This demonstration reviews documentation of most everything you can enter on the Histories Tab in NextGen.

This has been prepared for EHR 5.8 & KBM 8.3. Subsequent updates may display cosmetic & functional changes.

Use the keyboard or mouse to pause, review, & resume as necessary.
The **Histories tab** is where most all past medical, social, & family history is entered. There are several sections on this tab, which you can navigate through in several ways using the collapsible panels.

We’ll start with the **Problem List**. To add a problem, click **Add**.
The Problems Module opens, focused on the Problem List Tab.

This is sometimes called the Diagnosis Module because of the Dx Icon that will open it from the tic-tac-toe board.

To add a new problem, logically enough, click Add Problem.
The diagnosis search popup appears. Let's find glaucoma. Click in the **search field**, type **glauc**, then click **Search**.
A list of results appears. Notice you didn’t even have to type a complete word—though the more you type, the shorter your results list will be, & the quicker it will appear. We’ll select **Open-angle glaucoma** by double-clicking on it.
The diagnosis appears on the **Active** problem list.

There are a lot of details that can be added below, some of which you may use, & some of which you may ignore.
First look at **Onset Date**. Today’s date is entered by default, but unless this is truly the first day this diagnosis is being made (usually *not* the case), you’ll want to change this. If you know a date of onset, you can click the dropdown arrow to add one; you may need to approximate. But if you don’t know the onset date or it is immaterial, just click the checkbox to clear it.
The very nature of a “Problem List” would seem to imply “chronic,” but NextGen provides the option of distinguishing “chronic” from “not chronic”—though I’m not sure I’d go to the trouble to add something here that is not chronic.

Anyway, to indicate the diagnosis is chronic, click Set Chronic or the Chronic checkbox.
Notice that you can click the **Resolve button** or **Problem Status dropdown arrow** to **resolve** a problem, & indicate a **Resolved Reason**. We don’t want to do that for this exercise, so we’ll leave it **Active**.
When germane, you can specify **Side & Site**. You can also add further details. Click **View/Add Notes**.
Next click **Add Note**.

Type your entry, then click **OK**.
Your entry displays. Note that you can update or delete a note.

When done, click Close.
When you’ve addressed all the details you need to enter, click **Accept**. You can then add other diagnoses; I’ll go ahead & add diabetes & hypertension.

When done, click the X to close the **Problems Module**.
Your entries display in the grid.

When support staff and/or providers have reviewed the Problem List, click the Reviewed checkbox. Note that the Problem List is the only section that has its own Reviewed checkbox.

Note that you can update an entry by selecting it then clicking the Edit button.
Before we go any further, let’s talk about **History Review** for all the other sections. You’ll see a link at the top & at each section (Past Medical, Family, & Social History) for this.

It brings up this popup.
It is our expectation that all historical elements are at least briefly reviewed at every encounter, so most of these details appear in our notes by default anyway. However, only basic Social History details are defaulted into our notes, so if you’ve added a lot of other details, you need to specifically select **Detailed document** for Social History.
Now let’s move down to **Medical/Surgical/Interim History**. This section is for episodic events, usually surgeries or bouts of medical problems that limited in time frame. Click **Add**.
This popup has a **Medical** section, **Surgical** section, & a grid at the bottom. The **Surgical** section is shown expanded here.

The patient has had an appendectomy & a cholecystectomy, so we’ll select those checkboxes.
You can enter date & can click Manage to enter other details as desired.

Items that are blue lead to other picklists. Click Arthroscopy.
We’ll pick **Knee**, & in the rest of the popup indicate that it was the left in **2002**.
To enter something you don't see here, click **Other**.
Here, through a combination of searching & typing, I’ve recorded that she had some actinic keratoses frozen from her face in 2011.

When done click Save to Grid & Close.
Let's add some medical history. Click the Medical **Toggle Button**.
Last year the patient had hepatitis A. Click Hepatitis/liver disease.
The next popup presents a list of hepatic illnesses. Double-click **Hepatitis A**.
Enter other details to the extent you know them & they are pertinent.

When done click **Save to Grid & Close**.
If you need to add something that’s not on the list, click **Other**.
The patient had meningitis at age 5. To search for this, click the Dropdown Arrow.
Type meningitis then click Search.
We don’t really know many details, so just double-click **Meningitis**.
Again, we'll add details as desired, then click **Save to Grid & Close**.
Note everything we’ve entered has been added to the grid.

