

NEXTGEN GYN ROUTINE ANNUAL VISIT DEMONSTRATION

This demonstration reviews a typical routine GYN "well woman" visit. Details of the workflow will likely vary somewhat, depending on practice policy & clinic layout, though this should give you a good idea of NextGen functionality.

This has been prepared for EHR 5.8 & KBM 8.3, though some screen shots of older versions may appear if they don't compromise the presentation. Subsequent updates may display cosmetic & functional changes.

Use the keyboard or mouse to pause, review, & resume as necessary.

Work Flow [Duffy, Robert L]

Appointments 02/20/2013 Duffy

Time	Room	Patient/Subject	Reason	Status
09:00 AM		Flinstone, Wilma/Follow U...		Attended
10:45 AM		RUBBLE, BARNEY/Follow U...		KEPT
11:15 AM		FLINSTONE, FRED/Follow ...		BOOKED

Tasks All Tasks Refills Test Results Questions

Due Date	Patient/Subject	Description
01/23/2013	Quagmire, Charlene/F...	Unable to find insurance inf...
01/23/2013	Quagmire, Charlene/L...	Unable to find insurance inf...
10/24/2012	TEST, DEBBIE/notified ...	Testing Advanced audit ...
10/19/2012	TEST, DEBBIE	ORT SHOULDER COMPLETE
08/22/2012	Horton, PedsAsthma003	
08/10/2012	Test, Mickey	
06/28/2012	BarnesB, Example002	
06/28/2012	Osborn, Example002	
06/28/2012	DuffyR, Examp1-0017...	Communication
06/28/2012	BowenC, Example002	
06/28/2012	HepburnM, Example002	
06/28/2012	ColierK, Example002	
06/28/2012	BowenC, Example001...	Just bothering you.
06/27/2012	HortonT, IMEX001	
06/27/2012	MilteerH, IMEx001	
06/26/2012	BarnesC, Example001	

Patient Portal

Communications

- Inbox
- Outbox

Prescriptions

- Outbox

Appointments

- Outbox

Archived

Online Forms

- Inbox

From Subject Received

Offline

Compose Remove + To Do + To Chart Chart

The nurse begins by double-clicking on the patient from her provider's appointment list.

Our patient is in for a routine GYN exam. She's an established patient, but this is the 1st time she's been seen using NextGen, so we'll be entering some known medical history as we go.

Always begin by performing the 4-Point check.

Patient

Location

Provider

Date

NextGen EMR: Felonie Quagmire MRN: 000000007773 DOB: 01/06/1988 (Female) Age: 26 years 2 months - 03/19/2014 09:34 AM: "*USA Intake"

File Edit Default View Tools Admin Utilities Window Help

Logout Clear Deletes USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAR Medications Templates Documents Images Orders Problems Apps Close

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)

Address: 911 Run Dog Run Mobile, AL 36604 MRN: 000000007773 Emergency Relation: PCP: DELP, MEREDITH R DO
Contact: (251) 555-9876 (Home) Insurance: AMERICAN GENERAL Emergency Phone: Referring:
NextMD: No Pharmacy 1: Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM: "*USA Intake"

Specialty ▼ select a specialty Visit Type ▼ select a visit type

Care Guidelines Global Days Panel Control: Toggle Cycle

General
 Established patient New patient | Historical

Vital Signs
Health Promotion Plan | History | Graph

Time	Wt lbs	Ht in	BMI	Wt kg	Ht cm	BP	Pulse	Resp	TempF	TempC	O-sat	Pain level	Comments
------	--------	-------	-----	-------	-------	----	-------	------	-------	-------	-------	------------	----------

Patient History
Patie... Patie... Cate...
New Lock Search
03/19/2014 09:34 AM DUFFY, R

When you first open the chart to the Intake Tab, you'll note some red text demanding attention:
Specialty Select a specialty & Visit type Select a visit type.

Click **select a specialty** & make a selection from the picklist; here we'll pick **Gynecology**.

Then click **select a visit type** & pick from the list; select **Office Visit-GYN** for this example.

The screenshot displays a medical software interface for a patient named Felonie Quagmire (F), DOB: 01/06/1988 (26 years). The patient's address is 911 Run Dog Run, Mobile, AL 36684. The MRN is 000000007773, and the insurance is AMERICAN GENERAL. The patient's specialty is currently set to "select a specialty" and the visit type is "select a visit type".

Two picklist windows are open:

- Ngkbn Get Dbpicklist Items:** A list of medical specialties is shown, with "Gynecology" selected.
- Ngkbn Udp Visit Types:** A list of visit types is shown, with "Office Visit - GYN" selected.

The interface includes a navigation pane on the left, a patient history section on the right, and a status bar at the bottom with the text "NGDev | USA Health Services Foundation | rlduffy | CAP | NUM | SCRL | 03/19/2014".

Note whether the patient is listed as **New** or **Established**, since this sometimes needs to be changed. A patient seen elsewhere in the USA system might initially appear as **Established**, but if it's the first time he's been to your office, that would need to be changed to **New**. Conversely, if you've seen the patient before you started using the EHR, but today is the first visit in NextGen, you may need to change the encounter from **New** to **Established**, so we'll click **Established** here.

The screenshot displays the patient information section of the NextGen EHR. At the top, patient details include: Address: 512 Rain Dog Rd, Mobile, AL 36604; Contact: (251) 555-9876 (Home); Insurance: AMERICAN GENERAL; NextMD: No; Emergency Phone: ; Pharmacy 1: ; Referring: DUFFY, ROBERT LAMAR... The patient's name is partially visible as '...BERTH...'. Below this, there are tabs for Alerts, OBGYN Details, Patient, Lipid Clinic Data, Order Admin..., Sticky Note, Referring Provider, HIPAA, Advance Directives, and Screening Summary. The main content area shows a visit on 03/19/2014 at 09:34 AM, labeled as 'Intake'. The Specialty is Gynecology and the Visit Type is Office Visit - GYN. A navigation bar includes Intake, Histories, SOAP, Finalize, and Checkout. Below this are links for Standing Orders, Adult Immunizations, Peds Immunizations, My Plan, Procedures, Order Management, and Document Library. There are also links for Care Guidelines and Global Days. In the 'General' section, the 'Established patient' radio button is selected and circled in green, with a green arrow pointing to it from the text above. The 'New patient' radio button is unselected. A 'Historian:' field is also visible.

It's always good to begin by noting whether there are any **Sticky Note** or **Alerts** entries.

NextGen EHR: Felonie Quagmire MRN: 000000007773 DOB: 01/06/1988 (Female) AGE: 26 years 2 months - 03/19/2014 09:34 AM: "*Intake"

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAQ Medications Templates Documents Images Orders Problems Apps

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 911 Run Dog Run Mobile, AL 36604 MRN: 000000007773 Insurance: AMERICAN GENERAL Emergency Relation: PCP: DELP, MEREDITH R DO
Contact: (251) 555-9876 (Home) NextMD: No Emergency Phone: Referring: Rendering: DUFFY, ROBERT LAMAR ...
Pharmacy 1: Referring Provider HIPAA Advance Directives Screening Summary

Alerts **Sticky Note**

03/19/2014 09:34 AM: "*Intake"

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

We can tell by their appearances that there are no **Sticky Notes** or **Alerts**. But for demonstration purposes, we'll enter some. Click **Sticky Note**.

abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion

Like actual sticky notes, these are things that are nice to know, but aren't meant to be permanent chart records. We've entered here that her sister works in the Family Medicine clinic.



The screenshot shows a window titled "Patient Information" with a close button (X) in the top right corner. Below the title bar is a "Comments:" label followed by a text input field containing the text "Family Medicine nurse Broomhilda's sister.". At the bottom right of the window are two buttons: "Save & Close" and "Cancel". A green arrow points from the top-left text box to the "Comments:" label.

Other times a sticky note would be a temporary notice, like **Ask about Tdap next visit. RL Duffy 2/13/14.** It's good to put your name & date on such things; otherwise, you have no idea whether they're still pertinent when you see them in the future. And you should delete such sticky notes when they're no longer meaningful.

When done click **Save & Close.**

When a **Sticky Note** is present, the link will change to a magenta color with a solid diamond.

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 911 Run Dog Run MRN: 000000007773 Emergency Relation:
Mobile, AL 36604 Insurance: **AMERICAN GENERAL** Emergency Phone:
Contact: (251) 555-9876 (Home) NextMD: **No** Pharmacy 1:

PCP: **DELP, MEREDITH R DO**
Referring:
Rendering: **DUFFY, ROBERT LAMAR ...**

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... **Sticky Note** Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM : "*Intake" x

Specialty ▼ Gynecology Visit Type ▼ Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days Panel Control: Toggle Cycle

General

Established patient

Reason for Visit

Do not launch HPI Intake Comments

abnormal pap smear Chief Complaint History of Present Illness
abnormal bleeding

Now click **Alerts**.

The alerts displayed apply to the latest encounter. In order to add new alerts, the most recent encounter should be unlocked.

