

Patient Histories provide a snapshot of all recorded patient procedures, family, social, pregnancy, and implant histories. Information documented within the Histories Components are available for all subsequent encounters.

NOTE: Please check with individual practice for specific requirements regarding the documentation of patient histories.

Accessing Patient Histories

The **Histories** component on the Workflow MPage can be used to obtain a quick view of the documented histories for patients.



Procedure	Surgeon	Date	View
Endoscopic ultrasonography of stomach	--	--	>
REPAIR OF NASAL SEPTUM	--	--	>

Review Incomplete View Outside Records Mark as Reviewed

➤ Viewing the Histories Component

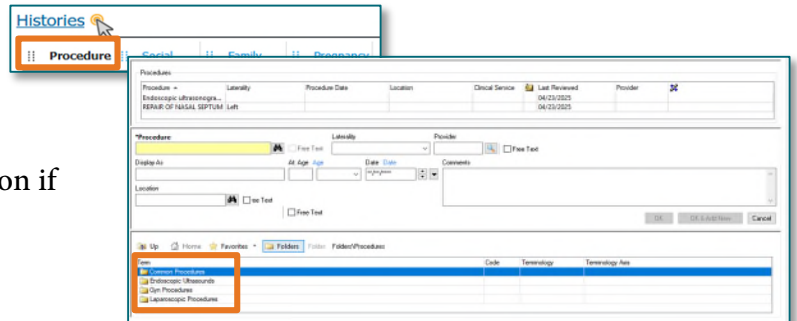
- Information displays based on the tab selected within the component. Selecting different tabs will display different information face up.
- Clicking the **Histories** header links directly to the **Histories** tool which allows for modifying and/or documenting patient histories.

Updating Patient Histories

All histories will be updated from the Histories component, except for the Social History. Social History is completed from within an intake form, as quality metrics are captured through the completion of fields at the bottom of that section in the form.

➤ Procedure History

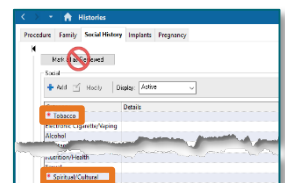
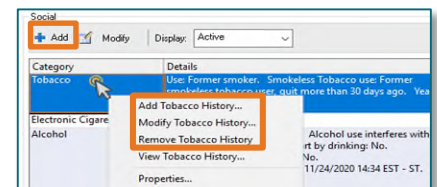
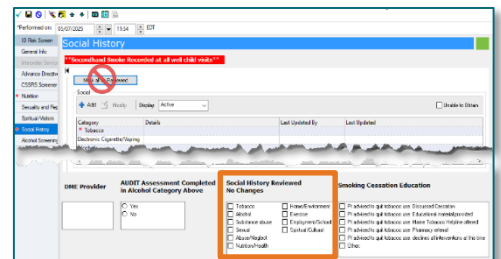
- Select **Procedure** tab, click the **Histories** header.
- Click the **Mark all as Reviewed** button if no changes are needed.
- Click the **+Add** button to document additional procedure history data.
 - The folders at the bottom of the pane can be used to quickly search for common procedures.
 - The binoculars button is used to manually search for procedures.
 - Enter information into the fields as appropriate and click the **OK** button to add a single entry or the **OK & Add New** button to save the current entry and enter another procedure.



NOTE: Procedure Histories should never be left blank. If a patient has never had a surgical procedure, adding the procedure named "Negative" or "None" will make it clear that the patient reports they have never had a surgical procedure performed.

➤ Social History


- Within an Intake Form, navigate to **Social History**.
- If all categories in the Social History are blank, click the **+Add** button to document new information.
- If modifying or adding information to a single social history category, right-click within the row of the category and select the **Add, Modify, Remove** as applicable.
- Click **OK** to save changes.
- Some categories are required to be re-documented annually. A red asterisk will display in the category if not updated in the last 365 days.
 - **Tobacco** category: **Smoking tobacco use**, and **Smokeless tobacco use** needs to be completed for the form to be signed.
 - **Spiritual/Cultural** category: **Restrictions/concerns** needs to be completed for the form to be signed.

