Health History

Health History

Version : 21

Published : April 2025

TruBridge
54 St. Emanuel Street
Mobile, AL 36602
T(877) 424-1777
trubridge.com

Table of Contents

Chapter 1 Attestation Disclaimer

Chapter 2 Overview

Chapter 3 Health History Review

Chapter 4 Surgical/Procedure History and Interventions

Chapter 5 Family Health History

Chapter 6 Medical History

Chapter 7 Health Concerns

Chapter 8 Social History-All

Social History-Exercise 16
Social History-Tobacco/Nicotine Use 16
Social History-Substance Use 18
Social History-Environmental 18
Social History-Travel 20
Social History-Sexual 20

Chapter 9 Functional/Cognitive Status

Chapter 10 Referral/Transition of Care

Referral/Transition of Care 25
Referral/Transition of Care Tracking Report 29

Chapter 11 Implantable Devices

Implantable Devices 32
Implantable Device History Detail Report 34

Chapter 12 Address History

Chapter 13 Disability - WA STATE ONLY

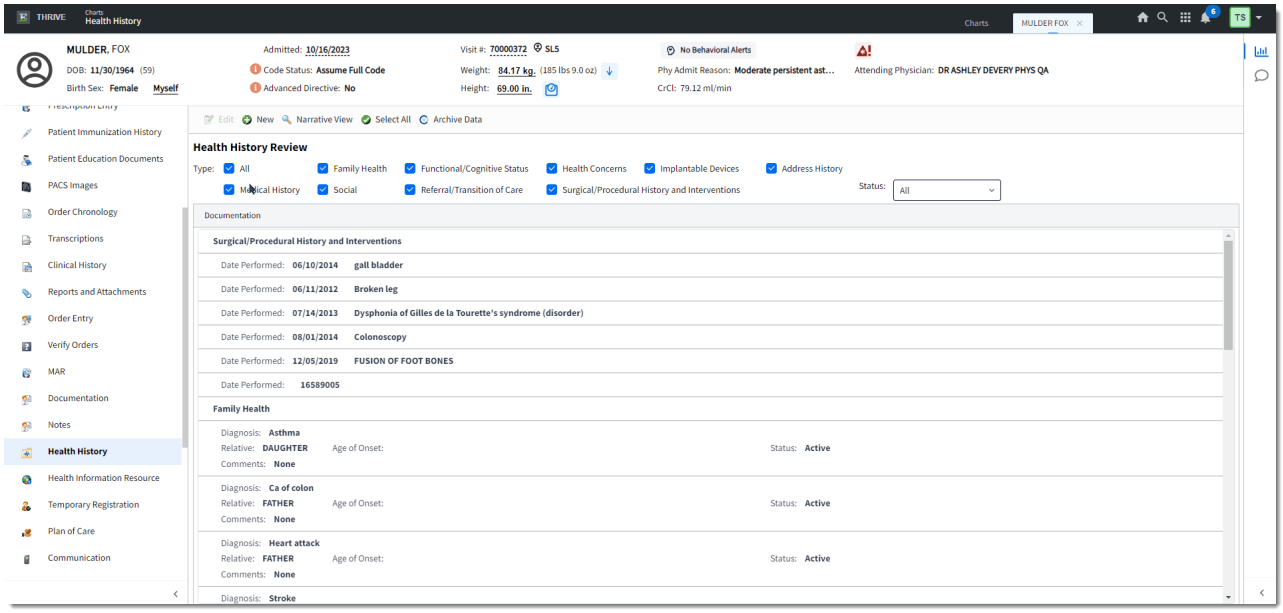
Chapter 14 Health History Report

Chapter 1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bear no responsibility for attestation information submitted by the client.

Chapter 2 Overview

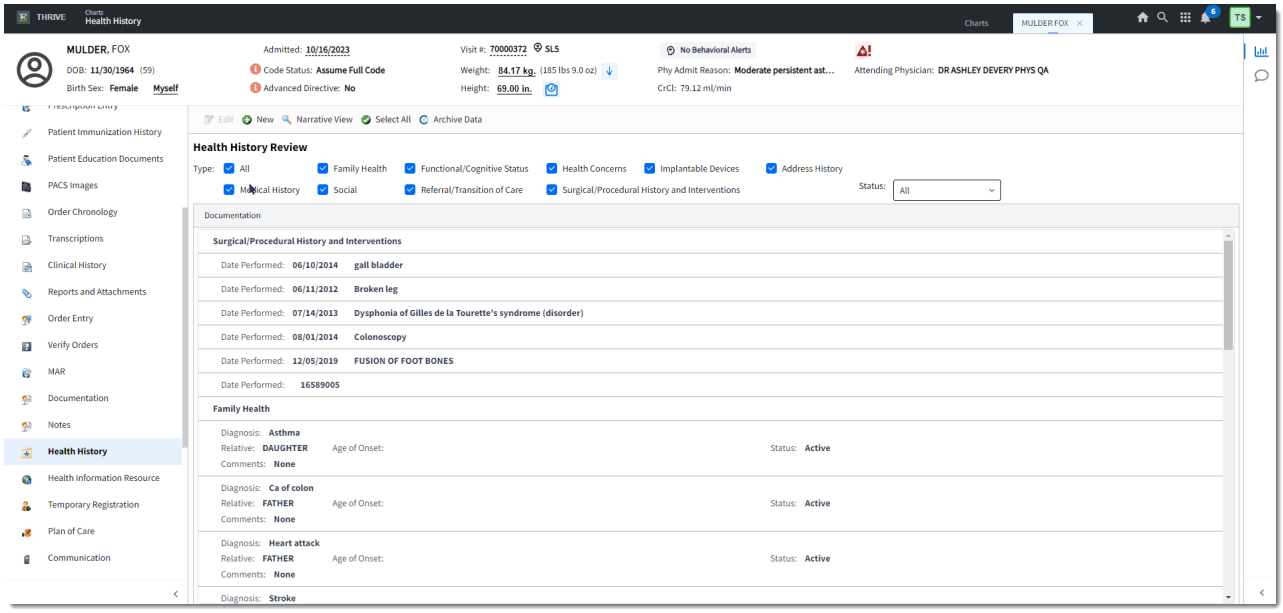
The **Health History** application provides a place for the patient's Surgical History, Procedure History, Family Health History, Medical History, Social History, Functional and Cognitive Status to be documented, reviewed, or printed. There is also an option to create and review patient referrals or transitions of care.



Health History - List View

Chapter 3 Health History Review

To access Health History, go to **Patient Chart > Health History**. The Health History Review page is displayed. If there is any previously entered information, it is displayed in the grid by health history category. From this page, you can enter new history items, edit existing ones, print health history items, or archive items.



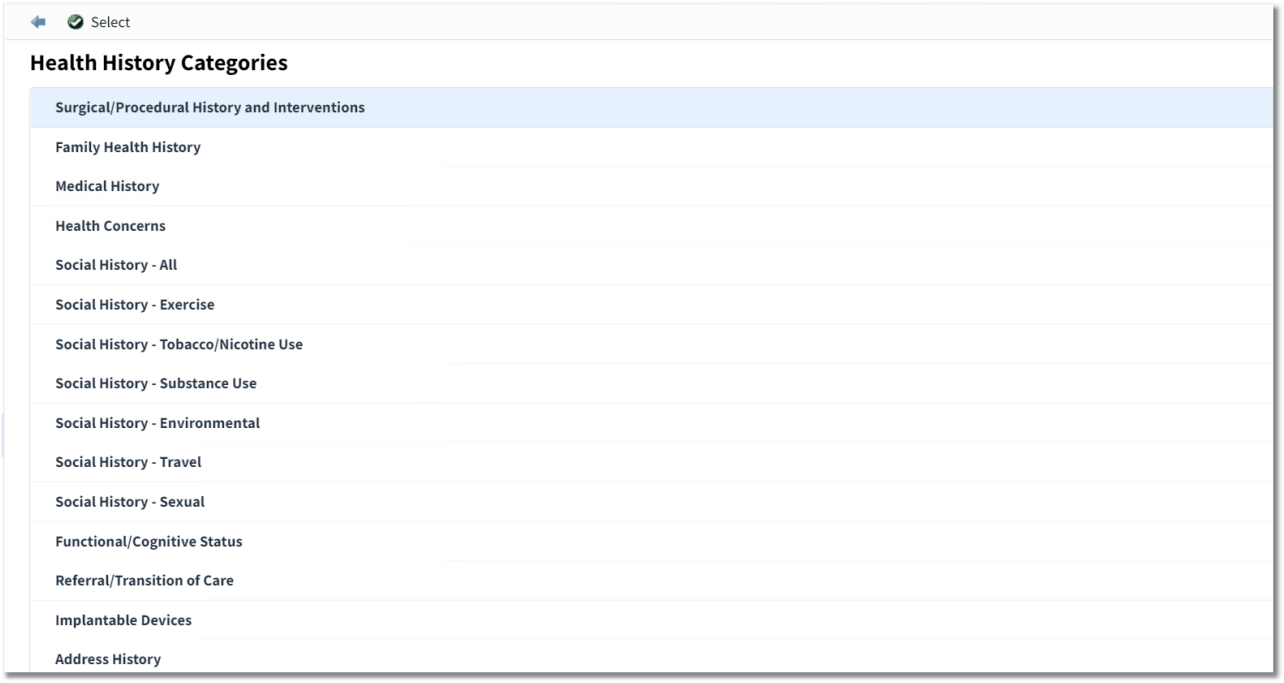
Health History - List View

Several different options and filters are available when viewing health history:

- View information in either a **Narrative View** or a **List View** by selecting the button in the action bar. To edit or delete items, you must be in **List View**.
- Filter the display by **Type**: **All**, **Family Health**, **Functional/Cognitive Status**, **Health Concerns**, **Implantable Devices**, **Address History**, **Medical History**, **Social**, **Referral/Transition of Care**, and **Surgical/Procedural History and Interventions**.
- The **Status** drop-down provides a filter to view **All**, **Active**, or **Inactive/Removed** items.
- Print Health History: Select **Print Health History**. The list of health history categories is displayed. Check the categories you wish to include. Select the box next to **Description** to select all categories. Click **Continue**. Select to export, send as a fax or message using the buttons on the screen.

To Add a New Health History Item

1. Select **New** from the action bar. A listing of the all the Health History Categories is displayed.



Health History Categories

2. Double-click the desired category (or single select and click **Select**.) Based on the category you choose, the appropriate entry screen is displayed. Details for entering each type of health history is detailed in the following sections:

- Surgical/Procedure History and Interventions
- Family Health History
- Medical History
- Health Concerns
- Social History - All
  - Social History-Exercise
  - Social History-Tobacco/Nicotine Use
  - Social History-Substance Use
  - Social History-Environmental
  - Social History-Travel
  - Social History-Sexual
- Functional/Cognitive Status
- Referral/Transition of Care
- Implantable Devices
- Address History

Chapter 4 Surgical/Procedure History and Interventions

Surgical/Procedure History and Interventions is the category to select when documenting the patient's procedure and surgery history, as well as other interventions the patient may have had. To view Surgical/Procedure History and Interventions, go to **Patient Chart > Health History** and see the entries under the **Surgical/Procedure History and Interventions** heading. *(**TIP:** Choose **List View** if you want to edit or delete items in the list.)*

This section covers the following topics:

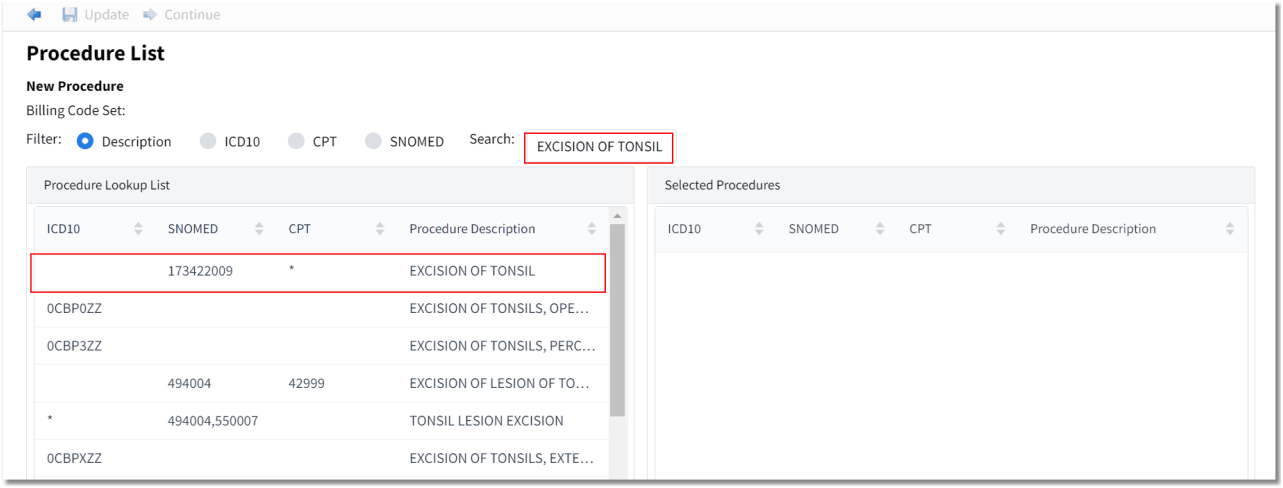
To Add Surgical/Procedure History Items
To Edit Surgical/Procedure History Items
To Remove Surgical/Procedure History Items

To Add a New Surgical/Procedure History Item

1. To add a new procedure or intervention, go to **Health History > New**. The Health History Categories page is displayed.