- Abuse
- Active addiction
- Active Tuberculosis
- Adult protective services alert
- Ambulance transit required
- Bed-ridden
- Deaf
- Discharged from this practice
- Do not use this chart
- Drug seeking
- Hard of hearing, left ear
- Hard of hearing, right ear
- History of alcohol abuse
- History of drug addiction
- History of fainting
- History of fainting with phlebotomy
- Immunizations due
- Interpreter required
- Legally blind
- Medicare Care Management Performance patient
- Mute
- No blood/blood products
- No blood pressure right arm
- No blood pressure left arm
- No information to family
- No medication refills
- No medication refills until seen in office
- No narcotics
- No narcotics until seen in office
- No sexual information sharing except with patient
- Palliative care
- Patient has expired
- Resuscitation status
- Terminally ill
- Wheelchair required
- Work restrictions:
- Other:

Additional comments can be typed as well.

❖ Suicide/Homicide Risk ⓘ

Date	Instrument	Severity	Completed By

Additional comments:

This gives you the opportunity to indicate several noteworthy alerts about the patient. For demonstration purposes we'll click Legally blind.

Alerts: Note: Add

Alert	Note

Remove Save & Close Cancel

Click Save & Close when you're done.

The Alerts button turns red when there is an entry.

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 911 Run Dog Run MRN: 000000007773 Emergency Relation:
Mobile, AL 36604 Insurance: **AMERICAN GENERAL** Emergency Phone:
Contact: (251) 555-9876 (Home) NextMD: **No** Pharmacy 1:

PCP: **DEL P, MEREDITH R DO**
Referring:
Rendering: **DUFFY, ROBERT LAMAR ...**

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... **Sticky Note** Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM : "*Intake" x

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

Intake Histories SOAP Finalize Checkout

When you remove entries the Sticky Note & Alerts return to their baseline appearance, as below.

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Address: 911 Run Dog Run MRN: 000000007773 Emergency Relation:
Mobile, AL 36604 Insurance: **AMERICAN GENERAL** Emergency Phone:
Contact: (251) 555-9876 (Home) NextMD: **No** Pharmacy 1:

PCP: **DEL P, MEREDITH R DO**
Referring:
Rendering: **DUFFY, ROBERT LAMAR ...**

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... **Sticky Note** Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM : "*Intake" x

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

Intake Histories SOAP Finalize Checkout

You can select a **Historian** from the picklist that appears if you click in that box; you can also type in an entry. This is most pertinent if the patient is a child or adult unable to care for himself.

The screenshot displays a medical software interface with a patient information header and a main content area. The header includes fields for Address (911 Run Dog Run, Mobile, AL 36604), MRN (000000007773), Insurance (AMERICAN GENERAL), and Referring Provider (DUFFY, ROBERT LAMAR ...). A picklist titled "Relationship of historian:" is open, showing a list of relationship types such as aunt, brother, daughter, father, and self. A green arrow points from the text in the top box to the "self" option in the picklist. The main content area shows a visit type of "Office Visit - GYN" and a "Historian:" field.

Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)

MRN: 000000007773
Insurance: AMERICAN GENERAL
NextMD: No

Emergency Relation:
Emergency Phone:
Pharmacy 1:

PCP: DELP, MEREDITH R DO
Referring:
Rendering: DUFFY, ROBERT LAMAR ...

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM : "*Intake" X

Relationship of historian:

- aunt
- brother
- daughter
- daughter-in-law
- father
- father-in-law
- foster child
- foster parent
- friend
- granddaughter
- grandfather
- grandmother
- grandson
- mother
- mother-in-law
- neighbor
- nephew
- niece
- self
- significant other
- sister
- son
- son-in-law
- spouse
- step daughter
- step parent
- step son
- uncle

Visit Type Office Visit - GYN

Historian:

Chief Complaint History of Present Illness

Note the PCP.

Address: 911 Run Dog Run Mobile, AL 36604 MRN: 00000007773 Insurance: AMERICAN GENERAL Emergency Relation: Emergency Phone: Pharmacy 1: PCP: DELP, MEREDITH R DO Referring: Rendering: DUFFY, ROBERT LAMAR ...

General

Established patient New patient | History

Reason for Visit

- Do not launch HPI
- abnormal pap smear
- abnormal bleeding
- amenorrhea
- annual exam
- breast mass/lump
- contraception
- genital lesion

If this needs to be changed, click Patient, which opens the Patient_demographics template.

Since Dr. Delp has graduated, we'll change the PCP by clicking in the **PCP** field.

Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Emergency Relation:

Emergency Phone:

Pharmacy 1:

PCP: **DELP, MEREDITH R DO**

Referring:

Rendering: **DUFFY, ROBERT LAMAR ...**

Note Referring Provider HIPAA Advance Directives Screening Summary

Patient Information

First name: Felonie

Middle name:

Last name: Quagmir

Previous last name:

Nickname:

Country of birth:

Race: White

LastName	FirstName	PhysicianName	P
STONE	GEOFFREY	GEOFFREY STONE MD	2
SUBEDI	LOCHAN	LOCHAN SUBEDI MD	2
SULLIVAN	PAULA	PAULA J SULLIVAN DO	2
SUMNER	EMILY	EMILY A SUMNER MD	2
SYED	YUNUS	YUNUS SYED MD	2
TAVERNARIS	MICHAEL	MICHAEL E TAVERNARIS MD	2
TAYLOR	DAVID	DAVID P TAYLOR MD	2
TAYLOR	BRANDON	BRANDON TAYLOR MD	2
THOMPSON	LAURA	LAURA HARRIS THOMPSON MD	2
TRAIRATVORAKUL	PON	PON TRAIRATVORAKUL MD	2
TULLOS	JOHN	JOHN TULLOS MD	2
VALAVALKAR	SUBHA	SUBHA VALAVALKAR MD	2
VARNER	STEPHEN	STEPHEN VARNER MD	2
VASHISHTA	NEHA	NEHA VASHISHTA MD	2
VOELKEL	CHRISTINA	CHRISTINA VOELKEL MD	2
WALKER	ROBERT	ROBERT KENNETH WALKER MD	2
WARNER	BARRY	BARRY A WARNER DO	2
WITTFERSHEIM	DANIEL	DANIEL WITTFERSHEIM MD	2

Refresh

OK

Cancel

Panel Control: Toggle Cycle

Social Security Number

date: 01/06/1988 Sex: F

Language: English

Ethnicity: Not Hispanic or Latino

Status: single

Name:

Religion: Nondenominational

Gender type:

Contact Information

Address History

PCP/Insurance/Pharmacy

PCP: MEREDITH R DELP DO

First visit: Last visit: Next visit:

Referred by:

Insurance: AMERICAN GENERAL

In the picklist that appears, scroll down to the desired choice; you can type the first few letters to jump down to that part of the alphabet. Here we'll double-click on **VARNER**.

Felonie Quagmire (F)

DOB: 01/06/1988 (26 years)

Allergies: **Unknown** Problems: (0)

Diagnoses: (0)

Medications: (0)



Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)

MRN: 000000007773
Insurance: **AMERICAN GENERAL**
NextMD: No

Emergency Relation:
Emergency Phone:
Pharmacy 1:

PCP: **DELPE, MEREDITH R DO**
Referring:
Rendering: **DUFFY, ROBERT LAMAR ...**

Alerts

OBGYN Details

Patient

Lipid Clinic Data

Order Admin...

Sticky Note

Referring Provider

HIPAA

Advance Directives

Screening Summary

03/19/2014 09:34 AM: **Intake*

Patient Demographics

Panel Control: Toggle Cycle

Patient Information

Social Security Number

First name:
Middle name:
Last name: Suffix:
Previous last name:
Nickname:
Country of birth:
Race:

Birth date: Sex:
Preferred language:
Ethnicity:
Marital status:
Spouse name:
Religion:
Blood type:

Save the template (e.g., via **control-S**), then close the Patient_Demographics template. (If you don't save first, it'll remind you.)

First visit: Last visit: Next visit:

Referred by:

Insurance:

The Navigation Bar is normally hidden at the left; it will slide out if you hover over it. But you probably won't need it very often.

NextGen EHR: Felonie Quagmire MRN: 000000007773 DOB: 01/06/1988 (Female) AGE: 26 years 2 months - 03/19/2014 09:34 AM: "*Intake"

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Deletes USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAR Medications Templates Documents Images Orders Problems Apps Close

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: Unknown Problems: (0) Diagnoses: (0) Medications: (0)

Address: 911 Run Dog Run Mobile, AL 36604 MRN: 000000007773 Emergency Relation: PCP: VARNER, STEPHEN MD
Insurance: AMERICAN GENERAL Emergency Phone: Referring:
Contact: (251) 555-9876 (Home) NextMD: No Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

Navigation

Intake
History
SOAP
Finalize
Check Out

Order Management
Orders/Plan
Standing Orders

Anticoagulation
Procedures
Tobacco Cessation
Tuberculin Skin Test
Nutrition

Chart Abstraction
Demographics
Document Library
Immunizations
Patient Comment
Provider Test Action
Vital Signs
Screening Tools
CQM Check
MU Check

Visit Type Office Visit - GYN

TOB HTN DM CAD

Histories SOAP Finalize Checkout

unizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

Panel Control: Toggle Cycle

Patient | Historian:

Patient History

Patie... Patie... Patie...