When done click **Save & Close**. (We’ve also added a copy of this button at the top to make navigation easier.)
Everything we just entered appears on the History Tab. Click Interim History.

You can use the Interim History button to make other entries, if you feel so moved.
We've entered that she's recently seen her eye doctor for a check on her glaucoma. When done, click **Save** then **Close**.
Notice that you can click on most column headers to sort top to bottom or bottom to top on that header, which can help when viewing a long list of entries.
In the next section, **Diagnostic Studies**, you can manually enter a variety of test results. This would probably be most appropriate when a patient brings in a test result from another facility. Here, we can get most of our study results electronically through Soarian, so you probably won’t need to do this very often. I’ll skip on down.
Next is the Family History section. Click the Add button.

Notice how you can collapse panels as desired; this is often faster than using the scrollbar to move down the template.
First click in the **Relationship** box & choose a relative; you can type in a designation if you don’t see what you need on the list. Here we’ll pick father.
Note that some entries are simple black checkboxes. For these, it is easy to select several at once. Here I’ve entered that her father had **Coronary artery disease & Hypertension**.

Click **Save to Grid**.
Other entries appear as blue links, which allow you to specify further information. Her father also had lung cancer, so I’ve again selected Father, & I’ll click Cancer.
Click in the **Condition** box & you’ll get another popup that allows you to specify what kind of cancer. Select **Lung**.
We’ll also add that it was the **Cause of death**, at age **65**.

When done, click **Save to Grid & Close**.
You can also indicate a negative family history by checking No family history of. (You can choose a specific relative if desired, or not.)

Here I’ll select Alcoholism, then click Save to Grid.
We’ll also indicate there is No family history of Diabetes mellitus. (Since Diabetes is a blue link, we have the additional popups to address—helpful in that we can be more precise, but also a tad frustrating in that it requires a couple extra clicks.)
I've gone ahead & added some other Family History. When done, click **Save & Close**.
Your entries display on the Histories Tab, & we can continue down to the Social History section.

In this example we’ll demonstrate the entry of adult social history. (At the end of the lesson, we’ll look at some aspects that differ for pediatric social history.)

Click Add.
The Social History popup opens. Note the left-side navigation that allows you to move among several aspects of social history. It begins at the top with Tobacco.

Note also that some of the popups have a good bit of vertical navigation, which can be easy to overlook.
One thing that may be a little counterintuitive is that there is both a Smoking Status & Tobacco Status. This is because, while you would like to document all forms of tobacco abuse, Meaningful Use rules specifically reference smoking. These two status interact, but there may be some times when you will need to manually intervene to make sure both statuses are properly documented.
If smoking/tobacco history has been previously entered, & nothing has changed, just click the Reviewed checkbox, then Save & Close the popup.
But when you need to enter this history, first address the **Have you ever used tobacco** question. If the answer is **No/never**, you’re done. In this example, the answer is **Yes**.
Now complete details to the extent they are known. Click the Cigarette checkbox.

Then click the Use daily checkbox.
Our patient smokes 1 pack per day. Click in the **Usage box** & enter **1** in the ensuing popup.

Then click in the **per day box** & select **Packs** in the next popup.
Enter other details if you know them. Click in the **Years used** box & enter 35 in the ensuing popup.
Notice that both Smoking & Tobacco Status have been updated (though you can manually enter them using the dropdown arrows if that's ever necessary).

35 Pack Years will be calculated.

Then scroll down to review Tobacco Cessation data.
You can document all sorts of details about efforts to quit smoking. With a brief amount of practice you’ll figure that out, so I’m not going into that at the moment.

But look at the **Tobacco cessation discussed checkbox**.
Your clinic may have a policy that nurses rooming patients always advise tobacco users to quit. If so, the nurse can click the **Tobacco cessation discussed checkbox**.

A sample dialog might go as follows: “Do you still smoke? Of course, we recommend that everyone quit smoking. [Check the **Tobacco cessation discussed checkbox**.] Would you like to talk to the doctor today about help quitting?” If the answer is YES, add **Smoking Cessation** to today’s **Reasons For Visit**.
In the ensuing popup, click the Tobacco cessation discussion dropdown arrow.