2. Double-click **Surgical/Procedure History and Interventions** from the list of Health History categories. The Procedure List is displayed.

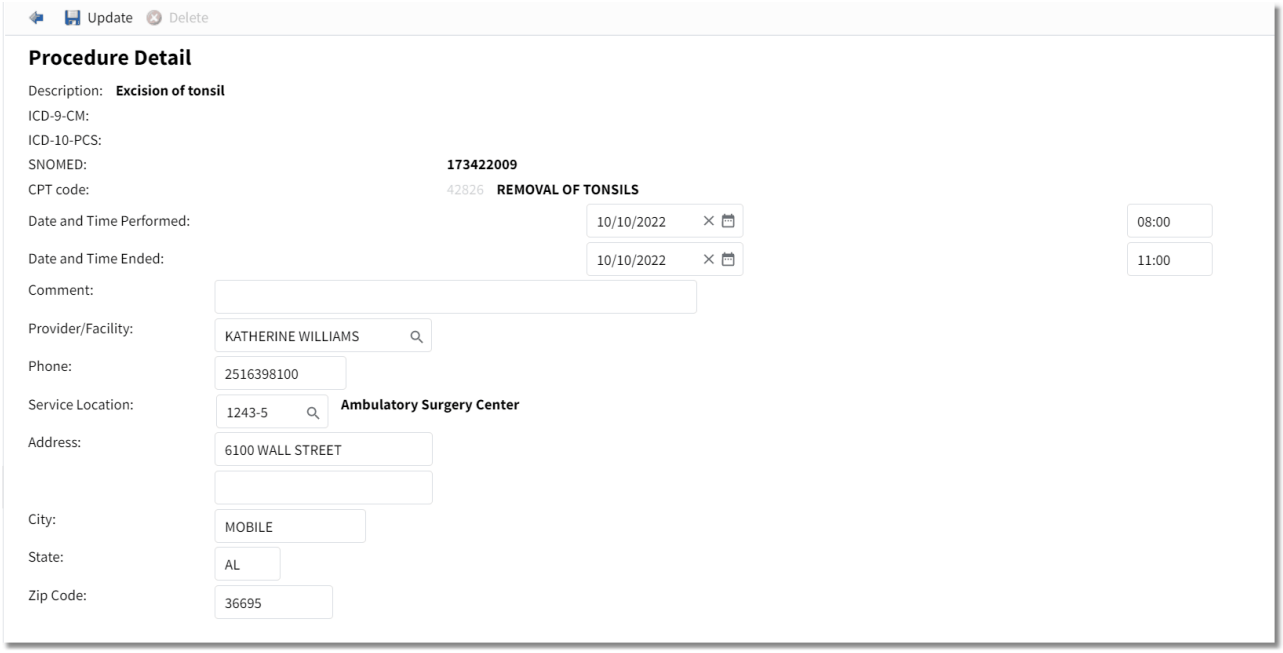
3. Search for and locate the appropriate procedure by selecting the **Description**, **ICD10** code, **CPT** code, or **SNOMED** code options and then entering information into the **Search** field.



Procedure List

4. Select the desired item from the list and select **Continue**. Depending on the item you select, you may be prompted for additional selections. If needed, make the appropriate selection and click **Continue** until the Procedure Detail screen is displayed.

   ***TIP:** Double-click the desired procedure/diagnosis to select it without adding details.Once selected, the item moves to the grid on the right side of the screen (**Selected Procedures**). Procedure Details can be added from the Health History grid by double-clicking the item to display the Procedure Detail screen.*



Procedure Detail

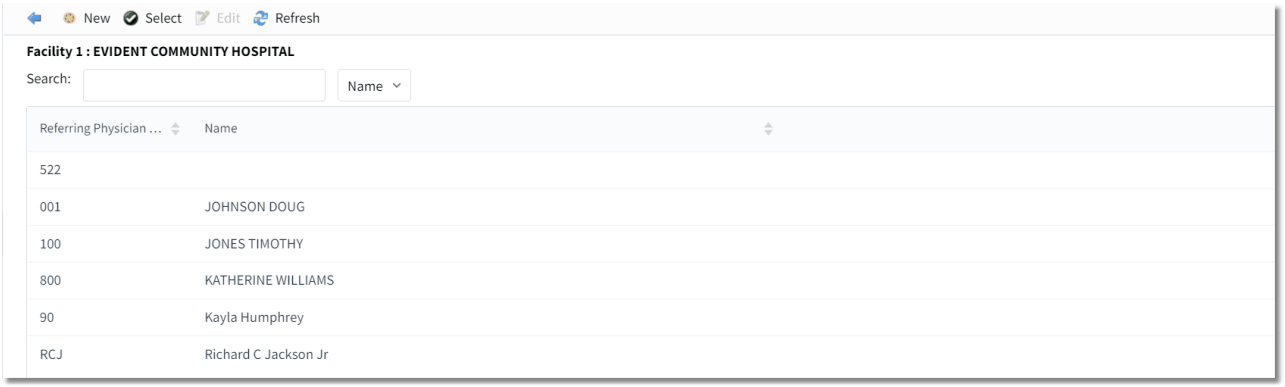
5. Enter the appropriate procedure details, which include the **Date and Time Performed**, **Date and Time Ended**, **Provider/Facility** (click the magnifying glass to search for the appropriate provider), **Service Location**, and **Address of Location**. Once you select the Provider or Facility, the remaining details will populate, if available.

    - Select the **Date and Time Performed** from the available calendar and select **Save**. The date field is not required. The system does not allow future dates to be entered. The time field is a free text box.
    - Select the **Date and Time Ended** from the available calendar and select **Save**. The time field is a free text box.
    - The **Comment** field allows a free text comment to be added for documentation.
    - The **Provider/Facility** field may be entered free text or a magnifying glass look-up is available using the Referring Physician table in Business Office Table Maintenance. The **Referring Physician** may be searched by **Name** or **Code**. From the Referring Physician search screen, you can add a new physician or edit an existing physician. (See Table Maintenance - Business Office.)

6. Click **Update** to save the procedure. You are returned to the Procedure List to search for additional procedures, if needed. Click the blue back button to return to the Health History Categories screen. Select a new category if you have additional items to add to the patient health history. Otherwise, click the blue back arrow to return to the Health History grid, where the item(s) you just added is displayed.

NOTE: *Facilities outside of the United States utilize a different address format, so the Surgical/Procedural History and Interventions screen will display Province and Postal Code instead of State and Zip Code if the Country Code field is set to a country other than the US. The address within Health History Procedure maintenance will allow user to toggle between different countries*

*and will retain all data until **Update** is selected. A TruBridge representative will need to be contacted in order for the foreign address fields to be activated.*



Provider/Facility Look-up

To Edit a Surgical/Procedure History Item

To edit a Surgical/Procedure History item, go to the Health History Review screen and select **List View** format. Double-click the item to display the Health History Edit screen (or highlight the desired entry and select **Edit**). Make edits to the details. Click **Update** to save the changes.

To Remove a Surgical/Procedure History Item

To remove a Surgical/Procedure History item, go to the Health History Review screen and select **List View** format. Double-click the item to display the Health History Edit screen (or highlight the desired entry and select **Edit**.) Select **Remove**. A confirmation message is displayed. Click **Yes** to continue with the remove process. Removed records will only display on the Health History Review screen when the Status filter is set to "All" or "Removed."

Chapter 5 Family Health History

The patient's family health history is documentation of conditions that the patient's family members have had. To view Family Health History, go to **Patient Chart > Health History** and see the entries under the **Family Health** heading. *(**TIP:** Choose **List View** if you want to edit items in the list.)*

This section covers the following topics:

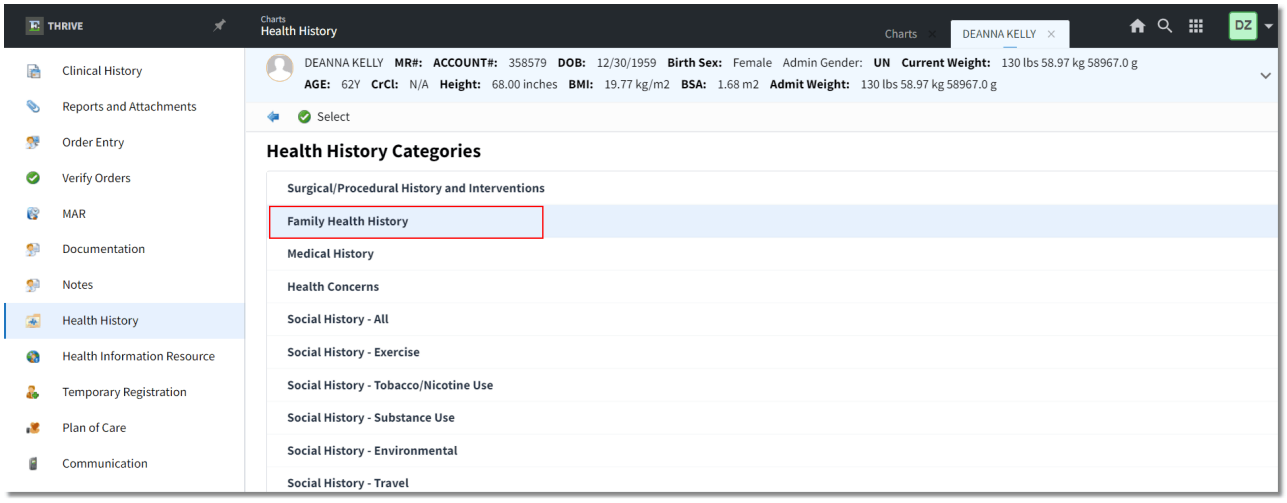
[To Document No Known Family History]
[To Add Family History Items]
[To Edit Family History Items]
[To Add Favorites for Family History Items]

To Document No Known Family History

If the patient has no known family history, it's important to document that. When there have been no entries for the patient's record under the Family Health History category, the **No Known Family History** button is enabled on the action bar. Select the **No Known Family History** option to note in the patient's record that there is no known family history. Once items have been added to Family Health History, the button is no longer enabled.

To Add a New Family Health History Item

1. To add a new family health history item, go to **Health History > New**. The Health History Categories page is displayed.

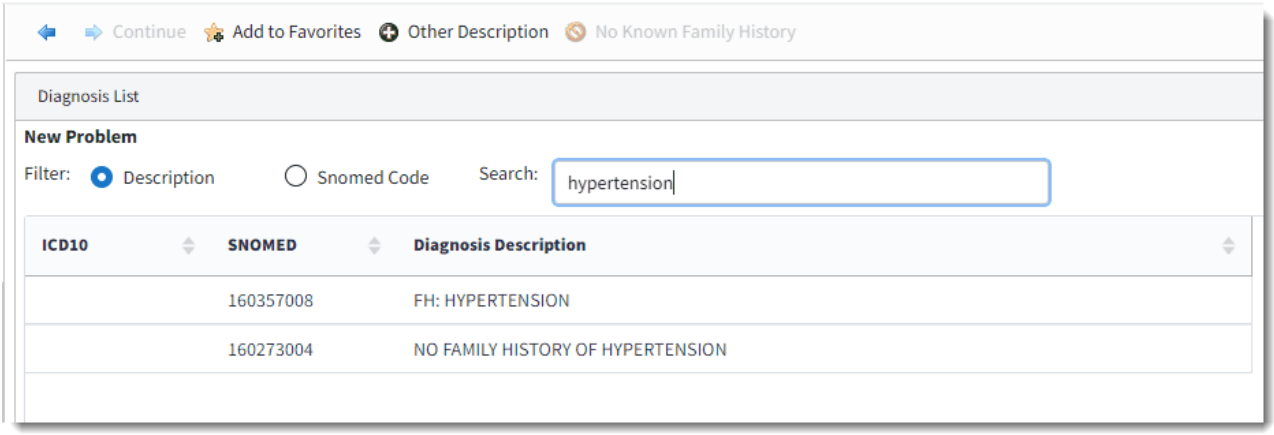


Family Health History

2. Double-click **Family Health History** from the list of Health History categories. The **New Problem** screen is displayed and your favorites are displayed in the grid. If you wish to select a favorite from the grid, double-click it and proceed to step 5. See [To Add Favorites] for details on how to create your "favorites." Otherwise, proceed to step 3.