New Lock Search

03/19/2014 09:34 AM DUFFY, R

*USA Intake
*Intake

Ready NGDevil USA Health Services Foundation rlduffy CAP NUM SCRL 03/19/2014

You can also show or hide the History Bar by clicking the History icon at the top.

You can make the History Bar do the same auto-hide trick if you click on the thumbtack to turn it sideways.

You can collapse the **Information Bar** down to a narrower strip if desired; that is particularly helpful on the small-screened laptops. Click [this button](#).

Established patient New patient Historian:

Reason for Visit

- Do not launch HPI
- abnormal pap smear
 - abnormal bleeding
 - amenorrhea
 - annual exam
 - breast mass/lump
 - contraception
 - genital lesion
 - menopausal symptoms
 - pelvic mass/cyst
 - STD exposure
 - urinary incontinence
 - urinary symptoms
 - pelvic pain
 - vaginal discharge/itching
- Additional / Manage

Chief Complaint History of Present Illness

Vital Signs

Time	Ht (in)	Wt (lb)	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	SpSA	Pain level	Comments

The nurse will probably next enter Vital Signs. It would be more convenient if that section were at the top of this template. So if it's not there already, let's move it there. Click on the [Vital Signs heading bar](#), & drag it up over **Reason for Visit**. (It can be a little touchy to make the drag work right, you'll eventually get it.)

The Info Bar is collapsed, & Vital Signs are at the top.

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Allergies: **Unknown** Problems: (0) Diagnoses: (0) Medications: (0)

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM : "*Intake" x

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

Navigation

Home **Intake** Histories SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

Care Guidelines | Global Days Panel Control: Toggle Cycle

General

Established patient New patient Historian:

Vital Signs

Health Promotion Plan | History | Graph

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
------	---------	---------	-----	----	-------	-------------	----------	---------------	-----	------------	----------

Add Edit Remove

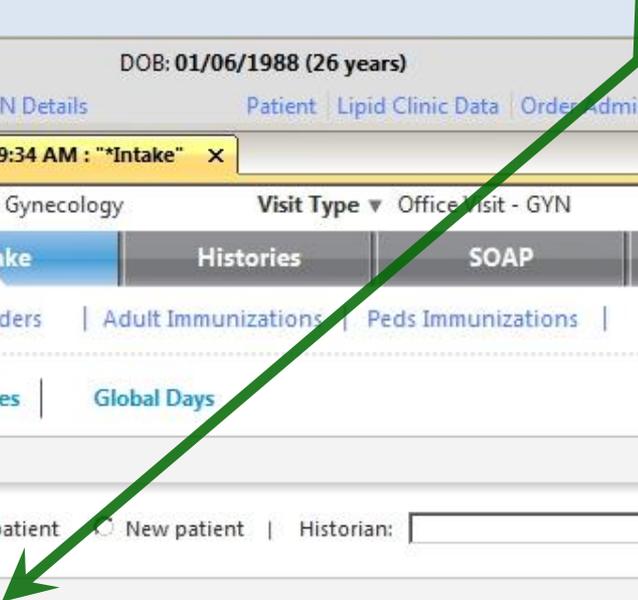
Reason for Visit

Do not launch HPI

abnormal pap smear
abnormal bleeding
amenorrhea

Chief Complaint History of Present Illness

Intake Comments



To enter Vital Signs, click **Add**.

Enter Vital Signs. (Details are reviewed in another demo.)

"Adult Vital Signs" - [New Record]

Height/length measurements:
ft in total in cm Position: Standing Lying
Last Measured: // Measured today Carried forward

Weight measurement:
lb kg Context: Dressed with shoes Dressed without shoes

Temperature: F C Site:

Blood Pressure and pulse:
Systolic Diastolic mm/Hg Position: Sitting Standing Lying Side: Right Left
Pulse: /min Pulse pattern: Regular Irregular Method: Manual Automatic Home monitor Cuff size: Pediatric Adult

Respiration and Pulse Ox:
Respiration: /min Pulse Ox Rest: % Pulse Ox Amb: %
Pulse Ox: Room air Oxygen - Method:
Pulse Ox measured: Pre-treatment Post-treatment

Pain scale:
Pain score: Method: HAQ-DI

Comments:

Peak Flow: Method:

Measure date: Time: 11:24 AM

Clear For Add Delete Save Close

Data used in this example:

Ht 65 inches, measured today.

Wt 184 lbs, dressed without shoes.

T 98.6.

BP 128/82.

HR 84.

Resp 16.

BMI of 30.62 will be calculated.

When done click Save then Close.

Vital signs now display.

03/19/2014 09:34 AM : "**Intake" x

General

Established patient New patient | Historian:

Vital Signs  Vital Signs Outside Normal Range

[Health Promotion Plan](#) | [History](#) | [Graph](#)

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
10:52 AM	65.00	184.00	30.62	128/82	84	16	98.6				

Reason for Visit

Do not launch HPI

- abnormal pap smear
 - abnormal bleeding
 - amenorrhea
 - annual exam
 - breast mass/lump
 - contraception
 - genital lesion
 - menopausal symptoms
 - pelvic mass/cyst
 - STD exposure
 - urinary incontinence
 - urinary symptoms
 - pelvic pain
 - vaginal discharge/itching
- Additional / Manage

Chief Complaint

Now enter Chief Complaints, or Reasons for Visit. The most common complaints used in each clinic will appear on this list. Our patient is here for pelvic/pap; though these are not always "annual" nowadays, annual exam seems like a logical choice. She doesn't voice any other complaints today.

The Reasons for Visit you've entered display.

03/19/2014 09:34 AM : "*USA Intake" x

Reason for Visit

Do not launch HPI Intake Comments

Chief Complaint	History of Present Illness
annual exam	

- abnormal pap smear
- abnormal bleeding
- amenorrhea
- annual exam
- breast mass/lump
- contraception
- genital lesion
- menopausal symptoms
- pelvic mass/cyst
- STD exposure
- urinary incontinence
- urinary symptoms
- pelvic pain
- vaginal discharge/itching

Additional / Manage

Intake Comments

Needs pap & BCP refill.

Save & Close Cancel

Click **Intake Comments** to enter some brief information about the patient's complaints.

Type a few brief details as pertinent or volunteered by the patient. When done click **Save & Close**.

Moving down the **Intake Tab**, we come to **Medications**. Since this is the first encounter documented in NextGen, we need to add the patient's meds. Click the **Add/Update** button.

The screenshot shows the 'Medications' section of a patient's record. At the top, there is a breadcrumb trail: '03/19/2014 09:34 AM : "*USA Intake"'. Below this are tabs for 'Reason for Visit' and 'Medications'. The 'Medications' tab is active. Underneath, there are checkboxes for 'Patient status: Transitioning into care' and 'Summary of care received'. To the right, there are three options: 'Comment' (with a plus icon), 'No medications' (with a checkbox), and 'Medications reconciled' (with a checkbox). Below these is a table with columns 'Medication' and 'Sig Description'. At the bottom right, there are two buttons: 'Add/Update' and 'Reconcile'. A green callout box at the top points to the 'Add/Update' button. Another green callout box at the bottom points to the 'No medications' checkbox.

03/19/2014 09:34 AM : "*USA Intake" ×

Reason for Visit

Medications

Patient status: Transitioning into care Summary of care received  [Comment](#) No medications Medications reconciled

Medication	Sig Description
------------	-----------------

If there were no meds, you'd click the **No medications** box.

Add/Update Reconcile

Medication Module

White Grid Preferences 26 year Old Female Weighing 184.00 lb | 83.46 Kg

Last Audit	Status	Medication Name	Generic Name	Start Date	Stop Date	Sig	Original Start
Status: Active (3 items)							
	Active	Levonest (28) 50-30 (6)/75-40(5)/125-3...	LEVONORGESTREL-ETH ESTRADIOL	03/19/2014		1 daily	03/19/2014
	Active	loratadine 10 mg tablet	LORATADINE	03/19/2014		1 daily as needed for allergies	03/19/2014
	Active	Singulair 10 mg tablet	MONTELUKAST SODIUM	03/19/2014		1 daily	03/19/2014

A detailed discussion of the Medication Module is included in another lesson.

Singulair 10 mg tablet
Sig: 1 daily Remove Sig Edit Sig

In this example, our patient is taking:

- Levonorest-eth.estradiol triphasic...BCP
- Loratadine 10 mg daily as needed for allergies.
- Singulair 10 mg daily.

Add these medications, then close the Med Module to return to the Intake Tab.

Medications display (though sometimes they may not show until the template is refreshed).

Click the **Medications reconciled** checkbox.

