Click the **Add** icon.

STEP 5: Locate the procedure in one of two ways:

1. Click the Procedure field; then type the name of the procedure.
 - Click the Search icon.
 - Click the correct result.

NOTE: To add this procedure as a favorite click the Add to Favorites option at the bottom of the Procedure Search result window. In the Folder Maintenance window that populates choose an existing folder or create a folder. Once a folder is selected, click Close.

- Click OK.
2. Best Practice is to scroll down to the bottom of the Procedure section to the folders.
 - Click the Procedures folder.

NOTE: Your Favorites folder will be listed here if you have created one.

- Click the Procedure type folder needed.
- Scroll as needed to find the procedure. Then double-click the needed procedure.

STEP 6: Document available details by clicking into the various fields and using the drop-down arrow options.

STEP 7: Scroll down to the bottom of the Procedure section and click **OK** or **OK & Add New**. **OK & Add New** is used if there are more procedures to add.

Document Family History

➤ **From the Ambulatory View in the patient's chart:**

STEP 1: Click **Histories** from the Ambulatory workflow menu.

STEP 2: Click the **Family** tab.

NOTE: This information is to be reviewed at each visit. Use the **Marked as Reviewed** option if there are no updates.

STEP 3: Click the **Add** icon.

STEP 4: Click the gray cell to document the family member has the condition. Click the white cell to document that the family member does not have the condition listed in the Quicklist.

STEP 5: Double-click the **Plus** icon for the condition to add more details as needed.

STEP 6: Search for conditions not listed.

STEP 7: Click the **Quicklist Search** icon.

STEP 8: Click the **Search** tab.

STEP 9: Type the condition in the Search field; then press the **[Enter]** key.

STEP 10: Double-click or single-click and press the **[Enter]** key to select the condition.

STEP 11: Click **OK** to save it to the grid and document family history.

STEP 12: Clear errors using a right-click in the field with the error. Then, click **Clear**.

STEP 13: Click **OK** once all family history is documented to save.

STEP 14: Alter how the information is viewed as needed by clicking the **Display** drop-down menu and chose the wanted view.

STEP 15: Modify condition details by right-clicking the needed condition. Then, click **Modify Family History** from the drop-down.

STEP 16: Document or clear details of the condition in the Update Family Member box as needed. Once finished Click **OK**.

NOTE: When you hover over a folder icon cell for the family member and condition, comments made in the Update Family Member box will display.

Document Social History

➤ **From the Ambulatory View in the patient's chart:**

STEP 1: Click **Histories** from the Ambulatory workflow menu.

STEP 2: Click the **Social** tab.

NOTE: Social history documentation carries over from encounter to encounter.

STEP 3: Review when the last time information was reviewed.

STEP 4: Select the **Unable to Obtain** check box if you are not able to review the social history information.

NOTE: Every effort should be made to obtain a patient's social history.

STEP 5: Click **Mark as Reviewed** if there is no change to the listed information.

STEP 6: Begin by clicking the **Add** icon on the top of the Social tab.

STEP 7: Document details as required by your hospital or practice's policy using the various drop-down lists, radio buttons, multi-select boxes, and free text comments.

STEP 8: Scroll down to the next section.

STEP 9: Document all sections in the same manner starting by clicking the **Add** icon to open each section.

STEP 10: Click **OK** to save all the documentation.

STEP 11: Modify sections from the Summary view using a right-click and clicking **Modify**. Do not add an additional section with the Add button.

Document Pregnancy

➤ **From the Ambulatory View in the patient's chart:**

STEP 1: Click **Histories** from the Ambulatory workflow menu.

STEP 2: Click the **Pregnancy** tab.

NOTE: This information is to be reviewed at each visit. Use the **Marked as Reviewed** option if there are no updates.

STEP 3: Click the **Add** icon.

STEP 4: Click the **Delivery/Outcome** field; then type the date or use the up and down arrows to set the date. The drop-down arrow icon will open a calendar if needed.

STEP 5: Click the **Gestation at Birth** radio button that best meets your need and document Weeks and Days typing the number in the appropriate field. For Unknown or Approximate click the drop-down arrow and click the needed option.

STEP 6: Click the **Pregnancy Outcome/Result** drop-down arrow. Choose the appropriate option.

STEP 7: Click the **Neonate Outcome** drop-down arrow and choose the appropriate selection.

STEP 8: Click additional fields and drop-down arrows to document any other additional information that is shared.

STEP 9: Click the **Add Baby** icon to add additional babies, if necessary, for multiple births, one pregnancy.

STEP 10: Scroll down to the bottom of the section when complete. Click **OK** to save or **OK & New** to save and add additional pregnancies.

NOTE: Each pregnancy needs to be added individually.

STEP 11: Review listed pregnancies. Click the **Modify** button, or right-click the pregnancy to make modifications.

NOTE: Do not manually update the Gravida and Para fields; these will be updated automatically by the system. Also, only click Delete if you charted the wrong patient.

Document Implants

➤ **From the Ambulatory View in the patient's chart:**

STEP 1: Click **Histories** from the Ambulatory workflow menu.

STEP 2: Click the **Implant** tab.

NOTE: This information is to be reviewed at each visit. Use the **Marked as Reviewed** option if there are no updates.

STEP 3: Click the **Add** icon.

STEP 4: Document the various fields by clicking the radio buttons, selecting the check boxes, and typing in information as appropriate.

NOTE: When all information is not known, chart by exception documenting only the fields for which you have information.

STEP 5: Click **OK** to save.

Document with Implant Cards

➤ **From the Implants tab:**

- STEP 1:** Uncheck the Free Text check box.
- STEP 2:** Click the Implant Description Ellipsis.
- STEP 3:** Select the Description check box at minimum.
- STEP 4:** Click the Search For field; then type the implant name.
- STEP 5:** Click Find Now.
- STEP 6:** Click the appropriate implant.
- STEP 7:** Click OK.
- STEP 8:** Use the implant card to document the additional information.
- STEP 9:** Click OK.