

Patient Encounter: History

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Version 14.19

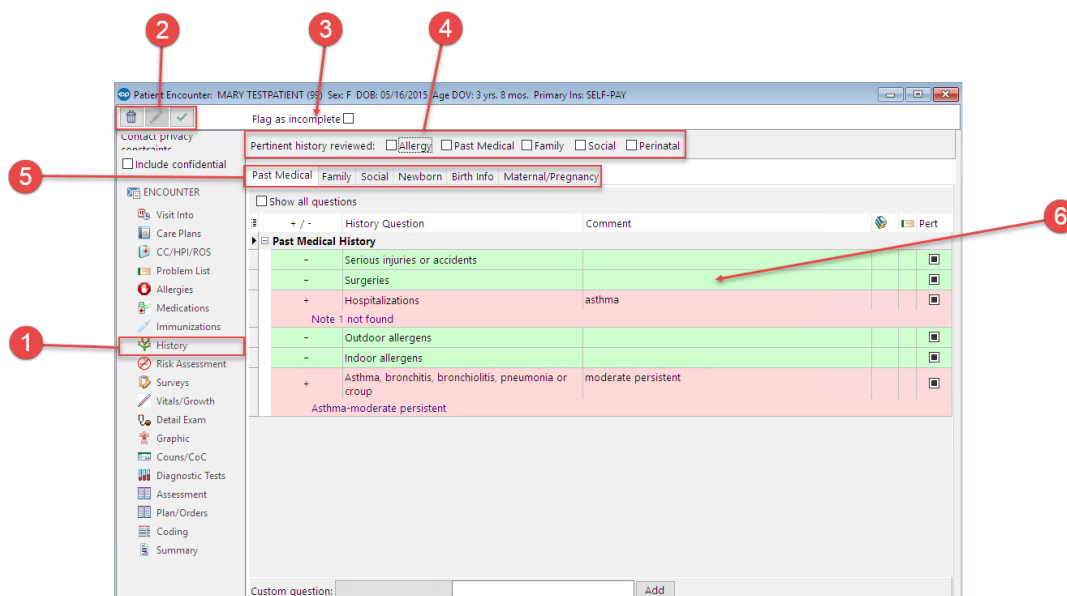


This window map article points out some of the important aspects of the window you're working with in OP but is not intended to be instructional. To learn about topics related to using this window, see the **Related Articles** section at the bottom of this page.

About Patient Encounter: History

Path: Clinical, Practice Management, or Billing tab > Patient Chart button > Encounter > New or Open Note button > History

The History window documents a patient's history. The Patient History captures and displays multiple sections of the patient's history (Past Medical, Family History, Social History, and Perinatal History) in a simple-to-use and easy-to-read format. This section of the Encounter Note is chart-driven, meaning that the information populated here is pulled from and pushed back to the same section in the Patient Chart.



Patient Encounter: History Map

Number	Section	Description
1	History button	The History button accesses the History window in the patient's Encounter Note.
2	Function buttons	The Function buttons delete an entire Encounter Note, edit an Encounter Note, or save an Encounter Note.
3	Flag as Incomplete checkbox	The Flag as Incomplete checkbox marks an Encounter as unfinished.
		The Pertinent History Reviewed checkboxes indicate that pertinent history notes have been reviewed. <ul style="list-style-type: none"> Allergy: If checked, at least one specific allergy must be documented as pertinent to

4	Pertinent History Reviewed checkboxes	<p>the problem in the HPI.</p> <ul style="list-style-type: none"> • Past Medical: If checked, at least one specific personal history item must be documented as pertinent to the problem in the HPI. • Family: If checked, at least one specific family history item must be documented as pertinent to the problem in the HPI. • Social: If checked, at least one specific social history item must be documented as pertinent to the problem in the HPI. • Perinatal: Marks newborn history as reviewed at this Encounter.
5	History tabs	<p>The history tabs documents or reviews based on the historical note categories:</p> <ul style="list-style-type: none"> • Past Medical History: The Past Medical History tab documents or reviews a patient's past medical history. You can link or add history to the Problem list from this area. • Family History: The Family History tab documents or reviews a patient's family medical history. Family members are linked based on how they are documented in the Contacts field. • Social History: The Social History tab documents a patient's social history such as pets, smokers in the home, siblings, visitation status, etc. • Perinatal History: The Perinatal History tab documents notes for newborn history, birth info, neonatal course, and maternal/pregnancy history.
6	History grid	<p>The History grid displays the patient's past medical history questions and comments.</p>