03/19/2014 09:34 AM : "*USA Intake" x

Reason for Visit

Medications

Patient status: Transitioning into care Summary of care received  [Comment](#) No medications Medications reconciled

Medication	Sig	Description
Levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet	1	daily
loratadine 10 mg tablet	1	daily as needed for allergies
Singulair 10 mg tablet	1	daily

[Add/Update](#) [Reconcile](#)

If you have questions about the medicines that you are unable to clarify with the patient, **DON'T** click the **Medications reconciled** checkbox. Instead, use the **Comment** link (or perhaps better, the **Intake Comments** link you used under **Reasons for Visit** above), and/or verbally tell the provider.

Reason for Visit

Medications

Patient status: Transitioning into care Summary of care received  [Comment](#) No medications Medications reconciled

Medication	Sig	Description
Levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet		1 daily
loratadine 10 mg tablet		1 daily as needed for allergies
Singulair 10 mg tablet		1 daily

Next, review allergies. If there are no allergies, just click the **No known allergies** box.

[Add/Update](#) [Reconcile](#)

Allergies

[Comment](#) No known allergies Allergies added today Reviewed, no change

Allergen	Reaction	Medication Name	Comment
----------	----------	-----------------	---------

[Add](#) [Update](#)

But our patient states she is allergic to sulfa, so click **Add**.

Add the patient's allergy to **Sulfa**; she gets a **Rash** from it. (A detailed discussion of the **Allergy Module** is covered in a separate exercise.)

Adult Allergies

Allergies entered here will not be checked against the current medication list.

<input type="checkbox"/> Accupril (Quinapril)	<input type="checkbox"/> Demerol	<input type="checkbox"/> Latex	<input type="checkbox"/> Prevacid
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Depakote	<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Prilosec
<input type="checkbox"/> Acyclovir	<input type="checkbox"/> Diabeta (Glyburide)	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Prinivil
<input type="checkbox"/> Advil (Ibuprofen)	<input type="checkbox"/> Diamox	<input type="checkbox"/> Lipitor	<input type="checkbox"/> Quinolones
<input type="checkbox"/> Altace (Ramipril)	<input type="checkbox"/> Dicloxacillin	<input type="checkbox"/> Lodine	<input type="checkbox"/> Ranitidine
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Lopressor (Metoprolol)	<input type="checkbox"/> Septra (Sulfamethoxazole)
<input type="checkbox"/> Amaryl (Glimepiride)	<input type="checkbox"/> Egg	<input type="checkbox"/> Micronase (Glyburide)	<input checked="" type="checkbox"/> Sulfa
<input type="checkbox"/> Augmentin (Amoxicillin)	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Minocin (Minocycline)	<input type="checkbox"/> Tagamet (Cimetidine)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Famotidine	<input type="checkbox"/> Morphine	<input type="checkbox"/> Tegretol (Carbamazepine)
<input type="checkbox"/> Bactrim (Sulfamethoxazole)	<input type="checkbox"/> Flagyl	<input type="checkbox"/> Motrin (Ibuprofen)	<input type="checkbox"/> Tenormin (Atenolol)
<input type="checkbox"/> Biaxin	<input type="checkbox"/> Floxin	<input type="checkbox"/> Naprosyn (Naproxen)	<input type="checkbox"/> Tetanus toxoid
<input type="checkbox"/> Carafate (Sucralfate)	<input type="checkbox"/> Glucotrol (Glipizide)	<input type="checkbox"/> Neptazane	<input type="checkbox"/> Tetracycline
<input type="checkbox"/> Ceclor (Cefaclor)	<input type="checkbox"/> Heparin	<input type="checkbox"/> Niacin	<input type="checkbox"/> Ticlid
<input type="checkbox"/> Celebrex	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Valium (Diazepam)
<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Inderal (Propranolol)	<input type="checkbox"/> Peanut	<input type="checkbox"/> Vancomycin
<input type="checkbox"/> Cipro (Ciprofloxacin)	<input type="checkbox"/> Indocin (Indomethacin)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Vasotec
<input type="checkbox"/> Clinoril (Sulindac)	<input type="checkbox"/> Insulin (Animal)	<input type="checkbox"/> Percocet (Oxycodone)	<input type="checkbox"/> Zestril
<input type="checkbox"/> Contrast media (Ioversol)	<input type="checkbox"/> Iodine or shellfish	<input type="checkbox"/> Persantine	<input type="checkbox"/> Zithromax
<input type="checkbox"/> Codeine	<input type="checkbox"/> Keflex (Cephalexin)	<input type="checkbox"/> Plavix	<input type="checkbox"/> Zocor (Simvastatin)
<input type="checkbox"/> Coumadin	<input type="checkbox"/> Klonopin	<input type="checkbox"/> Phenytoin	<input type="checkbox"/> Zylprim (Allopurinol)
<input type="checkbox"/> Dannon	<input type="checkbox"/> Lasix (Furosemide)	<input type="checkbox"/> Pravachol	

Reaction

- Altered Heart Rate
- Anaphylaxis
- Angioedema
- Blurred vision
- Bruising
- Burning eyes
- Conjunctivitis
- Contact dermatitis
- Corneal edema
- Cough
- Discomfort
- Dizziness
- Fever
- GI Bleeding
- GI problems
- Hives
- Hives/Skin Rash
- Iris color change
- Iritis
- Itching
- Jaundice
- Joint pain
- Liver toxicity
- Macular edema
- Muscular pain
- Myalgias
- Nausea
- Nausea/Vomiting
- Pulmonary toxicity
- Rash
- Red eyes
- Stomach Pain
- Trouble Breathing
- Unknown

Save & Close Cancel

Close

When done click **Save & Close**.

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Data

Sulfa now displays in the Allergies grid. Since this was just added, the Allergies added today bullet was selected.

General
Vital Signs Vital Signs Outside
Reason for Visit
Medications
Allergies

Comment No known allergies Allergies added today Reviewed, no change

Allergen	Reaction	Medication Name	Comment
SULFA (SULFONAMIDE ANTIBIOTICS)	Rash		

Now let's move to the Histories Tab.

Add Update

Instructions for entering most of the items on the **Histories Tab** are covered in the Histories lesson. We won't rehash them in detail here, but let's go through the general workflow.

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Weight: 184.00 lb (83.46 Kg) Allergies: (1) Problems: (0) Diagnoses: (0) Medications: (3)

Alerts **OBGYN Details** Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:37 AM: "*Histories" x

Specialty ▼ Gynecology Visit Type ▼ Office Visit - GYN

Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | History Review All History Review details are to be reviewed and included in visit note unless user indicates otherwise