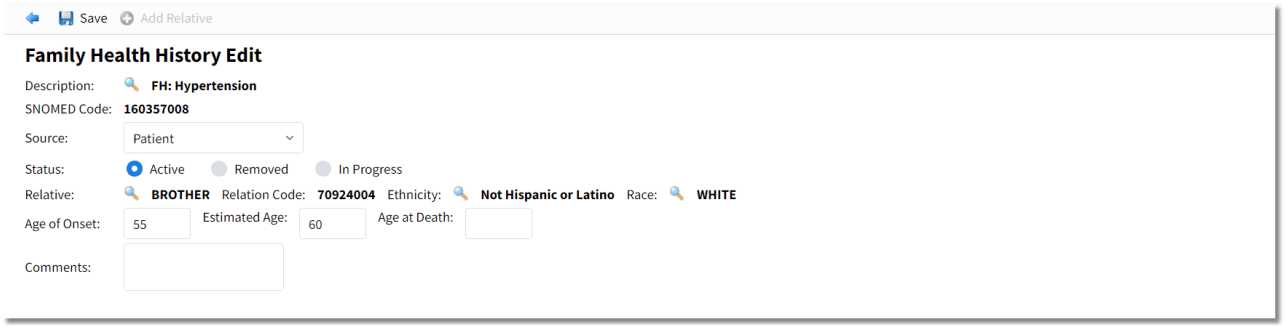
3. Search for and locate the appropriate health problem by selecting the **Description** or **SNOMED** option and then entering information into the **Search** field.

   NOTE: *The **Search** field in Family Health History is limited to diagnosis descriptions with no ICD9 or ICD10 codes attached, only SNOMED codes. If your search returns no results, select **Other Description** in the action bar to add your text as the Family Health History item.*



New Problem

4. Double-click the item to select it, or select the desired item from the list and select **Continue**. The Family Health History Edit screen is displayed. The **Description** and **SNOMED Code** are displayed.



Family Health History Edit

5. In the **Source** field, use the drop-down to select the source of the family history information. The **Source** is the person (or method) that gave you the family history information, and the list uses the **Problem List Source** table from Clinical Table Maintenance.

6. The **Status** defaults to **Active** but may be set as **Removed** or **In Progress** by selecting the available radio buttons.

7. In the **Relative** field, use the magnifying glass to display the Patient Relationship List. Search for the appropriate relative that had the selected health problem. The column title may be selected to alphabetize the listing. Double-click the relative from the list, or highlight the relative and choose **Select** from the action bar. Once the **Relative** is selected, the Relative SNOMED code will display as the **Relation Code**.

8. Select the magnifying glass for the **Ethnicity** and **Race** fields to search for and select the appropriate designation. The look up uses the Race Table and Ethnicity Table from Census.

9. Enter the **Age of Onset** or **Estimate Age** of onset along with the **Age at Death**. These fields allow three digits to be populated.

10. If additional comments are needed, add them in the **Comments** field. ***NOTE:*** *Comments are limited to 400 characters of free-text. Comments can be viewed in their entirety in the* ***Narrative View*** *or* ***List View*** *by hovering over the* ***Comments*** *field.*

11. Click **Save**. Select **Add Relative** to add additional relatives that also have a history the selected problem.

12. Click the blue back arrow to return to the Health History Categories list. If information has not yet been saved, the system will prompt, ***Are you sure you wish to exit without saving?*** Select **No** and then click **Save**.

13. Click the blue back arrow to return to the **Health History Review**. You can display the information in either **Narrative View** or **List View**.
    - The **Narrative View** may take a few moments to display if there is a lot of data. This view provides the diagnosis, relative, age of onset information, and comments, if present.
    - The **List View** provides the **Diagnosis**, **Relative**, **Age of Onset**, **Status**, and any **Comments** entered from the documentation. The existing Family Health may be edited when it is selected from the **List View**.

To Edit a Family Health History Item

To edit a Family Health History item, go to the Health History Review screen and select **List View** format. Double-click the item to display the Family Health History Edit screen (or highlight the desired family health entry and select **Edit**). Make edits to the Source, Status, Age fields, or Comments.

If the **Description** or **Relative** information is changed, a new record will be created and the original record will be deleted. Click **Save** to save the changes. (***NOTE:*** *You may need to click out of the field you edited to enable the* ***Save*** *button.)*

NOTE: *If the status of all previously entered Family History items are changed to* ***Removed****, the* ***No Known Family History*** *option will be available again. See* *To Document No Known Family History**.*

To Add Favorites

Users can add favorites and when the New Problem screen is displayed, the favorites are displayed for easy selection. To add favorites, single select the problem in the list and select **Add to Favorites** in the action bar. Favorites are displayed when you access the New Problem list.

Chapter 6 Medical History

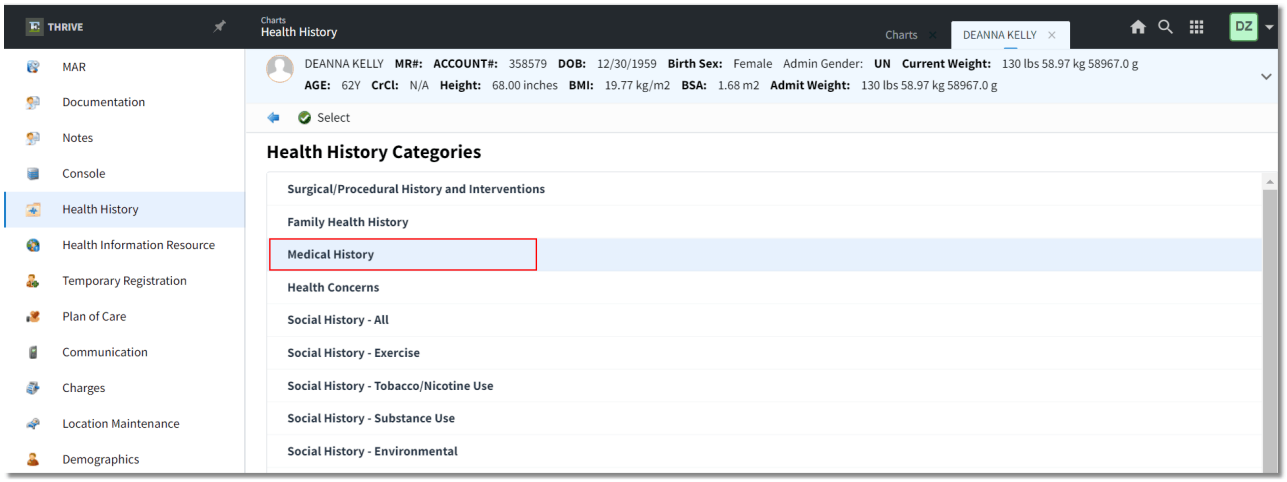
The patient's medical history is documentation of conditions that the patient has had previously. To view the patient's medical history, go to **Patient Chart > Health History** and see the entries under the **Medical History** heading. *(**TIP:** Choose **List View** if you want to edit items in the list.)* Updates to the Medical History will automatically update the Problem List, and entries in the Problem List may be designated to also be included in Medical History.

This section covers the following topics:

[To Add a New Medical History Item]
[To Edit Medical History Items]
[To Add Favorites for Medical History Items]

To Add a New Medical History Item

1. To add a new medical history item, go to **Health History > New**. The Health History Categories page is displayed.

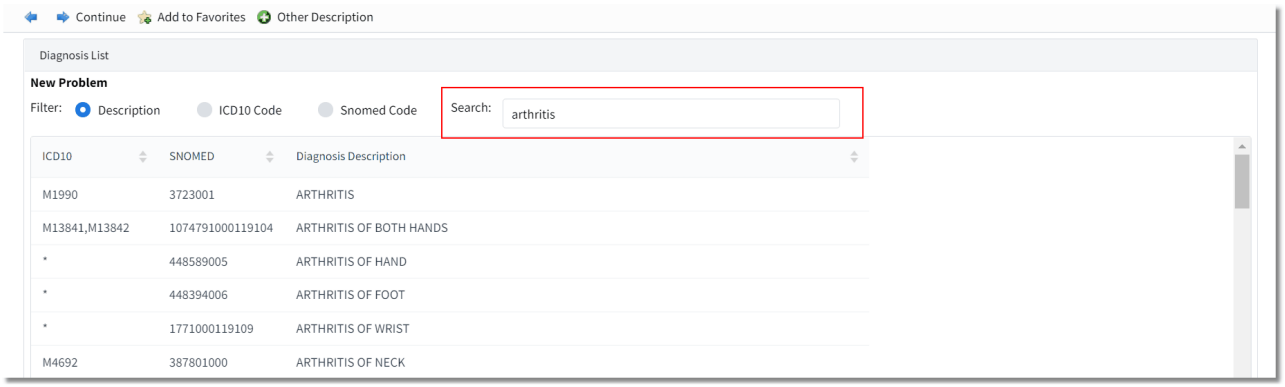


Health History Categories

2. Double-click **Medical History** from the list of Health History categories. The **New Problem** screen is displayed and your favorites are displayed in the grid. If you wish to select a favorite from the grid, double-click it and proceed to step 5. See [To Add Favorites] for details on how to create your "favorites." Otherwise, proceed to step 3.

3. Search for and locate the appropriate problem by selecting the **Description, ICD10 Code**, or **SNOMED** Code option and then entering free text information into the **Search** field.

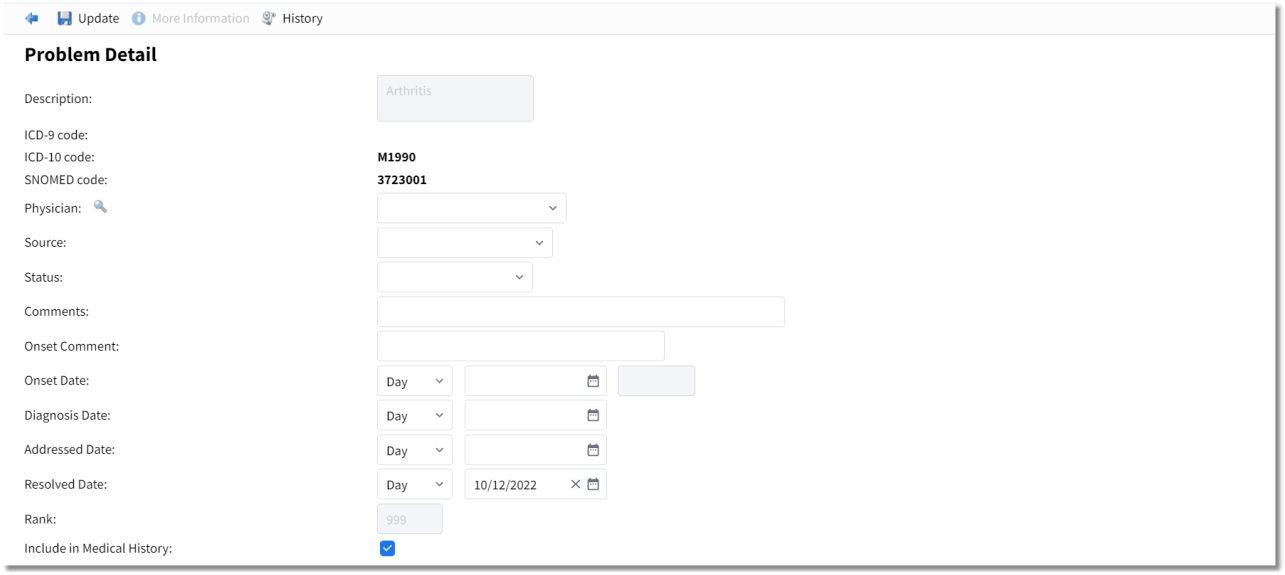
   ***NOTE:** The **Search** field in Family Health History is limited to diagnosis descriptions with no ICD9 or ICD10 codes attached, only SNOMED codes. If your search returns no results, select **Other Description** in the action bar to add your text as the Family Health History item. The **Other Description** option allows a free text entry for medical history not available in the lookup.*



New Problem

4. Double-click the item to select it, or select the desired item from the list (select **Add to Favorites** in the action bar if you wish to add it) and select **Continue**. The Problem Detail screen is displayed. The **Description, ICD-10 code,** and **SNOMED Code** are displayed.