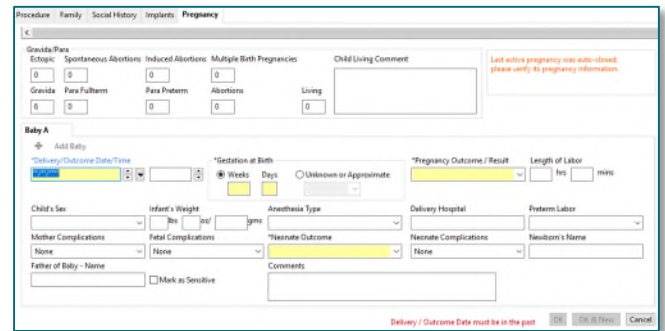


NOTE: The **Mark all as Reviewed** button should NOT be used in Social Histories. Use of this button leads to errors in reporting. If categories have been reviewed and no reported changes, those categories should be selected in Social History Reviewed No Changes checkboxes located below Social History.


NOTE: Providers entering Social History information outside the intake form, select Social History tab from the Histories component, then click the Histories header.

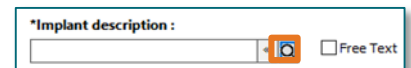
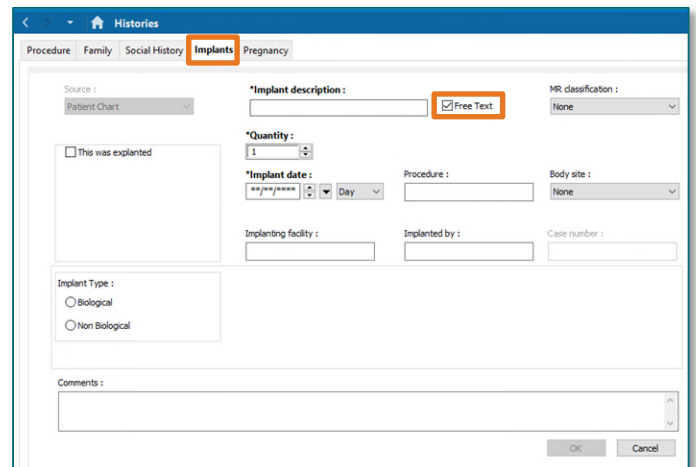
➤ Pregnancy

- From the histories tool, select **Pregnancy** tab.
- Click the **Mark all as Reviewed** button if no changes are needed.
- Click the **+Add** button  to enter new pregnancy history information.
- Document in the fields as appropriate. All yellow fields are required fields and must contain documentation to continue.
- Click the **OK** button to add a single entry or **OK & Add New** button to save the current entry and enter another.

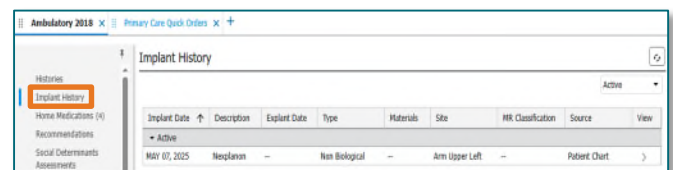


➤ Implants

- From the **Histories** tool, select **Implants** tab.
- Click the **Mark all as Reviewed** button if no changes are needed.
- Click the **+Add** button  to enter new implant history information.
- Document in the fields as appropriate. Fields that are bolded with asterisks are required fields and must contain documentation to continue.
 - Implants can be searched for by deselecting the **Free Text** checkbox and clicking the magnifying glass button.
- Click **OK** to save the current entry.



NOTE: Implant History can be viewed on the Workflow MPage from the Implant History Component, however, modifications cannot be made from this view.



Implant Date	Description	Explant Date	Type	Materials	Site	MR Classification	Source	View
MAY 07, 2025	Neuplan		Non Biological		Arm Upper Left		Patient Chart	

Customizing Histories Views

Each history section can be edited to add or remove columns from view to enhance the viewing experience, as necessary.

STEP 1: From within a history section, right-click any column header

STEP 2: Click **Properties**

STEP 3: The **Properties** window will open. Click to highlight desired columns to add to view from the **Available Columns:** list then click **Add** to move them to the **Current Columns:** list.

- Clicking the **OK** button here will save these additions and return to the history view.

STEP 4: If removing columns from view is desired, click to highlight columns from the **Current Columns:** list then click **Remove** to move them to the **Available Columns:** list.

STEP 5: Click **OK** button when finished to save the changes.

NOTE: Each history section has their own unique list of available and current columns. Some columns cannot be removed from view.