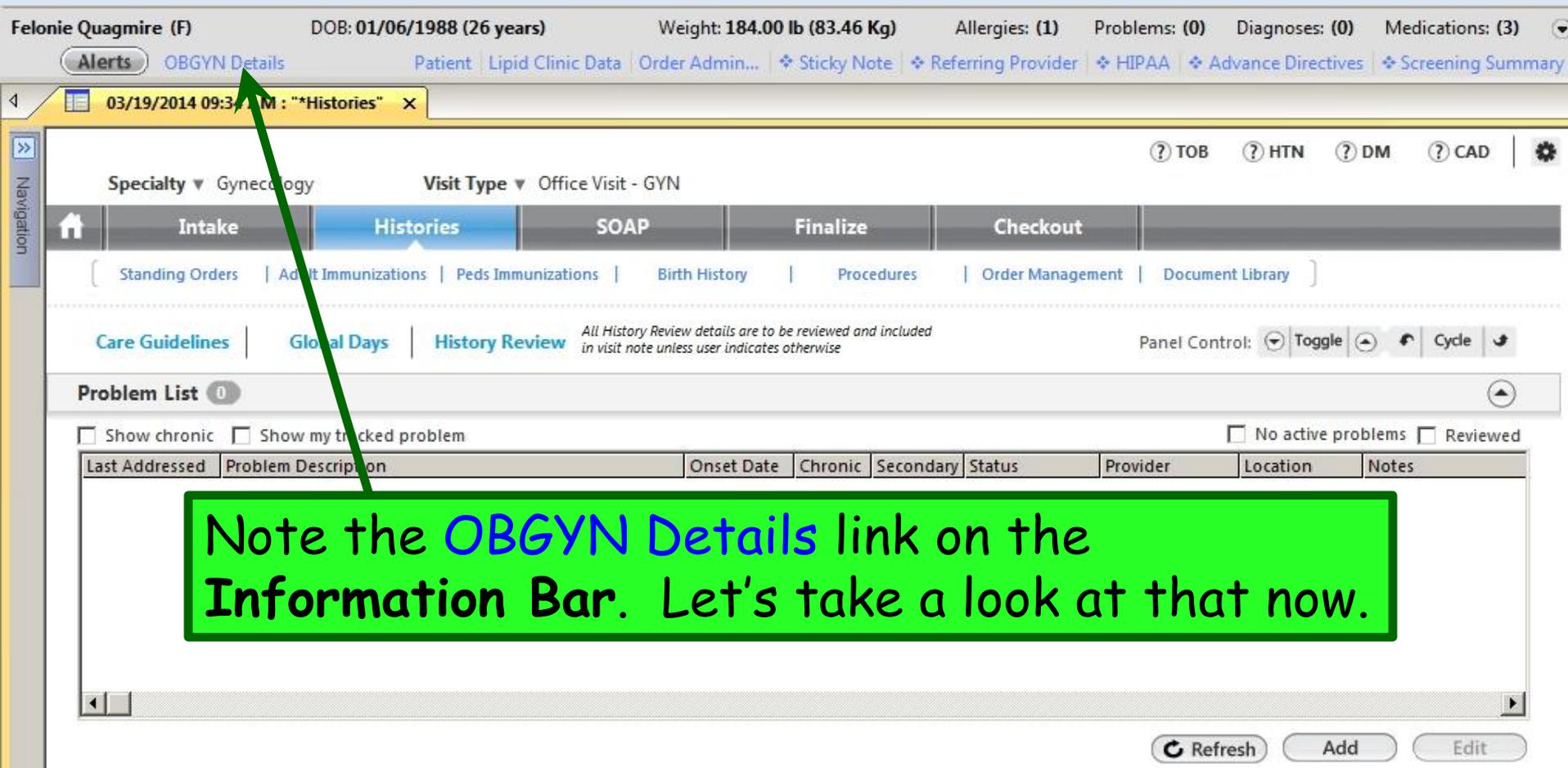
Panel Control: Toggle Cycle

Problem List 0

Show chronic Show my tracked problem No active problems Reviewed

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Status	Provider	Location	Notes
----------------	---------------------	------------	---------	-----------	--------	----------	----------	-------

Refresh Add Edit



Note the **OBGYN Details** link on the Information Bar. Let's take a look at that now.

Some details can be entered directly here. We've added that she's sexually active, sometimes practicing safer sex, & using oral contraceptive.

OB/GYN Synopsis

- Detailed document
 Reviewed, no changes
 Reviewed, updated

History unobtainable

Reason:

Last update/detailed doc:

Primary OBGYN provider:

Provider at this encounter:

Primary care provider:

Gynecologic History:

Menopausal stage:

- Premenopausal
 Perimenopausal
 Postmenopausal

LMP:

Menopause detail:

Age:

Year:

Type:

Hysterectomy:

No

Yes

Type:

Age of Menarche:

Pregnancy History:

G P T P A L

Currently pregnant: No Yes Possible Not pertinent

Details

To enter pregnancy history, click **Details**.

Safer Sex Information/Contraception History:

Include information in the document

Sexual orientation:

Sexually active:

- No
 Yes
 Previously

Practices safer sex:

- No
 Yes
 Sometimes

Safer sex detail:

Birth control:

Save & Close

Cancel

Enter data in the white boxes & they'll be summarized in the gray boxes above. She's had one term vaginal delivery & one miscarriage.

Parity Detail

Gravida/Parity:
G: T P A L Currently pregnant:
 No Yes Possible Not pertinent

Full term: Premature: Abortion induced: Abortion spontaneous: Ectopic: Living: C-section: SVD: Multiple Births:

Pregnancy History:

Pregnancy #	Baby #	Date	Gestational Age	Labor(hrs)	Weight	Sex	Place of Delivery	Delivery type	Anesthesia

If you want to enter further details about each pregnancy, you can double-click on the **grid** to do so.

When done click **Save & Close** (twice) to close these popups.

New.

Back on the Histories Tab, we'll address the Problem List.

Specialty Visit Type Office Visit

Intake **Histories** SOAP

Standing Orders | Adult Immunizations | Peds Immunizations | Birth Hist

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: Toggle Cycle

Problem List 0

Show chronic Show my tracked problem No active problems Reviewed

Problem Description | Side | Notes | Addtl

A note to those transitioning from earlier versions of NextGen: The new Problem List replaces the old Chronic Conditions, due to Meaningful Use requirements. While some conversion may happen automatically, the old Chronic Conditions list may need to be reviewed & used to complete the new Problem List. See the What's New lesson for details.

Old.

Refresh Add Edit

Intake **Histories** Summary

Sticky Note | Referring Provider | HL

Chronic Conditions

Reviewed

Problem	Comments

Add

Navigation

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

? TOB ? HTN ? DM ? CAD ⚙

Home Intake **Histories** SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations Birth History Procedures Order Management Document Library

Care Guidelines Global Days **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: Toggle Cycle

Problem List 0

Show chronic Show my tracked problem No active problems Reviewed

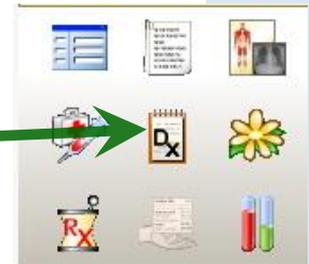
Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Status	Provider	Location	Notes
To add diagnoses, click Add .								

Refresh **Add** Edit

The screenshot shows the 'Problems' module interface. At the top, there are two tabs: 'Problem List' (highlighted with a green box) and 'Billing ICD List'. Below the tabs is a toolbar with buttons for 'Refresh', 'Preferences', and a dropdown menu for 'Show All Statuses'. There are also two checkboxes: 'Show My Tracked Problems Only' and 'Show Chronic Problems Only'. Below the toolbar, there is a section labeled 'No Active Problems'. The main area is a table with columns: 'Concept Id', 'Description', 'Fully Specified Name', and 'Chronic'. At the bottom, there is a toolbar with buttons for 'Add Problem', 'Re-Code', 'Resolve', 'Set Chronic', 'Delete', 'Resources', 'View/Add Notes', 'View History', and 'Reconcile'. Below this toolbar are three more buttons: 'Add to Billing ICD List', 'Add to My Tracked Problems', and 'Remove from My Tracked Problems'.

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**.

Problems

Problem List | Billing ICD List

Refresh Preferences Show All Statuses Show My Tracked Problems Only Show Chronic Problems Only

No Active Problems

Concept Id	Description	Fully Specified Name	Chronic	Secondary Condition
------------	-------------	----------------------	---------	---------------------

🔍 Allergic rhinitis Search

Description	Fully Specified Name	Concept Id
Allergic rhinitis	Allergic rhinitis	61582004
Rhinitis due to pollen allergy	Allergic rhinitis due to pollen	21719001
Allergic rhinitis due to animal dander	Allergic rhinitis due to animal dander	429195002
AR - Allergic rhinitis	Allergic rhinitis	61582004
Allergic rhinitis due to animals	Allergic rhinitis due to animals	91925003
Allergic rhinitis due to food	Allergic rhinitis due to food	41978001
Allergic rhinitis due to pollen	Allergic rhinitis due to pollen	91926002
Allergic rhinitis due to house dust mite	Allergic rhinitis due to house dust mite	449729000
Allergic rhinitis due to pollen	Allergic rhinitis due to pollen	21719001
Allergic rhinitis due to pollens	Allergic rhinitis due to pollen	21719001
Allergic rhinitis due to tree pollens	Allergic rhinitis due to tree pollens	91927006
Allergic rhinitis due to weed pollens	Allergic rhinitis due to weed pollens	91928001

36 rows returned

Add to My Tracked Problems Select Cancel

A review of diagnosis search is covered in the Histories lesson. We'll add the patient's allergic rhinitis, which is her only chronic problem, & return to the Histories Tab.

These problems now display. Note the Problems count on the Info Bar now shows 1.

Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations Birth History Procedures Order Management Document Library

Care Guidelines Global Data **History Review** All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Panel Control: Toggle Cycle

Problem List 1

Show chronic Show my tracked problem No active problems Reviewed

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Status	Provider	Location	Notes
	Allergic rhinitis							

Click the Reviewed checkbox. This is the only individual "Review" checkbox on this template you need to click each encounter.

Medical/Surgical/Interim

No relevant past medical/surgical history

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome

History Review

All of the other History Review links lead to the same popup. Click one of them.

Specialty Gynecology Visit Type Office Visit - GYN

Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: Toggle Cycle

Problem List 1

Show chronic Show my tracked problem

Problem Description	Side	Notes
Allergic rhinitis		

History Review

Med/Surg/Interim Hx: Detailed document Reviewed, no changes (last updated 05/04/2014)
 Reviewed, updated History unobtainable:

Family: Detailed document Reviewed, no changes (last updated 05/04/2014)
 Reviewed, updated History unobtainable:

Social: Detailed document Reviewed, no changes (last updated 05/13/2014)
 Reviewed, updated History unobtainable:

Save & Close Cancel

Refresh Add Edit

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 we'll enter other **Medical/Surgical/Interim** history. While the **Problem List** includes ongoing medical issues, the **Medical/Surgical/Interim** history is for isolated episodes of illness or events such as surgery. Click **Add**.

Problem List 1

Show chronic Show my tracked problem

No active problems Reviewed

Problem Description	Side	Notes	Addtl
Allergic rhinitis			

Refresh Add Edit

Medical/Surgical/Interim

No relevant past medical/surgical history

All History Review details are to be reviewed and included in visit notes unless user indicates otherwise [History Review](#)

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
------------------	------	------------	------------	------	------	----------------	---------

Refresh Interim History Add Edit Remove

There is a list of items that can be quickly checked. In 2010 she had an episode of **Pelvic inflammatory disease**, so we'll check that.