Version 14.10

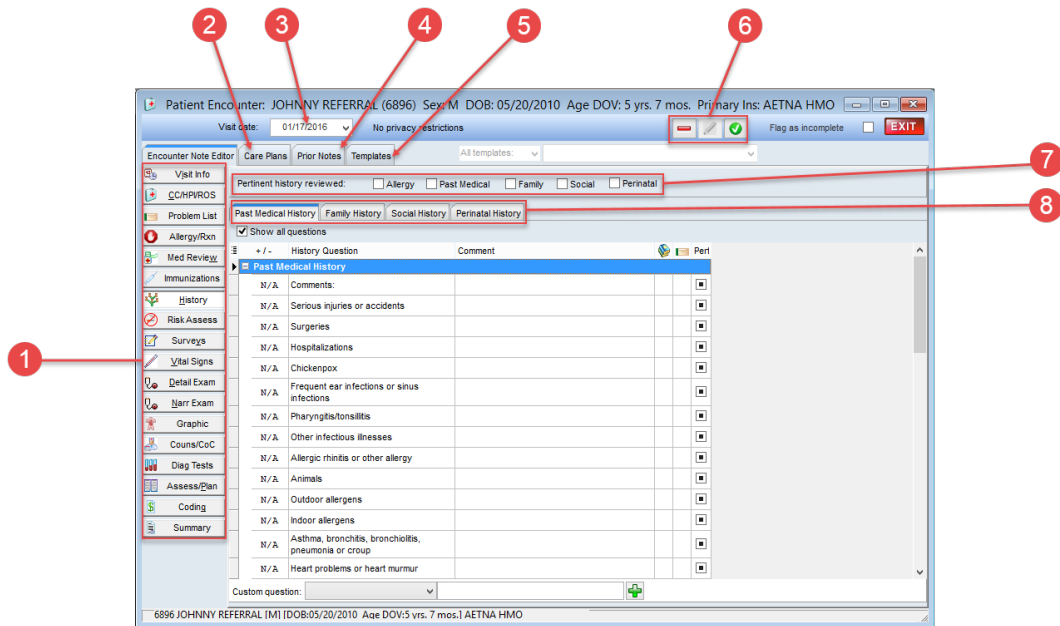
About Patient Encounter: History Tab

Path: Smart Toolbar > Chart button > Encounters tab > Open Note > History tab

Path: Smart Toolbar > Schedule Button > Encounters tab > Edit button > History tab

The Patient Encounter helps to code and complete an encounter visit. The encounter note encompasses both narrative and comprehensive formats. It also allows you to customize the layout of the note. The note is added to the patient chart.

The History tab documents a patient's history. The Patient History captures and displays multiple sections of the patient's history (Past Medical, Family History, Social History, and Perinatal History) in a simple-to-use and easy-to-read format.



Patient Encounter: History Tab Map

Number	Section	Description
1	Encounter Note Editor tabs	<p>The Patient Encounter Note Editor contains the following tabs:</p> <ul style="list-style-type: none"> • Visit Info • CC/HPI/ROS • Problem List • Allergy/Rxn • Med Review • Immunizations • History • Risk Assesses • Surveys • Vital Signs • Detail Exam • Narr Exam • Graphic • Couns/CoC • Diag Tests • Assess/Plan • Coding • Summary
2	Care Plans tab	The Care Plans tab lists, prints, and manages care plans for a patient's health maintenance schedule.
3	Visit Date	The Visit date field indicates the date that the patient encounter occurred.
4	Prior Notes tab	The Prior Notes tab lists the previous encounter notes and messages.
5	Templates tab	The Templates tab lists the templates that are created, edited, and reviewed in the Encounter Templates Editor . Templates are pre-written scenarios you can use in an encounter to document common pediatric diagnoses. Templates include detailed descriptions for the usual pertinent positive and negative findings of a wide variety of illnesses, with a standard assessment, plan and ICD-10 coding. Included with your

		installation of Office Practicum are Pediatric specific templates.
6	Function buttons	The Function buttons delete an entire encounter note, edit an encounter note, or save an encounter note.
7	Pertinent History Reviewed checkboxes	<p>The Pertinent History Reviewed check boxes indicate that pertinent history notes have been reviewed.</p> <ul style="list-style-type: none"> • Allergy: If checked, at least one specific allergy must be documented as pertinent to the problem in the HPI. • Past Medical: If checked, at least one specific personal history item must be documented as pertinent to the problem in the HPI. • Family: If checked, at least one specific family history item must be documented as pertinent to the problem in the HPI. • Social: If checked, at least one specific social history item must be documented as pertinent to the problem in the HPI. • Perinatal: Marks newborn history as reviewed at this encounter.
8	History tabs	<p>The history tabs documents or reviews based on the historical note categories:</p> <ul style="list-style-type: none"> • Past Medical History: The Past Medical History tab documents or reviews a patient's past medical history. You can link or add history to the Problem list from this area. • Family History: The Family History tab documents or reviews a patient's family medical history. Family members are linked based upon how they are documented in the Contacts field. • Social History: The Social History tab documents a patient's social history such as pets, smokers in the home, siblings, visitation status, etc. • Perinatal History: The Perinatal History tab documents notes for newborn history, birth info, neonatal course, and maternal/pregnancy history.