Choose from the picklist; here we'll select Smoking cessation education.
Click **Add**, then **Save & Close**.
While we’re here, note that passive smoke exposure can be documented.

But enough of this. If we were done, we could just click Save & Close. But let’s scroll back to the top & move to the Alcohol/Caffeine heading.
Enter detail to the degree it is known & pertinent. There are several popups that offer to help you with this, but often it is easiest just to type in a brief entry like this.

Typically one would enter at least tobacco & alcohol history. But let’s review the other offerings. Move to the **Statuses** heading.
Enter details to the degree they’re known or pertinent. Some demographic info may already display. In particular, note that we need to record language, since it is one of the Meaningful Use criteria. Occupation is a bit redundant, since there is a separate section for that.

Note the Pediatric/adolescent Social History link. This gives you the chance to toggle to & from the pediatric version of the social history—particularly useful for adolescents. It’s a little odd that the Statuses heading is the only place you see it.

Now move to Lifestyle.
As before, enter as much detail as desired, then move to Occupation.
Enter occupational data as desired, then move to **Comments**.
While you've got all these headings, it's nice to have a spot to be able to free-type other social history notes.

Diet History gives you a tedious way to record meals that seems impractical, unless that is the entire focus of the visit, so instead let's move to Environmental.
Enter data to your heart’s content. When done, save everything & close this popup to return to the Histories Tab.
Your entries display on the Histories Tab. You can few data by selecting headings on the left. (Note that only a subset of the data displays here, since it would be impossible to display everything in this limited space. If you need to review or edit other details, click the Add button again.)

Now click the Confidential History button.
Here you have the opportunity to document other aspects of the social history that are not included on the previous popups.
Now perhaps you’re thinking “Isn’t all medical information confidential?” Yes, of course, & many of the issues listed here are things we would commonly ask. A better way to think of this popup is information that is not subject to subpoena. Unless you click the Include all... checkbox, this info won’t be included in your visit note. This is done so you could theoretically generate notes that could be turned over to the court without further review.

At USA any requested records are reviewed & redacted as appropriate; since information here is often necessary for thorough documentation of a visit, feel free to include this in your visit notes as appropriate.
Note that information you’ve entered via Confidential History doesn’t display on the Histories Tab; you’ll have to click the Confidential History button again to see it.

But now let’s go back to the top of the template & talk about a couple other things.
We just recorded a history of smoking, so we’ll add Tobacco Abuse to the Problem List, as previously demonstrated.
We can also record her pregnancy history & other gynecologic information by clicking **OBGYN Details** on the **Information Bar**.
You can enter several details directly. To enter pregnancy history, click the Details button.
Enter data in the white boxes, & the program will summarize it in the gray boxes.

If desired you can double-click on the grid & enter details about each pregnancy.

When done click **Save & Close**.
Enter any other details as desired. When done click **Save & Close**.
Finally, notice the **Risk Indicators**, which appear at the top of most templates to alert you to high-risk conditions. The Tobacco risk indicator has already changed to red because of the tobacco history we entered earlier.

Sometimes, when the wind is right & Jupiter aligns with Mars, some of the other Risk Indicators will convert as you enter the corresponding history. But many times you’ll need to click the configure icon to manually set this.
While tobacco has been taken care of, we need to click the bullets for Hypertension Yes, Diabetes Yes, & Coronary Artery Disease No. When done click Save & Close.
All Risk Indicators are now configured.
Now, as promised, let's briefly look at **Pediatric Social History** to see how it differs. Click **Add**.

![Image showing a medical chart with the text highlighted]
The popup initially opens on Relationships. Enter details as desired, then click **Home Environment**.
Once again record your entries, then move to Education.
Note there are a few items here beyond “education.” When done, go to Nutrition/Elimination.
Say what you have to say, then go to Comments.
Note that you have access to **Tobacco & Adult Social History**, which is particularly useful for adolescents.

When done click **Save & Close**.
This concludes the NextGen Past Medical, Social, & Family History Documentation demonstration.

A conclusion is the place where you got tired of thinking.

R. Lamar Duffy, M.D.
Associate Professor
University of South Alabama
College of Medicine
Department of Family Medicine