Past Medical History

Specialty:

Panel Control:

Medical

To add comments, click manage. Onset Date:

<input type="checkbox"/> Abnormal PAP	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Polycystic ovary syndrome
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fibroid uterus	<input type="checkbox"/> Prolapsed uterus
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Pulmonary embolism
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Genital herpes simplex	<input type="checkbox"/> Recurrent miscarriages
<input type="checkbox"/> Bartholin's gland cyst	<input type="checkbox"/> Genital herpes, exposure	<input type="checkbox"/> Renal disease
<input type="checkbox"/> Breast mass	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Bruising/bleeding disorder	<input type="checkbox"/> Hepatitis/liver disease	<input type="checkbox"/> STI
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypercoagulable disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Clotting disorder	<input type="checkbox"/> Incompetent cervix	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cystocele	<input type="checkbox"/> Infertility, female	<input type="checkbox"/> Urinary tract infection, r...
<input type="checkbox"/> Depression	<input type="checkbox"/> Mental disorder	<input type="checkbox"/> Vaginal infections, recurr...
<input type="checkbox"/> DES Exposure	<input type="checkbox"/> Obesity	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ovarian cyst	<input type="checkbox"/> Other
<input type="checkbox"/> Elevated lipids	<input checked="" type="checkbox"/> Pelvic inflammatory disease	

2010

Surgical

To add comments, click manage. Onset Date:

Angi...

A lot more detail can be added by clicking **Manage**, as reviewed in the Histories lesson. But for this example we'll just click **Add To Grid**.

Past Medical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Clotting disorder | <input type="checkbox"/> Incompetent cervix | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cystocele | <input type="checkbox"/> Infertility, female | <input type="checkbox"/> Urinary tract infection, r... |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mental disorder | <input type="checkbox"/> Vaginal infections, recurr... |
| <input type="checkbox"/> DES Exposure | <input type="checkbox"/> Obesity | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Other |
| <input type="checkbox"/> Elevated lipids | <input type="checkbox"/> Pelvic inflammatory disease | |

Add To Grid

Clear

Surgical

To add comments, click manage.

Date:

- Angioplasty
- Appendectomy
- Arthroscopy
- Back surgery
- Bilateral oophorectomy
- Bilateral tubal ligation
- Blood transfusion
- Breast augmentation
- Breast reduction
- CABG

Date:

- Cardiac pacemaker
- Chemotherapy
- Cholecystectomy
- D&C
- Gastric bypass
- Hernia repair
- Hip replacement
- Hysterectomy
- Knee replacement
- Mastectomy

Date:

- Myomectomy
- Pelvic sling
- Radiation therapy procedure
- Thyroidectomy
- Other

Add To Grid

Clear

Past Medical History Grid

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome	Comment
Pelvic inflammatory disease		2010						

That's all we'll add, so click **Save & Close**.

Edit

Remove

Save & Close

Cancel

Specialty ▼ Gynecology Visit Type ▼ Office Visit - GYN

This history now displays.

Finalize

Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | History Review

All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Panel Control: ▼ Toggle ▲ ↺ Cycle ↻

Problem List 1

 Show chronic Show any tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl
Allergic rhinitis			

Refresh

Add

Edit

Medical/Surgical/Interim

 No relevant past medical/surgical history

All History Review details are to be reviewed and included in visit note unless user indicates otherwise [History Review](#)

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
Pelvic inflammatory disease		2010					

Now we'll use the collapsible panels to move down to the Family History.

Refresh

Internal History

Add

Edit

Remove

Diagnostic Studies

Family



Specialty v Gynecology Visit Type v Office Visit - GYN

Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise* Panel Control: Toggle Cycle

Problem List 1

Medical/Surgical/Interim

Diagnostic Studies

Family 

No relevant family history Adopted - no family history known *All History Review details are to be reviewed and included in visit note unless user indicates otherwise* [History Review](#)

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments

Click Add.

Add Edit Remove

Specialty:

No family history of:

Relationship:

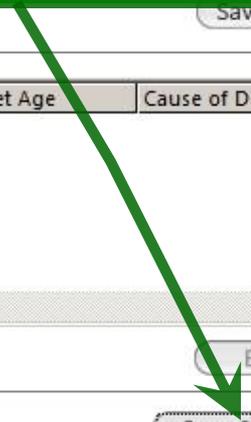
Family member name:

Alive and well Deceased

- | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hemophilia-A | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coagulopathy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Renal disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Down syndrome | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <input type="checkbox"/> Elevated lipids | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Enter this Family History:
 Her brother has hypertension.
 Her mother died from alcoholism at age 52.
 (Family History is covered in detail in the Histories lesson.)
 When done click *Save & Close*.

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments



Specialty ▾ Gynecology

Visit Type ▾ Office Visit - GYN



Intake

Histories

SOAP

Finalize

Checkout

Standing Orders | Adu

Patient Library

These additions display in the grid.

Care Guidelines

Global Days

History Review

in visit note unless user indicates otherwise

Panel Control:

Toggle



Cycle

Problem List 1

Medical/Surgical/Interim

Diagnostic Studies

Family

 No relevant family history Adopted - no family history known

All History Review details are to be reviewed and included in visit note unless user indicates otherwise

History Review

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments
Brother				Hypertension		N	
Mother		Y	52	Alcoholism		Y	
Mother		Y	52				

Now move down to Social History & click the **Add** button.

Social

 History Review *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*
 Last documented All ?

Substances	Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Package Per Day	Pack Years	Date Quit
<ul style="list-style-type: none"> ▶ Tobacco Alcohol/Caffeine Statuses Lifestyle Occupation Comment Diet History Environmental 							
	Encounter Date:Time						

Confidential History

Add

- ◆ Tobacco
- ◆ Alcohol/Caffeine
- ◆ Statuses
- ◆ Lifestyle
- ◆ Occupation
- ◆ Comments
- ◆ Diet History
- ◆ Environmental

Panel Control: **Tobacco Use**Have you ever used tobacco? No/never Yes Unknown Exclusions Reviewed Updated:

Enter this Social History:

She's never smoked.

She drinks an average of 2-3 drinks per wk.

She's single.

She works full time in customer service.

(Social History is covered in detail in the Histories lesson.)

When done click **Save & Close**.

Smoking Tobacco Use				Non Smoking Tobacco Use							
Tobacco type:	Use daily:	Usage per day:	Years used:	Age started:	Age stopped:	Tobacco type:	Use daily:	Usage per day:	Years used:	Age started:	Age stopped:
<input type="checkbox"/> Cigarette	<input type="checkbox"/>	<input type="text"/> units	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Chewing	<input type="checkbox"/>	<input type="text"/> units	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Cigar	<input type="checkbox"/>	<input type="text"/> units	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Smokeless	<input type="checkbox"/>	<input type="text"/> units	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Pipe	<input type="checkbox"/>	<input type="text"/> units	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Snuff	<input type="checkbox"/>	<input type="text"/> units	<input type="text"/>	<input type="text"/>	<input type="text"/>

Smoking status:

Tobacco use status:

Click here to see tobacco history prior to 7.9.1

Encounter Date	Tobacco Type	Usage Per Day	Years Used	Pack Year	Status	Age Started	Age Stopped
----------------	--------------	---------------	------------	-----------	--------	-------------	-------------

Efforts To Quit Tobacco

Passive Smoke Exposure

Specialty Gynecology Visit Type Office Visit - GYN

You can click on the left-side headings to display many of the details in the grid (though you may have to open the popup to view everything).

- Intake
- Standing Orders
- Care Guidelines
- Problem List 1
- Medical/Surgical/Inte
- Diagnostic Studies
- Family
- Social

Document Library

Panel Control: Toggle Cycle

Dropdown arrows and icons

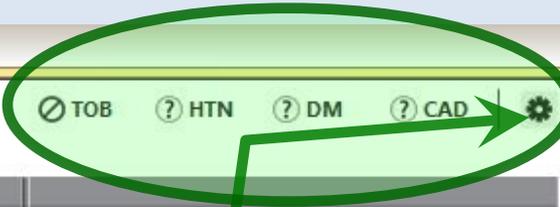
History Review All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Last documented All

Substances	Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
Tobacco	03/19/2014	No/Never		Never smoker			
Alcohol/Caffeine							
Encounter Date:Time							

Confidential History Add

Intake Note



Specialty v Gynecology Visit Type v Office Visit - GYN

Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Panel Control: Toggle Cycle

Problem List 1

Medical/Surgical/Interim

Diagnostic Studies

Family

Social

History Review All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Last documented All

Note the **Risk Indicators** at the top. Since we just recorded tobacco history in the **Social History**, it indicates she's tobacco-free. Click the **Configure** link to complete the other **Risk Indicators**.

Confidential History Add

Intake Note

Risk Factors Config

No risk indicators

Tobacco:

Smoking status:

Tobacco use:

Tobacco cessation discussed ⓘ

Tobacco Usage:

Enc Date	Use	Type	Total Pk Yrs
11/05/2012	never		

Hypertension:

Yes No Unknown

Diabetes:

Yes No Unknown

CAD:

Yes No Unknown

Tobacco has already been addressed.
Click the bullets for Hypertension No, Diabetes No, & Coronary Artery Disease No.
When done click Save & Close.