   NOTE: *If you'd like to access a database of additional information regarding the selected problem/diagnosis, select* ***More Information*** *in the action bar. This launches a third party database of clinical information in a new tab.*



Problem Detail

5. In the **Physician** field, use the drop-down to select the physician for the problem.

6. In the **Source** field, use the drop-down list to select the source who informed you of the problem.

7. The **Status** field defaults to an **Inactive Status**. If needed, use the drop-down list to select the appropriate status.

8. If needed, enter additional notes in the **Comments** field. There is a 80 character limit and not all text will display in the field.

9. Enter the **Onset Comment**, **Onset Date**, **Diagnosis Date**, and **Addressed Date** if known. The **Resolved Date** will default to the current date but may be edited.

10. The **Rank** will default to **999** in the **Problem List**.

11. Select the **Include in Medical History** check box if you want the entered problem to display in the patient's medical history.

12. Select **Update**. You are returned to the Health History Categories list. If desired, enter more health history entries. Otherwise, click the blue arrow button to return to the Health History Review screen where your new entry is displayed under the Medical History header. You can display the information in either **Narrative View** or **List View**.
    - The **Narrative View** may take a few moments to display if there is a lot of data. This view provides the diagnosis, relative, age of onset information, and comments, if present.
    - The **List View** provides the **Diagnosis**, **Onset**, **Status** and any **Comments** entered from the documentation. The existing entries may be edited when selected from the **List View**.

To Edit a Medical History Item

To edit a Medical History item, go to the Health History Review screen and select **List View** format. Double-click the item to display the Problem Detail screen (or, highlight the desired medical history entry and select **Edit**). Make edits to the fields, as needed. Click **Update** to save the changes. Changes are tracked and can be viewed by selecting **History** in the action bar. Any **Medical History** entered from the **Heath History** application will also update the patient's **Problem List**.

To Add Favorites

Users can add favorites and when the New Problem screen is displayed, the favorites are displayed for easy selection. To add favorites, single select the problem in the list and select **Add to Favorites** in the action bar. Favorites are displayed when you access the New Problem screen.

Chapter 7 Health Concerns

The patient's health concerns is documentation of health related matters that are of interest, importance, or worry to the patient, patient's family, or provider. To view the patient's health concerns, go to **Patient Chart > Health History** and see the entries under the **Health Concerns** heading. (***TIP:*** *Choose* ***List View*** *if you wish to edit items in the list.)*

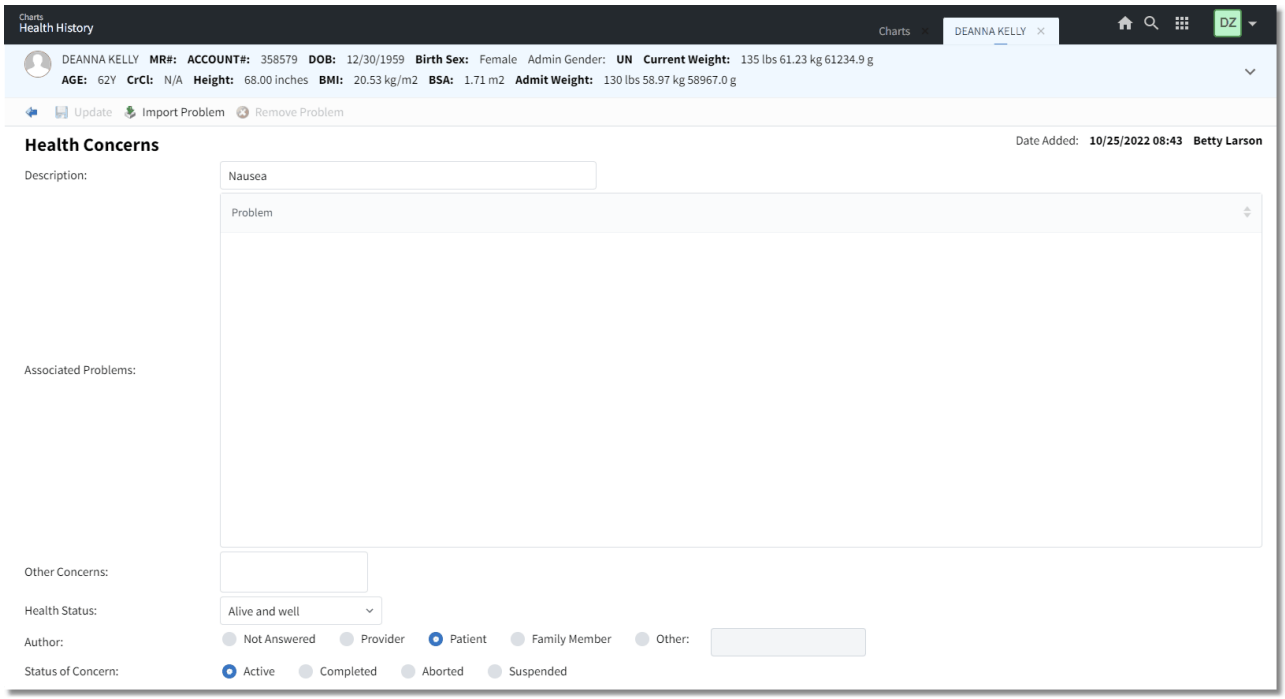
This section covers the following topics:

[To Add a New Health Concern](#)
[To Edit a Health Concern](#)

To Add a New Health Concern

1. To add a new health concern, go to **Health History > New**. The Health History Categories page is displayed.

2. Double-click the **Health Concerns** category. The Health Concerns page is displayed.



Health Concerns

3. In the **Description** field, enter the description of the concern.

4. In the **Associated Problems** box, you can associate active or inactive problems from the problem list to associate with this concern. Select **Import Problem** to display the Problem List. Use the filter options to display all, active, or inactive problems. Then double-click the problem to add it to the health concern. The selected problem is displayed in the **Associated Problems** box. Repeat the process to add additional problems.

5. In the **Other Concerns** field, enter other concerns.

6. In the **Health Status** field, use the drop down menu to select the patient's current health status.

7. Select the appropriate person who provided information about the concern in the **Author** field: Not Answered, Provider, Patient, Family Member, or Other.

8. In the **Status of Concern** field, select one of the following statuses:
   - **Active:** This field will make the concern active. This field defaults to **Active**.
   - **Completed:** Completes the health concern.
   - **Aborted:** Aborts the health concern. This reflects an inactive status.
   - **Suspended:** Use this field if the concern is suspended.

9. Select **Update** to save changes and return to the list of health history categories. Click the blue back arrow to return to the Health History Review page where your entry is now displayed.

Chapter 8 Social History-All

The patient's social history is documentation of the patient's social history. To view all Social History, go to **Patient Chart > Health History** and see the entries under the **Social History** heading. *(**TIP:** Choose **List View** if you want to edit items in the list.)*

To Document Social History

To document social history, select **New**. From the list of Health History Categories, select **Social History - All**, which will display all the social history subcategories for documentation, or select one of the following subcategories to document only that section of the social history:

Social History - Exercise
Social History - Tobacco/Nicotine Use
Social History - Substance Use
Social History - Environmental
Social History - Travel
Social History - Sexual

8.1 Social History-Exercise

Exercise History provides documentation of exercise habits.

1. Complete the fields in **Habits** for **Exercise Routine**, **Exercise Frequency**, and **Type of Exercise** performed.

2. Once documentation is completed, select **Update**.

***NOTE:** If information is not saved, the system will prompt "Are you sure you wish to exit without saving?"*

8.2 Social History-Tobacco/Nicotine Use

Tobacco/Nicotine Use provides documentation for use of tobacco that is smoked, smokeless, or electronic, as well as a full comprehensive tobacco history.

1. Complete the information in the sections below, as needed.

- **Tobacco Use Screening Completed:** This section displays the status of the tobacco screening. This is updated when addressed in either Health History or within the Census area of the ADT Registration screens.
  - o **Screening Status** allows the user to indicate if it was complete. If **Yes** is selected, the date it was answered will display within the date field.
  - o **Reason for Not Screening** will display the reason for not completing the smoking status.

- **Smoked Tobacco:** This section includes the **Smoking Status** of the patient.
  - o The number of **Packs per Day**, **Week**, or **Year** may be documented in **Frequency**.
  - o **Duration** will define the type of tobacco, **Cigarettes**, **Cigars**, and **Pipes**, and number years they have used smoking tobacco. The start and end dates may also be recorded.

- **Smokeless Tobacco:** This section includes the **Smokeless Tobacco Status** of the patient. If the patient is a smokeless tobacco user, the **Frequency**, **Duration**, and start and end dates may be documented.
  - o The number of times the patient uses the product per **Day**, **Week**, or **Year** may be documented in **Frequency**.
  - o **Duration** will define the number years they have used smokeless tobacco.
  - o The start and end dates may also be recorded.

NOTE: *The* ***Smoking Status****,* ***Smokeless Tobacco Status****,* ***Smoke Start Date****, and* ***Smoke End Date*** *will update to the* ***Person Profile*** *if fulfilled during registration or in Health History.*

- **Electronic Cigarettes:** This section documents the patient's electronic cigarette use. The number of years may be entered for the **Duration**, along with the start and end dates of the Electronic Cigarettes.

- **History of Tobacco Use:** This section will display the historic smoking status, as well as the details about the smoking habit. The following options will display with the ability to enter the start date and end date:
  - o Chews tobacco
  - o Cigar smoker
  - o Cigarette smoker
  - o Exposed to tobacco use smoke at home
  - o Light tobacco smoker
  - o Maternal tobacco use
  - o Passive smoker
  - o Pipe smoker
  - o Rolls own cigarettes
  - o Snuff user
  - o Thinking about quitting smoking

- **Tobacco Cessation Counseling:** Tobacco Cessation Counseling needs to be added only if not providing tobacco counseling. If Smoking Cessation Education Documents are given during the visit, **Counseling Given** will update to **Yes**, and the name of the document will be listed as **Cessation Counseling Given**. If no cessation counseling is given, select the magnifying glass for **Reason Not Given**. Answers may include **Not Answered**, **Medical**, **Patient Refused**, and **Other**. The system will display a list of specific medical reasons along with the associated SNOMED codes that are acceptable.

2. Once documentation is completed, select **Save**.

NOTE: *If information is not saved, the system will prompt "Are you sure you wish to exit without saving?"*

8.3 Social History-Substance Use

Substance Use History provides documentation of miscellaneous substances that the patient has used.

1. Complete the information in the sections below, as needed.

- **Substance Use:** Defines the patient's substance use.
  - **Use** may be documented as **Never**, **Rare**, **Occasional**, **Frequent**, **Addiction**, and **Recovering Addiction**.
  - The **Usage Routes** may be documented as **Oral**, **Smoking**, **Intranasal**, **Inhalation**, **Subcutaneous**, **Intravenous**, or **Other**. Selecting **Other** allows free-text entry.
  - The **Types** available for documentation are **Cocaine**, **Methamphetamine**, **Heroin**, **Marijuana**, **Prescription Drug Abuse**, or **Other**. Selecting **Other** allows free-text entry.
  - **Frequency** defines the number of **Times per Day**, **Times per Week**, or **Times per Month** that the patient uses the substance. The number of years of Substance Use may be documented along with the **Substance Use Start Date** and **Substance Use End Date**.
  - **Usage Amount** may be documented as **Increasing**, **Decreasing**, or **Unchanged**.

- **Alcohol:** Defines the patient's current alcohol use.
  - **Use** may be documented as **Never**, **Rare**, **Occasional**, **Frequent**, **Binge Drinker**, **In Recovery**, **Quit**, or **Abuse History**. You can select multiple options.
  - **Type** provides a way to define the type of alcohol (**Beer**, **Wine**, and **Liquor**).
  - The number of **Drinks per Day**, **Week**, or **Month** may be documented in **Frequency**. LOINC code is attached.
  - **Screening** date may be given. Current date will be the default but may be changed.
  - **Duration** will define the number years they have used alcohol. The start and end dates may also be recorded.

- **Caffeine Use:** Caffeine Use may be documented with the number of **Servings per Day** of **Coffee**, **Tea**, and **Soda/Pop** consumed.

2. Once documentation is completed, select **Save**.

NOTE: *If information is not saved, the system will prompt, "Are you sure you wish to exit without saving?"*

8.4 Social History-Environmental

Environmental History provides documentation for socioeconomic information on the patient.