Address: 911 Run Dog Run
Mobile, AL 36604
Contact: (251) 555-9876 (Home)

Alerts OBGYN Details

MRN: 000000007773 Emergency Relation: PCP: VARNER, STEPHEN MD

All Risk Indicators are now configured.



03/19/2014 09:34 AM : "USA Histories" x

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: Toggle Cycle

- Problem List** 1
- Medical/Surgical/Interim
- Diagnostic Studies
- Family
- Social

History Review

Now click Intake Note. (There's a similar button on the bottom of the Intake Tab as well.)

Substances

Substance	Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
Tobacco							
Alcohol							

Encounter Date:Time

Statures
Lifestyle
Occupation
Comment
Diet History
Environmental

Confidential History Add

Intake Note

03/19/2014 09:34 AM : "USA Histories" 03/19/2014 09:34 AM : Document "intake note"

TX Text

Segoe UI Semibold 10 B I U [List Icons] 100%

NEXTGEN
HEALTHCARE INFORMATION SYSTEMS

PATIENT: Felonie Quagmire
 DATE OF BIRTH: 01/06/1988
 DATE: 03/19/2014 9:34 AM
 VISIT TYPE: Office Visit - GYN

The Intake Note is created, summarizing all of the data you've just entered.

Close this & return to the Histories Tab.

History of Present Illness:

- 1. annual exam

Intake Comments: Needs pap & BCP refill.

Problem List:

Problem Description
Allergic rhinitis

Family History

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death
Brother				Hypertension		N
Mother		Y	52	Alcoholism		Y
Mother		Y	52			

SOCIAL HISTORY

Tobacco use reviewed.
Preferred language is English.

EDUCATION/EMPLOYMENT/OCCUPATION

Employment	History	Status	Retired	Restrictions
	Customer service representatives	full-time		

MARITAL STATUS/FAMILY/SOCIAL SUPPORT

Currently single.
Smoking status: Never smoker.

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

TOB HTN DM CAD

Home Intake **Histories** SOAP Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | Birth History | Procedures | Order Management | Document Library

Care Guidelines | Global Days | **History Review** *All History Review details are to be reviewed and included in visit note unless user indicates otherwise*

Panel Control: Toggle Cycle

Problem List 1

Medical/Surgical/Interim
 Diagnostic Studies
 Family
 Social

The patient is ready for the provider. On the re-expanded Info Bar & click the Tracking icon.

History Review *All History Review details are to be reviewed and included in visit note unless user indicates otherwise* Last documented All ⓘ

Substances	Encounter Date	Tobacco Use	Tobacco Type	Smoking Status	Usage Per Day	Pack Years	Date Quit
<ul style="list-style-type: none"> ▶ Tobacco Alcohol/Caffeine Statuses Lifestyle Occupation Comment Diet History Environmental 	03/19/2014	No/Never		Never smoker			
	Encounter Date:Time						

Click in the **Room** box & select a room; alternately, you can just type a room number in the box.

Appointment date: 02/21/2014

Today's date: 02/24/2014

Appointment information:

9:00 AM DUFFY MD, ROBERT LAMAR Reason:

Room:

Status:

Ngkbn Get Dbpicklist Items [X]

List Item
Checkout
Exam 1
Exam 2
Exam 3
Exam 4
Exam 5
Exam 6
Lab
Procedure room
Waiting room
X-ray

Refresh OK Cancel

Patient Tracking:

Appt Time	Room

Appointment date shown.

Today's Patient Tracking



Appointment date: 02/21/2014

Today's date: 02/24/2014

Appointment information:

9:00 AM DUFFY MD, ROBERT LAMAR Reason:

Room:

Exam 1

Status:

waiting for provider

(Entries uploaded on "Save and Close".)

Patient Tracking:

The Inbox will update today's calendar and not the appointment date shown.

Appt Time ▾	Room	Status	Time	Documented By

When done click **Save & Close.**



Task EHR Appointments **Save & Close** Cancel

Patient

Location

Provider

Date

NextGen EHR: Felonie Quagmire MRN: 0000000773 DOB: 01/06/1988 (Female) AGE: 26 years 2 months - 03/19/2014 09:34 AM: "*USA Home Page"

File Edit Default View Tools Admin Utilities Window Help

Logout Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAR Medications Templates Documents Images Orders Problems Apps Close

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Weight: 184.00 lb (83.46 Kg) Allergies: (1) Problems: (1) Diagnoses: (0) Medications: (3)

Address: 911 Run Dog Run Mobile, AL 36604 MRN: 0000000773 Emergency Relation: PCP: VARNER, STEPHEN MD
 Contact: (251) 555-9876 (Home) Insurance: AMERICAN GENERAL Emergency Phone: Referring:
 NextMD: No Pharmacy 1: Rendering: DUFFY, ROBERT LAMAR ...

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM: "*USA Home Page"

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Care Guidelines Global Days Panel Control: Toggle Cycle

Medical Chart Summary

HPI's	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Plans	03/19/2014	10:52 AM	98.6	128/82	84	16	65.00	184.00	30.62				

HPI's
Plans
Problem List
Medications
Allergies
Labs
Diagnostics
Vitals
Physical Exams
Office Procedures
Referrals
Past Medical/Surgical History
Family History
Tobacco Usage
Procedures

Patient History

- Patie...
- Patie...
- Cate...
- New Lock Search
- 03/19/2014 09:34 AM
 - *Intake
 - *USA Intake
 - Medication
 - *Histories
 - USA Histories
 - intake_note

Ready NGDev1 USA Health Services Foundation rlduffy CAP NUM SCRL 03/19/2014

The provider then opens the chart from the appointment list & performs the 4-point check.

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Weight: 184.00 lb (83.46 Kg) Allergies: (1) Problems: (1) Diagnoses: (0) Medications: (3)

Address: 911 Run Dog Run Mobile, AL 36604 MRN: 00000007773 Insurance: AMERICAN GENERAL Emergency Relation: PCP: VARNER, STEPHEN MD
Contact: (251) 555-9876 (Home) NextMD: No Emergency Phone: Referring: Rending: DUFFY, ROBERT LAMAR ...
Pharmacy 1:

Alerts GYN Details Patient Lipid Clinic Data Order Admin Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM: "*USA Home Page"

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations Birth History Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

Medical Chart Summary

TOB HTN DM CAD

Patient History: 03/19/2014 09:34 AM: *Intake *USA Intake Medication *Histories USA Histories intake_note

The provider generally starts on the Home Tab.
It's good to begin by looking for **Sticky Notes & Alerts**; there are none on this patient.
Also take note of the **Risk Indicators**.

HPI's	Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
Plans	03/19/2014	10:52 AM	98.6	128/82	84	16	65.00	184.00	30.62				

You can select any of the headings on the left to view various aspects of the chart. In particular, this is a good place to look at Office Lab results or review previous vital signs.

The screenshot displays a medical chart interface. On the left, a navigation pane lists various chart sections: HPI's, Plans, Problem List, Medications, Allergies, Labs, Diagnostics, Vitals (highlighted), Physical Exams, Office Procedures, Referrals, Past Medical/Surgical History, Family History, Tobacco Usage, and Procedures. A green arrow points from the 'Vitals' section to a table of vital signs. The table has columns for Date, Time, Temp F, BP, Pulse, Respiration, Ht In, Wt Lb, BMI, BSA, Pain Score, HAQ Score, and Pulse. The first row of data shows: 03/19/2014, 10:52 AM, 98.6, 128/82, 84, 16, 65.00, 184.00, 30.62. Above the table, there are tabs for Intake, Histories, SOAP, Finalize, and Checkout. A second green arrow points to a circular icon in the top right corner of the chart area. On the right side, a 'Patient History' panel shows a tree view of the patient's history, including folders for '03/19/2014 09:34 AM' with sub-items like '*Intake', '*USA Intake', Medication, '*Histories', USA Histories, and intake_note. The interface also includes a top navigation bar with 'Alerts', 'OBGYN Details', and other patient-related links.

Date	Time	Temp F	BP	Pulse	Respiration	Ht In	Wt Lb	BMI	BSA	Pain Score	HAQ Score	Pulse
03/19/2014	10:52 AM	98.6	128/82	84	16	65.00	184.00	30.62				

Note also you can use the collapsible panels or scroll down to see a lot more information.

The Problem List is viewable & editable here.

Medical Chart Summary

Problem List 1

Show chronic Show my tracked problems No active problems Reviewed

Last Addressed	Problem Description	Onset Date	Chronic	Secondary	Clinical Status	Provider	Location	Notes
	Allergic rhinitis		Y	N		DUFFY, ROBERT LAMAR	USA FAMILY MEDICINE	

Refresh Add Edit

History Summary

All History Review details are to be reviewed and included in visit note unless user indicates otherwise

Confidential

History Review

No relevant past medical/surgical history

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type
Pelvic inflammatory disease		2010				

- Medical
- Surgical/Intent
- Interim
- Social
- Family
- Diagnostic

Likewise, you can review & update everything else that appears on the Histories Tab from here. Select the category of history desired on the left.