1. Complete the information in the sections below, as needed.

- **Environmental History:** Environmental History consists of:
  - **Relationship Status**, which may be selected as **Not Answered**, **Single**, **Married**, **Divorced**, **Separated**, **Widowed**, or **Significant Other**.
  - **Domestic Violence Risk** provides a **Not Answered**, **Yes**, or **No** risk.

- **Occupational History** may be recorded as **Not Answered**, **Full Time**, **Part Time**, **Homemaker**, **Retired**, **Unemployed**, or **Disabled**.
- **Occupational Exposures** provides documentation of hazards, including **Chemicals**, **Sounds** ,**Overuse Injury**, **Stress**, and **Other**. (Selecting **Other** allows free-text entry.)
- The **Occupation** field provides a magnifying glass lookup to search for the Industry Code association with the patient's employer. The Date range of employment may be entered or selected from the calendar icon available. A start date may be entered with no end date.

- **Living Condition**
  - **Assessment Performed** may be selected as **Not Answered**, **Yes**, or **No**. If **Yes** is selected, the **Date** field displays the current date, and the **Living Condition** is enabled for completion.
  - **Living Condition** options include **Home**, **Nursing Home**, **Home Health Care**, **College**, **Lives Alone**, **With Spouse/Significant Other**, **Assisted Living**, **Homeless**, and **Other**. (Selecting **Other** allows up to 50 characters of free text.)

- **Health Equipment Use**
  - **Assessment Performed** may be selected as **Not Answered**, **Yes**, or **No**. If **Yes** is selected, the **Date** field displays the current date, and the **Health Equipment Use** fields are enabled for completion.
  - **Health Equipment Use** allows documentation for use of **Oxygen**, **CPAP**, **BiPAP**, **Nebulizer**, **Wheelchair**, **Walker**, **Ventilator**, **Wheeled Walker**, **Cane**, **Shower Chair**, **Bedside Commode**, **Tens Unit**, and **Hospital Bed**.
  - **Began Use** and **Ended Use** may be entered for any Health Equipment Use option.

  ***NOTE: List View**, **Narrative View**, **Patient Summary**, and the **Health History** report in **Print EMR** have all been updated to display these options. In addition, each health equipment option has been associated with a SNOMED code to be compliant with CMS guidelines for 2021.*

- **Patient from Multiple Birth:** Allows for documenting if the patient was born from a multiple birth pregnancy. The default is **Not Answered**. If **Yes** is selected, the **Birth Order** drop-down is enabled with options **1-9** and **Unknown**.

- **Number of children:** Allows for documenting the number of children the patient has.

- **Number of grandchildren:** Allows for documenting the number of grandchildren the patient has.

- **Social Activities** provides a way to document the patient's involvement in **Volunteer Work**, **Religious Group(s)**, **Sports**, and **Social Group(s)**.

- **Education** options include **Not Answered**, **None**, **Elementary**, **Some High School**, **High School**, **Some College**, **College**, and **Graduate**.

2. Once documentation is completed, select **Save**.

***NOTE:** If information is not saved, the system will prompt, "Are you sure you wish to exit without saving?"*

8.5 Social History-Travel

Travel History provides documentation for travel information.

1. Complete the information as needed:

- Indicate whether patient has **Traveled Outside of the Country**. Options are **Not Answered**, **Yes**, and **No**.
- Indicate whether the patient reported **Extended time sitting during travel**. Options are **Not Answered**, **Yes**, and **No**.

2. Once documentation is completed, select **Save**.

NOTE: *If information is not saved, the system will prompt, "Are you sure you wish to exit without saving?"*

Any Travel documentation may be edited by selecting the **Travel History** from the **List View**.

8.6 Social History-Sexual

Social History - Sexual History provides documentation for the patient's sexual history.

1. Complete the information in the **Sexual History** fields as needed.

- **Are you sexually active:** LOINC code is attached to answers.
  - o **Not Answered** (Default)
  - o **Yes**
  - o **No**
  - o **Screening** will auto populate the current date but may be changed if necessary.

- **Sexual Orientation:**
  - o **Not Answered** (Default)
  - o **Straight or Heterosexual**
  - o **Lesbian, Gay or Homosexual**
  - o **Bisexual**
  - o **Doesn't Know**
  - o **Chooses Not to Disclose**
  - o **Sexually attracted to neither male nor female sex**
  - o **Other** (provides free text up to 50 characters)

- **History of unsafe sexual activity:**
  - o **Not Answered** (Default)
  - o **Yes**
  - o **No**

- **Gender Identity:**
  - o **Not Answered** (Default)

- **Identifies as Male**
- **Identifies as Female**
- **Female to Male (FTM) Transgender Male/Trans Man**
- **Male to Female (MTF) Transgender Female/Trans Woman**
- **Genderqueer, neither exclusively Male nor Female**
- **Non-Binary**
- **Chooses Not to Disclose**
- **Additional Gender, Specify** (provides free text up to 50 characters)

- **Personal Pronoun(s):** Use this field is to document the patient's personal gender pronoun(s). This is a drop-down list and contains the following options:
  - **He, Him, His, Himself**
  - **She, Her, Hers, Herself**
  - **They, Them, Their, Theirs, Themself**
  - **Ze, Zir, Zirs, Zrself**
  - **Xie, Hir ("Here"), Hir, Hirs, Hirself**
  - **Co, Co, Cos, Cos, Coself**
  - **En, En, Ens, Ens, Enself**
  - **Ey, Em, Eir, Eirs, Emself**
  - **Yo, Yo, Yos, Yos, Yoself**
  - **Ve, Vis, Ver, Ver, Verself**
  - **Unknown Pronouns**
  - **Uses Other Pronouns** (NOTE: A text box is provided when this option is selected.)

  Updates made to a patient's personal pronouns will pull to the ID Panel, Narrative or List View in Health History Review, Patient Summary, and the System Menu > Print EMR Report. If a patient's Personal Pronouns are entered via Health History > Sexual History, they will display when hovering over the **Gender Identity** information in the ID Panel.

2. Once documentation is completed, select **Save**.

NOTE: *If information is not saved, the system will prompt, "Are you sure you wish to exit without saving?"*

Chapter 9 Functional/Cognitive Status

A patient's **Functional/Cognitive Status** includes activities of daily living, cognitive, and disability status. To view the patient's Functional/Cognitive Status documentation, go to **Patient Chart > Health History** and see the entries under the **Functional/Cognitive Status** heading. Functional/Cognitive Status documentation will also display on the Patient Summary in the Function Status section. *(**TIP:** Choose **List View** if you want to edit items in the list.)*

This section covers the following topics:

To Document No Functional Impairments
To Document No Cognitive Impairments
To Add a New Functional/Cognitive Status Item
To Edit Functional/Cognitive Status Items
To Remove Functional/Cognitive Status Items

To Document No Functional Impairments

If the patient has no known functional impairments, it's important to document that. Select the **No Known Functional Impairments** option to note in the patient's record that there is no known functional impairments.

***NOTE:** Any new entry updated will overwrite the No Impairments entry.*

To Document No Cognitive Impairments

If the patient has no known cognitive impairments, it's important to document that. Select the **No Known Cognitive Impairments** option to note in the patient's record that there is no known cognitive impairments.

***NOTE:** Any new entry updated will overwrite the No Impairments entry.*

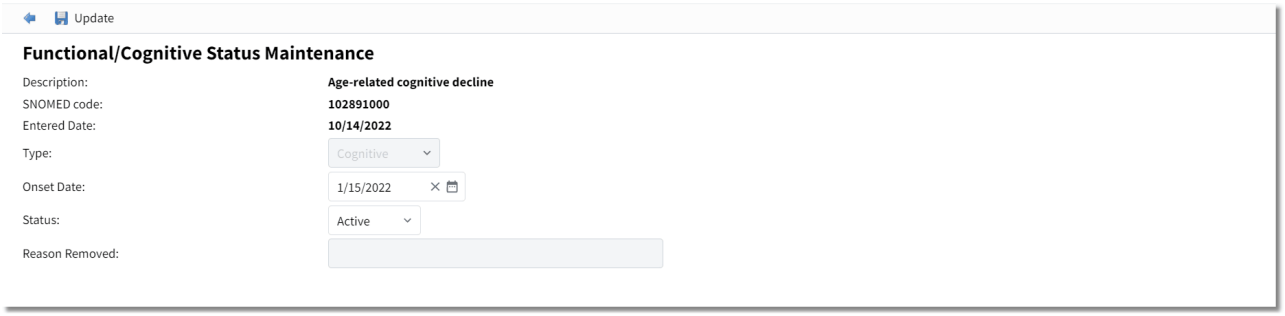
To Add a New Functional/Cognitive Status Item

1. To add a new family health history item, go to **Health History > New**. The Health History Categories page is displayed.

2. Double-click **Functional/Cognitive Status** from the list of Health History categories. The Functional/Cognitive Status Search screen is displayed. A list of impairments and disabilities is displayed. The **Type** column displays whether the description is a **Functional** or **Cognitive** impairment.

3. Search for and locate the appropriate status by selecting the **Description** or **SNOMED** option in the drop-down list and then entering information into the **Search** field. Descriptions display in alphabetical order.

4. Double-click the desired impairment or disability (or select the desired impairment or disability and select **Insert**). The Functional/Cognitive Status Maintenance screen is displayed, and the **Description**, **SNOMED code**, **Entered Date** (current date), and **Type** are populated based on the item selected.



Functional/Cognitive Status Maintenance

5. Enter the **Onset Date** or select from the calendar.

6. In the **Status** field, select **Active**, **Inactive**, or **Removed** from the available drop-down. See To Remove Functional/Cognitive Status Items for additional details.

7. Select **Update**.

NOTE: *If information is not saved, the system will prompt, "Are you sure you wish to exit without saving?"*

To Edit Functional/Cognitive Status Items

1. Go to the Health History Review screen and select **List View** format.

2. Double-click the item to display the **Functional/Cognitive Status Maintenance** screen (or highlight the desired entry and select **Edit**).

3. Make the desired edits.

4. Select **Update** to save**.**

To Remove Functional/Cognitive Status Items

1. To remove a Functional/Cognitive Status item, go to the Health History Review screen and select **List View** format.

2. Double-click the item to display the **Functional/Cognitive Status Maintenance** screen (or, highlight the desired entry and select **Edit**).

3. In the **Status** field, select **Removed**. The **Reason Removed** field is enabled.

4. In the **Reason Removed** field, document the reason for removal (up to 50 characters).
5. Select **Update** to save the changes.

Chapter 10 Referral/Transition of Care

10.1 Referral/Transition of Care

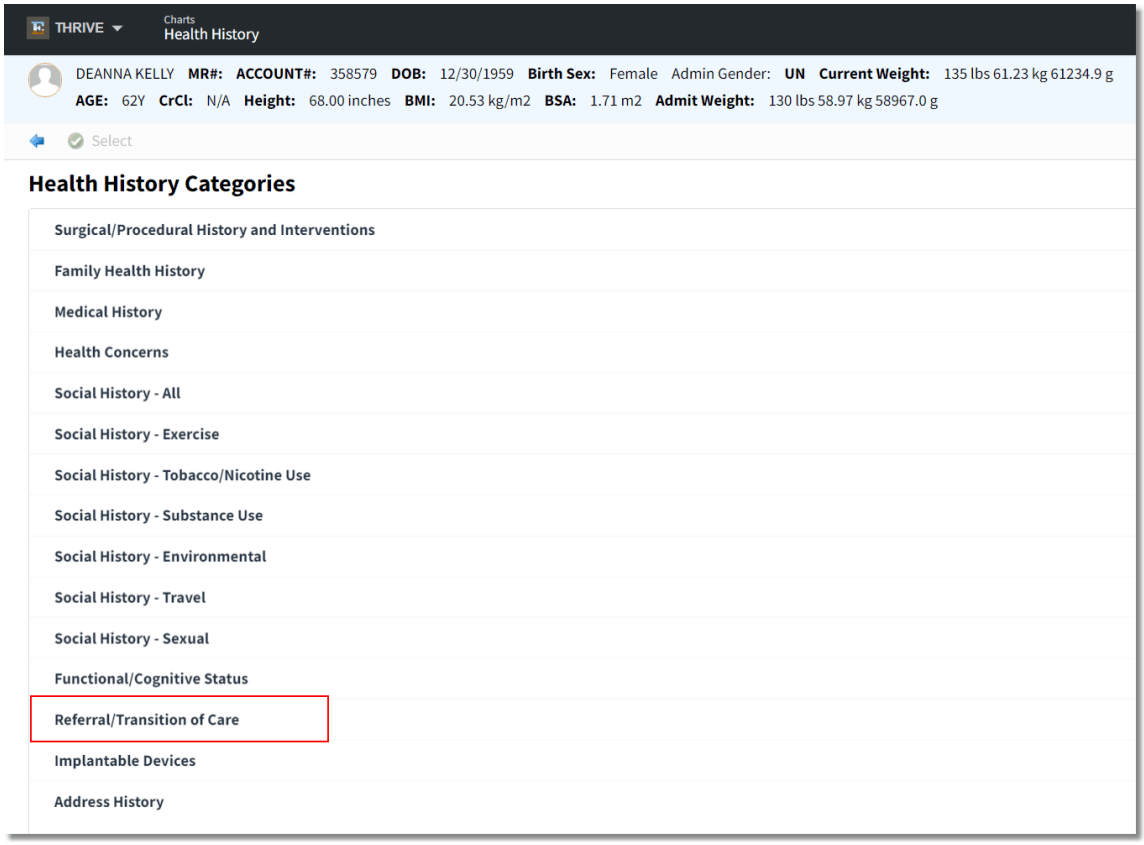
The **Referral/Transition of Care** is used to record when a patient is being referred to a follow-up physician or care is being transitioned to another provider. To view Referral/Transition of Care history, go to **Patient Chart > Health History** and see the entries under the **Referral/Transition of Care** heading. *(**TIP:** Choose **List View** if you want to edit items in the list.)*

This section covers the following topics:

To Add a Referral/Transition of Care
To Print a Referral/Transition of Care
To Edit a Referral/Transition of Care
To Delete a Referral/Transition of Care
To View Patient Medical Summaries
Additional Information

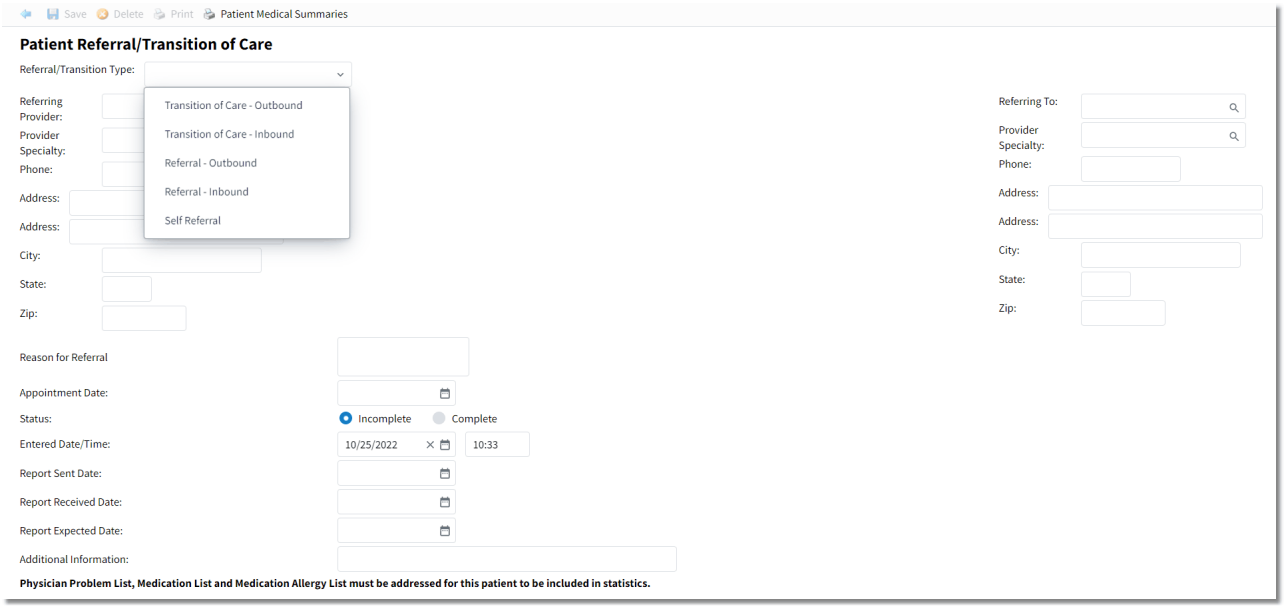
To Add a New Referral/Transition of Care

1. To add a new referral/transition of care, go to **Health History > New**. The Health History Categories page is displayed.



Health History Categories

2. Double-click **Referral/Transition of Care** from the list of Health History categories. The Patient Referral/Transition of Care screen is displayed.



Patient Referral/Transition of Care

3. In the **Referral/Transition Type** field, select one of the following: **Transition of Care - Outbound**, **Transition of Care - Inbound**, **Referral - Outbound**, **Referral - Inbound**, or **Self Referral**. This is a required field. Based on the type of referral selected, some fields will populate with the patient's provider information.

   NOTE: Referral - Inbound *and* ***Self Referral*** *will NOT be included in the Meaningful Use Denominator. If* ***Referral - Inbound*** *is selected, a field is displayed for* ***Request Made but Document not Received****.*

4. Complete the **Receiving Provider** information:
   - **Receiving Provider:** Enter the receiving provider's name using free text or use the look-up icon to select a specific individual from the predefined Referring Physicians or Referring Facilities Table in the Business Office Tables.
   - **Provider Specialty:** Use the magnifying glass to search for and document the provider's specialty.
   - **Phone:** If the provider is selected from the Referring Physician Table, this automatically pulls from the table. It may be entered manually as well. Enter this information without hyphens or spaces.
   - **Address:** Consists of two separate lines that pull automatically from the Referring Physician Table or may be manually typed in.
   - **City:** Pulls automatically from the Referring Physician Table or may be manually typed in.
   - **State:** Pulls automatically from the Referring Physician Table or may be manually typed in.
   - **Zip:** Pulls automatically from the Referring Physician Table or may be manually typed in. Enter up to nine numeric characters.

5. Enter the **Transferring Provider** information (on the right side of the screen):

- **Transferring/Referring Provider:** Allows for entry of provider or facility to which the patient is being transferred/referred. ***NOTE:*** *If an active hospitalist is assigned to the patient, the default will be the hospitalist instead of the attending physician.*
- **Provider Specialty:** Provides a magnifying glass search to document the specialty.
- **Phone:** If the provider is selected from the Referring Physician Table, this automatically pulls from the table. It may be manually entered as well. Enter this information without hyphens or spaces.
- **Address:** Consists of two separate lines that pull automatically from the Referring Physician Table or may be manually typed in.
- **City:** Pulls automatically from the Referring Physician Table or may be manually typed in.
- **State:** Pulls automatically from the Referring Physician Table or may be manually typed in.
- **Zip:** Pulls automatically from the Referring Physician Table or may be manually typed in. Enter up to nine numeric characters.

6. In the **Reason for Referral** or **Reason for Transfer** field, enter the reason using free text. This field accepts 160 characters.

7. In the **Appointment Date** field, use the calendar to select the appropriate date or enter the date using the MMDDYY or MMDDYYYY format.

8. The **Status** field defaults to **Incomplete**. Change to **Complete** if needed.

9. The **Entered Date/Time** field displays the date/time the Patient Referral/Transition of Care was entered. However, this field will change when the Referral/ Transition of Care is updated with a new date/time. The changes are viewable in the Security Change Log in System Administration.

10. In the **Report Sent Date**, **Report Received Date**, and **Report Expected Date** fields, enter the date using the calendar icon or by manually typing the date in MMDDYY or MMDDYYYY format.

11. If needed, enter additional information in the **Additional Information** field. this field accepts 80 characters.

12. At the bottom of the screen a message is displayed as a reminder. The Physician Problem List, the Medication List, and the Medication Allergy List must be addressed for this patient in order to be included in the statistics for the Transition of Care Promoting Interoperability objective.

13. Click **Save** to save changes. Click the blue back arrows to return to the Health History Review screen where your newly created referral/transition of care is displayed.

NOTE: *Referral/Transition of Care documentation is displayed in the Patient Summary in the* ***Referral/Transition of Care*** *section.*

To Print a Referral/Transition of Care

1. Go to the Health History Review screen and select **List View** format.

2. Double-click the item to display the Referral/Transition of Care Edit screen (or highlight the desired family health entry and select **Edit**). The **Referral/Transition of Care** is displayed.

3. Select **Print**. A PDF of the Referral is displayed. Select the printer icon and make the appropriate printer selections. Then select **Print**.

To Edit a Referral/Transition of Care

1. Go to the Health History Review screen and select **List View** format.
2. Double-click the item to display the Referral/Transition of Care Edit screen (or highlight the desired family health entry and select **Edit**). The **Referral/Transition of Care** is displayed.
3. Make the desired edits.
4. Select **Save** to save changes.

To Delete a Referral/Transition of Care

1. Go to the Health History Review screen and select **List View** format.
2. Double-click the item to display the Referral/Transition of Care Edit screen (or highlight the desired family health entry and select **Edit**). The **Referral/Transition of Care** is displayed.
3. Select **Delete**. A confirmation message is displayed. Click **Yes** to confirm the deletion.
4. Select **Save** upon completion.

To Generate Patient Medical Summaries

1. Go to the Health History Review screen and select **List View** format.
2. Double-click the item to display the Referral/Transition of Care Edit screen (or highlight the desired family health entry and select **Edit**). The **Referral/Transition of Care** is displayed.
3. Select **Patient Medical Summaries**. The Patient Medical Summaries options are displayed: **Discharge Summary**, **Patient Summary**, and **Referral Note**.
4. Double-click the desired document to generate (or single click and select **View**). The Patient Summary is displayed. From the display, you can submit to the provider, submit to HIE, copy to portable media, print, view XML, view the CDA viewer, and edit exclusions. See the Patient Medical Summaries (CCDA) User Guide for additional information.
5. Click the blue back arrow to return to the Referral/Transition of Care screen.

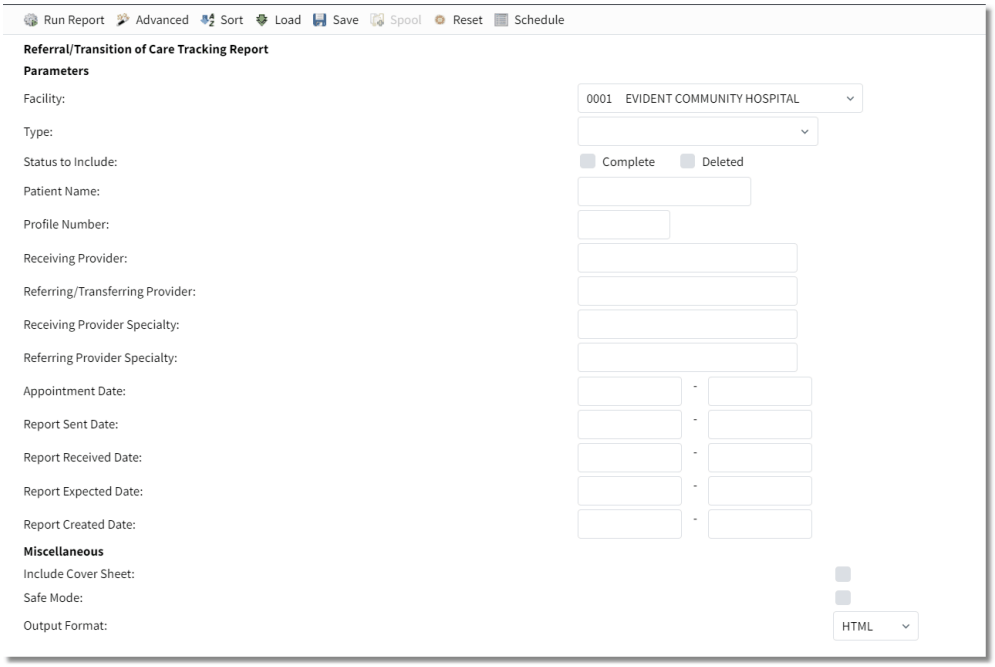
Additional Information

The Referral/Transition of Care screen can also be accessed from the following locations:

- **Communication:** Select **Patient Account > Communication > Referral/Transition of Care**.
- **Health Information Resource:** Select **Patient Account > Health Information Resource > Referral/Transition of Care**.
- **Whiteboard:** Go to **Whiteboard > Patient**. The Referral/Transition of Care may be added to any of the available tabs on the virtual chart. See the *Virtual Chart Setup* section of the POC Setup User Guide for additional information on adding the Referral/Transition of Care to the tabs.

10.2 Referral/Transition of Care Tracking Report

The **Referral/Transition of Care Tracking Report** is used to track outstanding referrals. To access, go to Report Dashboard and select **Referral/Transition of Care Tracking Report**.



Referral Transition of Care Tracking Report

1. Select options in the following fields to customize the data that appears on the report:

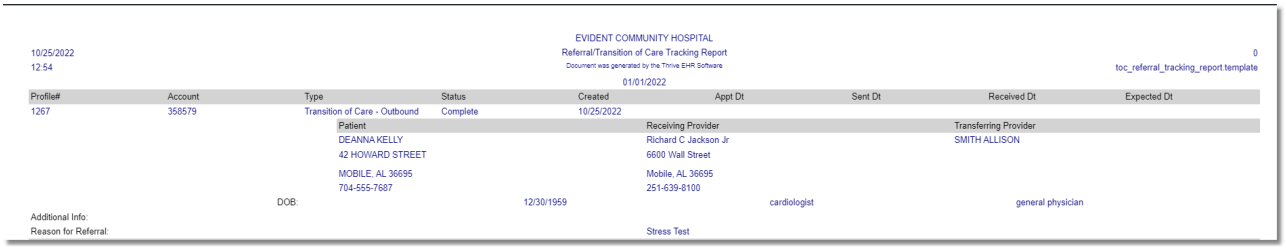
   - **Facility:** This drop-down allows the user to select a facility.
   - **Type:** Allows the user to choose a type of referral: **Referral - Outbound**, **Referral - Inbound**, **Transition of Care - Outbound**, **Transition of Care - Inbound**, or **Self Referral**. When **Outbound** is selected, the **Provider** field is changed to **Referring/Transferring Provider** and a **Transferring/Referring Provider** section is created that will display the physician's information.
   - **Status to Include:** Allows for **Complete** or **Deleted** choice.
   - **Patient Name:** Allows for entry of patient name.
   - **Profile Number:** Allows for entry of a specific profile number.

- **Receiving Provider:** Allows for entry of a specific provider.
- **Referring/Transferring Provider:** Allows for entry of referring/transferring provider.
- **Receiving Provider Specialty:** Allows for entry of receiving provider specialty.
- **Referring Provider Specialty:** Allows for entry of referring provider specialty.
- **Appointment date:** Allows for entry of appointment date range that falls between and includes dates selected.
- **Report Sent Date:** Allows for entry of report sent date range.
- **Report Received Date:** Allows for entry of report received date range.
- **Report Expected Date:** Allows for entry of report expected date range.
- **Report Created Date:** Allows for entry of report created date range.
- **Include Cover Sheet:** Allows user to include a cover sheet.
- **Safe Mode:** Allows user to run the report in Safe Mode.

2. Select a document type from the **Output Format** drop-down menu.

3. Select **Run Report**. See sample report below.

Sample Referral/Transition of Care Tracking Report



EVIDENT COMMUNITY HOSPITAL

10/25/2022 — Referral/Transition of Care Tracking Report — 0

12:54 — Document was generated by the Thrive EHR Software — toc_referral_tracking_report.template

01/01/2022

Profile#	Account	Type	Status	Created	Appt Dt	Sent Dt	Received Dt	Expected Dt
1267	358579	Transition of Care - Outbound	Complete	10/25/2022				

Patient	Receiving Provider	Transferring Provider
DEANNA KELLY	Richard C Jackson Jr	SMITH ALLISON
42 HOWARD STREET	6600 Wall Street	
MOBILE, AL 36695	Mobile, AL 36695	
704-555-7687	251-639-8100	
DOB: 12/30/1959	cardiologist	general physician

Additional Info:

Reason for Referral: Stress Test

Referral/Transition of Care Tracking Report

The following information is displayed on the report:

- **Profile Number:** This area displays the patient's profile number.
- **Account Number:** This area displays the account number.
- **Type:** This area displays the type of transition/referral.
- **Status:** This area displays the status: Incomplete, Complete, or Deleted. Incomplete is the default.
- **Created:** This area displays date created.
- **Appt Dt:** This area displays the appointment date.
- **Sent Dt:** This area displays the date sent.
- **Received Dt:** This area displays the date received.
- **Expected Dt:** This area displays the expected date.
- **Patient:** This area displays patient name.
- **Receiving Provider:** This area displays the receiving provider as well as their address and phone number.
- **Referring Provider:** This area displays the referring provider as well as their address and phone number.
- **DOB:** This area displays the patient's date of birth.
- **Additional Info:** This area displays any documented additional information.
- **Reason for Referral:** This area displays an explanation for the referral.

NOTE: *Facilities outside of the United States utilize a different address format. If a foreign address format is used, the province/territory and postal code appear on the* ***Referral/Transition of Care*** *report. A TruBridge representative will need to be contacted for the foreign address fields to be activated.*

Chapter 11 Implantable Devices

11.1 Implantable Devices

Implantable Devices history allows any Unique Device Identifiers (UDI) to be documented within a patient's electronic health record. The information may be entered at the time of implementation by scanning the UDI barcode or manually keying the UDI number. Once entered, the system will query the database and automatically load all the available information about the UDI. The information may also be entered from a previous implantation. An audit log is available for all records and any subsequent changes to those records.

To view Implantable Device History, go to **Patient Chart > Health History** and see the entries under the **Implantable Devices** heading. *(**TIP:** Choose **List View** if you want to edit items in the list.)*

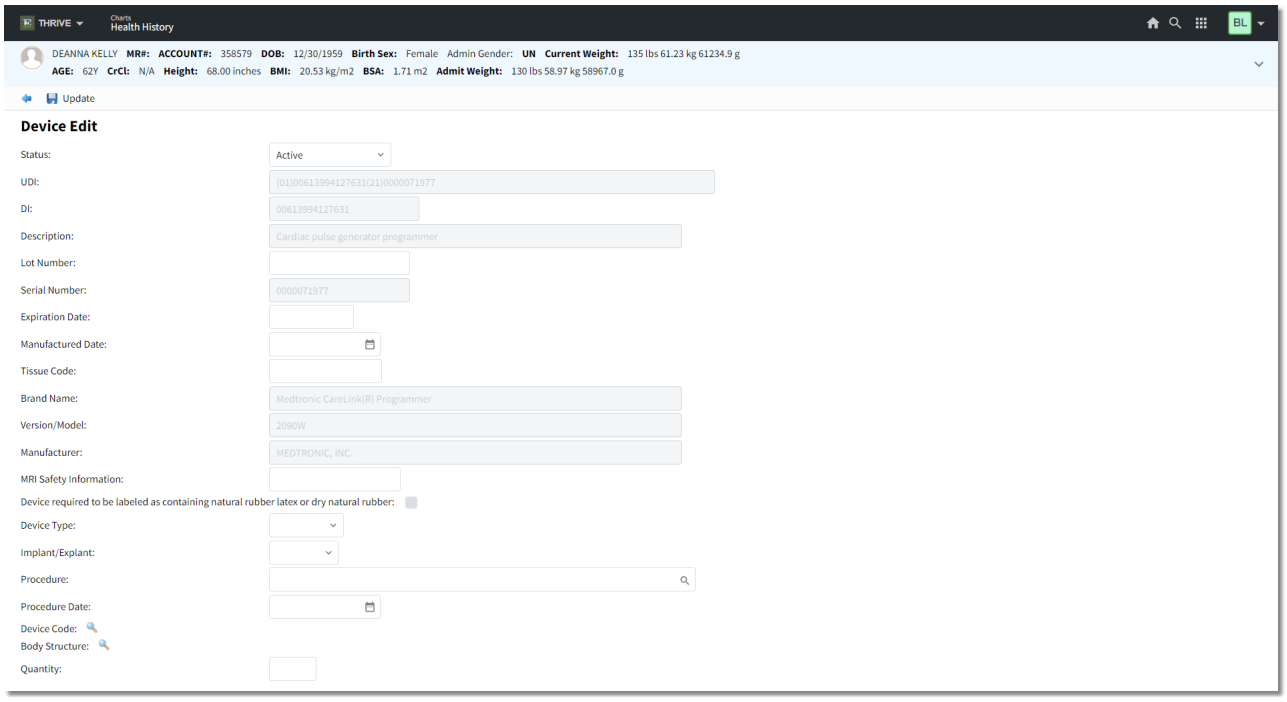
This section covers the following topics:

[To Add an Implantable Device]
[To Edit an Implantable Device]

To Add an Implantable Device

1. Go to **Health History > New**. The Health History Categories page is displayed.

2. Double-click **Implantable Devices** from the list of Health History categories. The Device Edit screen is displayed.



Device Edit

2. In the **UDI** field, any GSI, HIBCC, and ICCBBA issuing device bar code may be scanned. Scan the bar code and press **<Tab>**, or enter the UDI and press **<Tab>**. Pressing **<Tab>** initiates the query to the database. Any fields populated by the database query will no longer be editable. If the UDI is not found, the system will populate the fields that are provided by the bar code. If there is no response from the query, the system will prompt, "No Connection to the GUDID database. Please contact Support." If the search returns no results based on the UDI query, the system will prompt, "No matching devices found."

3. Complete the following fields, if not populated:

   - **Status:** When a new UDI is entered, it will default to **Active**. The drop-down allows a previously entered UDI to be edited to **Inactive** or **Entered in Error**. They may be filtered from the Health History Review by **Active**, **Inactive/Removed**, or **All**.
   - **UDI:** The FDA is establishing and requiring a unique device identification system to adequately identify medical devices through their distribution and use. The label of most devices will include a unique device identifier (UDI) in human and machine readable form. The UDI must contain the Device Identifier (DI) and Product Identifiers (PI). Device labelers must submit certain information about each device to FDA's Global Unique Device Identification Database (GUDID). Once a UDI is entered, TruBridge will query the GUDID and the attached information will automatically populate. These fields will not be accessible for editing once populated.
   - **DI:** The Device Identifier is a number specific to the version or model of the device. This is the primary lookup for a device type.
   - **Description:** The description is a Global Medical Device Nomenclature (GMDN), which is a generic name used to identify medical device products. This description is used to exchange medical device information and support patient safety.
   - **Lot Number:** The lot or batch number within which a device was manufactured.
   - **Serial Number:** The serial number of a specific device.
   - **Expiration Date:** The expiration date of a specific device.
   - **Manufactured Date:** The date the specific device was manufactured.
   - **Tissue Code:** The distinct identification code indicates the product contains or consists of human cells or tissues (HCT/P's) that are intended for implantation, transplantation, infusion, or transfer into a human recipient and the Donation Identification Number. This will on be available on HCT/P implants.
   - **Brand Name:** The proprietary, trade, or brand name of the medical device as used in device labeling or in the catalog.
   - **Version/Model:** The version or model found of the device label or accompanying packaging used to identify a category or design of a device.
   - **Manufacturer:** The manufacturer name of the specific device.
   - **MRI Safety Information:** Indicates the MRI Safety Information, which include MR Safe, MR Unsafe, or MR Conditional.
   - **Device required to be labeled as containing natural rubber latex or dry natural rubber:** The selected check box will indicate a caution that the device or packaging contains rubber or latex that may cause allergic reaction.
   - **Device Type:** The field defaults to **Implant**, but a drop-down is available to define **Implant**, **Graft**, or **Hardware**. This field is not automatically populated.

- **Implant/Explant:** The field defaults to **Implant**, but a drop-down is available to define if the device is being implanted (**Implant**) or removed (**Explant**). This field is not automatically populated.
- **Procedure:** The magnifying glass is available to access the Surgical/Procedural History Review screen. If the procedure is already documented, the user may select the entry to populate the field. If a new entry is created, it will populate the Surgical/Procedure History and Interventions. This field is not automatically populated.
- **Procedure Date:** The procedure date will auto populate if entered in Surgical/Procedure History and Interventions during documentation or may be manually entered.
- **Device Code:** The magnifying glass is available to search a listing of Device Codes with SNOMED Codes. The search may be done by SNOMED Code or Description. This field is not automatically populated.
- **Body Structure:** The magnifying glass is available to search a listing of Body Structures. The search may be done by SNOMED Code or Description. This field is not automatically populated.
- **Quantity:** This field may be used to document if multiple devices are implanted. This field is not automatically populated.

4. Click **Update** to save.

5. Click the blue back arrow to return to **Health History Review** in either **Narrative View** or **List View**. The **Implantable Device** displays with the device description, Status, UDI, DI, manufacturer information, procedure information, and other pertinent information in the **List View**.

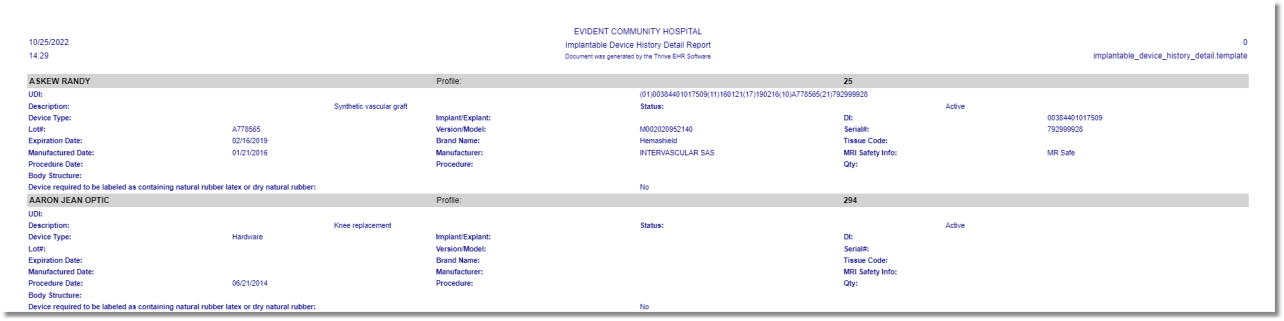
To Edit an Implantable Device

To edit a Family Health History item, go to the Health History Review screen and select **List View** format. Double-click the item to display the Device Edit screen (or, highlight the desired implant and select **Edit**). Make edits as needed. Click **Update** to save the changes.

11.2 Implantable Device History Detail Report

Within the Report Dashboard, the Implantable Device History Report may be accessed. This report may be filtered by profile number, expiration date, manufacture date, procedure date, serial number, lot number, and version/model number. All fields from the Implantable Device area of the Health History application will display in the report.

Go to **Application Drawer > Report Dashboard > Implantable Device History Detail Report**. A sample report is shown below.



EVIDENT COMMUNITY HOSPITAL

10/25/2022 — Implantable Device History Detail Report — 0

14:29 — Document was generated by the Thrive EHR Software — implantable_device_history_detail.template

ASKEW RANDY		Profile:		**25**		
UDI:			(01)00384401017509(11)160121(17)190216(10)A778565(21)792999928			
Description:	Synthetic vascular graft		**Status:**		Active	
Device Type:		**Implant/Explant:**		**DI:**		00384401017509
Lot#:	A778565	**Version/Model:**	M002020952140	**Serial#:**		792999928
Expiration Date:	02/16/2019	**Brand Name:**	Hemashield	**Tissue Code:**		
Manufactured Date:	01/21/2016	**Manufacturer:**	INTERVASCULAR SAS	**MRI Safety Info:**		MR Safe
Procedure Date:		**Procedure:**		**Qty:**		
Body Structure:						
Device required to be labeled as containing natural rubber latex or dry natural rubber:			No			
AARON JEAN OPTIC		Profile:		**294**		
UDI:						
Description:	Knee replacement		**Status:**		Active	
Device Type:	Hardware	**Implant/Explant:**		**DI:**		
Lot#:		**Version/Model:**		**Serial#:**		
Expiration Date:		**Brand Name:**		**Tissue Code:**		
Manufactured Date:		**Manufacturer:**		**MRI Safety Info:**		
Procedure Date:	06/21/2014	**Procedure:**		**Qty:**		
Body Structure:						
Device required to be labeled as containing natural rubber latex or dry natural rubber:			No			

Implantable Device History Detail Report

Chapter 12 Address History

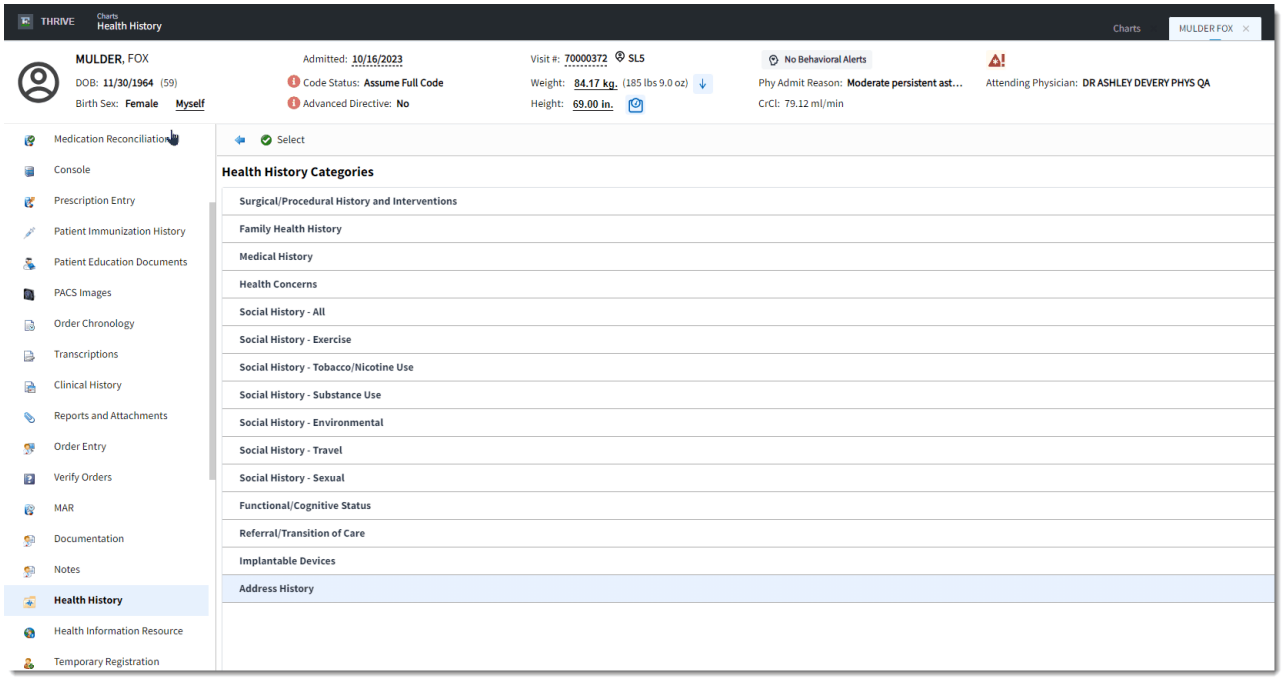
This option in Health History allows users to add any current or previous address information. To view the patient's adress history, go to **Patient Chart > Health History** and see the entries under the **Address History** heading. *(**TIP:** Choose **List View** if you want to edit items in the list.)*

This section covers the following topics:

[To Add a New Address](#)
[To Edit an Address](#)
[To Delete an Address](#)

To Add a New Address

1. To add a new address, go to **Health History > New**. The Health History Categories page is displayed.



Address History

2. Double-click **Address History** from the list of Health History categories. The **Past Patient Address** screen is displayed.

3. Click the edit icon located next to the Address field to enter a new address. The Address Edit screen is displayed.

4. Enter the Address, City, State and Zip Code information.

5. Click **Update** to save. The Past Patient Address screen is displayed.

6. Enter the **Start Date** and **End Date** for how long the patient lived/resided at the address. These fields will accept dates in MMYY and MMDDYY format.

To Edit an Address

1. Go to the Health History Review screen and select **List View** format.
2. Double-click the item to display the Past Patient Address screen (or highlight the desired family health entry and select **Edit**).
3. Make edits as needed.
4. Select **Update** to save changes.

To Delete an Address

1. Go to the Health History Review screen and select **List View** format.
2. Double-click the item to display the Past Patient Address screen (or, highlight the desired family health entry and select **Edit**).
3. Select **Delete**. A confirmation message is displayed. Select **Yes** to continue.

Chapter 13 Disability - WA STATE ONLY

The **Disability** section of the Health History application will allow the documentation of the patient's disability information. ***NOTE:*** *This section of the Health History application is used only by facilities located within the state of Washington.*

1. Enter information in the following sections.

   - **Daily Living:** The initial question, **Daily Living**, may be answered by selecting **Not Answered**, **No Limitation**, **Patient Declined to Respond**, or **Unknown**. Within the Daily Living section, the questions may be answered by selecting **Not Answered**, **Yes** or **No**. These are in a radio button format allowing one selection per question. If **Other, not listed above** is selected, the Daily Living question will become disabled.

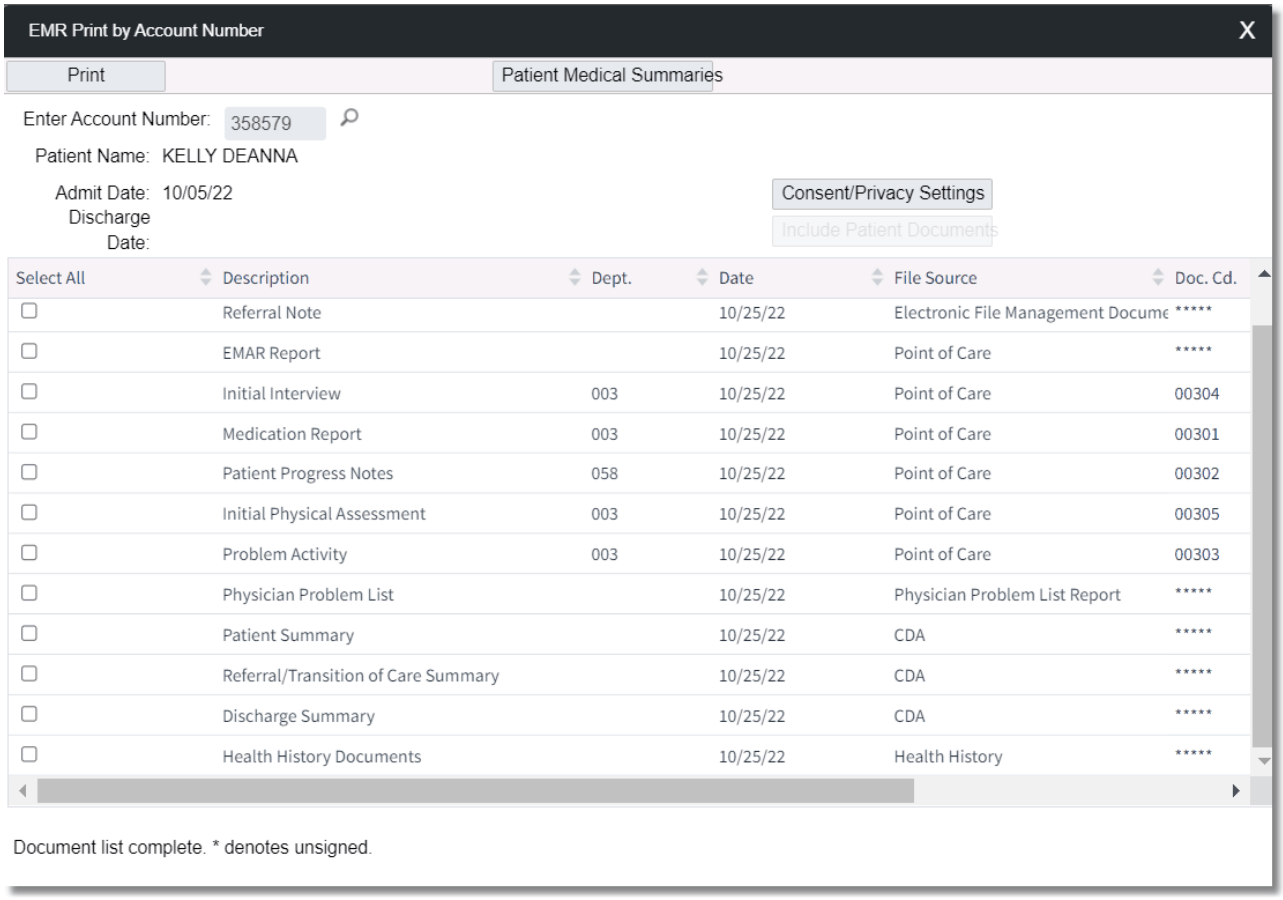
   - **Condition:** The initial question, **Condition**, may be answered by selecting **Not Answered**, **No Limitation**, **Patient Declined to Respond**, or **Unknown**. The options may be multi-selected by selecting any needed conditions. If **Other, not listed above** is selected, the Daily Living question will become disabled.

2. Select **Save**. This saves any changes made and returns the user to the Health History category selection screen.

Chapter 14 Health History Report

A report for Health History can be printed from **Print EMR**. **Print EMR** can be added to a **Virtual Chart** tab. This can also be accessed from Medical Records.

Go to the **Application Drawer > System Menu > POC Access > Select Patient > Virtual Chart > Print EMR**.



Health History Report from Print EMR