Add Edit Remove

Allergies

Comment
 No known allergies
 Allergies added today
 Reviewed, no change

Allergen	Reaction	Medication Name	Comment
SULFA (SULFONAMIDE ANTIBIOTICS)	Rash		

Allergies, meds, vital signs, office labs—everything that can be found on the **Intake & Histories** Tabs can be reviewed & if necessary updated from this tab. Update

Medications

Patient status:
 Transitioning into care
 Summary of care received
 

Comment
 No medications
 Medications reconciled
 

Medication	Sig	Description
Levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet	1 daily	
loratadine 10 mg tablet	1 daily as needed for allergies	
Singulair 10 mg tablet	1 daily	

Add/Update Reconcile

Vital Signs ⚠ Vital Signs Outside Normal Range

[History](#) | [Graph](#)

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
10:52 AM	65.00	184.00	30.62	128/82	84	16	98.6				

Add Edit Remove

Orders

[Lab/Radiology Order Processing](#) |
 [Order Management](#) |
 [Immunizations](#) |
 [Standing Orders](#) |
 [Task](#)

View of All Orders Labs	Ordered	Status	Order	Timeframe	Comments

NextGen EHR: Felonie Quagmire MRN: 000000007773 DOB: 01/06/1988 (Female) AGE: 26 years 2 months - 03/19/2014 09:34 AM : "*USA Home Page"

File Edit Default View Tools Admin Utilities Window Help

Logout Save Clear Delete USA FAMILY MEDICINE DUFFY, ROBERT LAMAR MD Patient History Inbox PAR Medications Templates Documents Images Orders Problems Apps Close

Felonie Quagmire (F) DOB: 01/06/1988 (26 years) Weight: 184.00 lb (83.46 Kg) Allergies: (1) Problems: (1) Diagnoses: (0) Medications: (3)

Address: 911 Run Dog Run Mobile, AL 36604 MRN: 000000007773 Insurance: AMERICAN GENERAL Emergency Relation: PCP: VARNER, STEPHEN MD
Contact: (251) 555-9876 (Home) NextMD: No Emergency Phone: Referring: Rending: DUFFY, ROBERT LAMAR ... Pharmacy 1:

Alerts OBGYN Details Patient Lipid Clinic Data Order Admin... Sticky Note Referring Provider HIPAA Advance Directives Screening Summary

03/19/2014 09:34 AM : "*USA Home Page"

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations Birth History Procedures Order Management Document Library

Care Guidelines Global Days

Medical Chart Summary

HPT's Plans Problem List Medications Allergies Labs Diagnostics Vitals Physical Exams Office Procedures Referrals Past Medical/Surgical History Family History Tobacco Usage Procedures

Date Time Temp F BP Pulse Respiration Ht In Wt Lb BMI BSA Pain Score HAQ Score Pulse

03/19/2014 10:52:00 98.5 128/80 74 20 54 20 20.5

Patient History

Patie... Patie... Cate...

New Lock Search

03/19/2014 09:34 AM

- *Intake
- *USA Intake
- Medication
- *Histories
- USA Histories
- intake_note

TOB HTN DM CAD

Panel Control: Toggle Cycle

Ready

NGDev| USA Health Services Foundation | rlduffy | CAP | NUM | SCRL | 03/19/2014

You can also just review the intake_note to see a summary as well. Regardless of the method chosen, the provider is responsible for reviewing & confirming this information, & updating it as necessary.

When you're done reviewing the chart, move to the SOAP tab.

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize Checkout

We'll start entering the HPI. First note that you can keep or edit this introductory line—or delete it all together.

Reason for Visit

Introduction:

This 26 year old female presents for annual exam.

Do not launch HPI

Intake Comments

Reason for Visit	History of Present Illness
<ul style="list-style-type: none"> abnormal pap smear abnormal bleeding amenorrhea annual exam breast mass/lump contraception genital lesion menopausal symptoms pelvic mass/cyst STD exposure urinary incontinence 	<ul style="list-style-type: none"> annual exam

If you didn't previously note them, you can review the nurse's Intake Comments.

Next, you have some options as to how to proceed. You can click on one of the Reasons for Visit to open the HPI Popup. We'll click annual exam.

Diagnostics Comments

Concern:

Pregnancy G P T P A L [Detail](#)
Currently No Yes Possible Not pertinent
Contemplating No Yes

[Framingham 10 year CHD Event Risk](#)
[Depression Screening](#)
[Advanced Directives](#)



Birth Control: [OBGYN Confidential Information](#)

Menses:
LMP: regular irregular
Flow:
Frequency:

No Yes
 Dysmenorrhea:
 Menorrhagia:

Postmenopausal:
No Yes
 Postmenopausal
Age: Type:
 Hormone replacement therapy
Type: Years taken:

Additional Symptoms:
 No associated symptoms No pertinent negatives All others negative

<input type="radio"/> <input type="radio"/> Abnormal bleeding	<input type="radio"/> <input type="radio"/> Nocturia	<input type="radio"/> <input type="radio"/> Other: <input type="text"/>
<input type="radio"/> <input type="radio"/> Anxiety	<input type="radio"/> <input type="radio"/> Sexual dysfunction	<input type="radio"/> <input type="radio"/> Other: <input type="text"/>
<input type="radio"/> <input type="radio"/> Decreased libido	<input type="radio"/> <input type="radio"/> Sleep disturbances	
<input type="radio"/> <input type="radio"/> Depression	<input checked="" type="radio"/> <input type="radio"/> Urinary incontinence	
<input type="radio"/> <input type="radio"/> Difficulty falling asleep	<input checked="" type="radio"/> <input type="radio"/> Urinary urgency	
<input checked="" type="radio"/> <input type="radio"/> Dyspareunia	<input checked="" type="radio"/> <input type="radio"/> Vaginal discharge	
<input checked="" type="radio"/> <input type="radio"/> History of Infertility	<input checked="" type="radio"/> <input type="radio"/> Vaginal Itch	

[View Medical/Surgical History](#) [View Family History](#)
 Detailed document Reviewed, updated
 Reviewed, no changes History unobtainable Last Update:

Comment

You can use picklists, checkboxes, & bullets to document elements of the HPI. You can type a little more info in the Comments box.

And you can save & reuse presets.

When done click OK.

Diagnostic history: Diagnostics Lab/pathology
Test: Date: Details:
Lab/Pathology
Report Interpretation

Calcium Dietary sources mg/day Contraindication:
Supplement mg/day
Vitamin D Supplement
Adequate sunlight exposure
Multivitamin Daily Occasionally
Folic acid Daily Occasionally

Social History
 Detailed Reviewed and updated
 Reviewed, no changes History unobtainable
Marital status:
Comments:
Exercise/Activity:
Activity level: Exercise frequency:
Tobacco/Alcohol
 Former Current Never
Drinks alcohol [Details](#)

Entries from the HPI popups display on the SOAP Tab.

Specialty: Gynecology | Visit Type: Office visit - GYN

Intake | **Histories** | SOAP | Finalize | Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

Care Guidelines | Global Days | Panel Control: Toggle Cycle

Reason for Visit

Introduction:
This 26 year old female presents for annual exam.

Do not launch HPI ◆ Intake Comments

Reason for Visit	History of Present Illness
annual exam	Gravida: 2. Parity: Term: 1. Abortion: 1. Living: 1. The patient states she uses oral contraceptive for birth control. Last LMP was 03/04/2014. Her menses is regular with a frequency of every 28 days. Negative for dysmenorrhea and menorrhagia. Negative for: breast lump(s) and breast pain. Pertinent negatives include dyspareunia, history of infertility, sexual dysfunction, urinary incontinence, urinary urgency, vaginal discharge and vaginal itching. The patient does not use tobacco. She does drink alcohol. Additional information: Doing well; no complaints.

abnormal pap smear
abnormal bleeding
amenorrhea
annual exam
breast mass/lump
contraception
genital lesion
menopausal symptoms
pelvic mass/cyst
STD exposure
urinary incontinence
urinary symptoms
pelvic pain
vaginal discharge/itching

Additional / Manage

Diagnostics | Comments

Specialty ▾ Gynecology

Visit Type ▾ Office Visit - GYN

Intake

Histories

SOAP

Finalize

Checkout

Comments about HPI Popups:

- HPI popups can present a rapid way to document key elements of the HPI if the user is very familiar with the popup. This Well Woman HPI may actually fit your needs quite well.
- For some common complaints you may find yourself saying the same thing repeatedly throughout the day, & using presets may be of help there—though it takes some care not to inadvertently document erroneous or conflicting HPI details when the patient's story differs from the preset.
- And the elements you pick allow the coding assistant to help you bill for the visit—particularly useful for new patient encounters, which require all 3 billing elements.

Specialty ▾ Gynecology

Visit Type ▾ Office Visit - GYN

Comments about HPI Popups:

- But many users find the "pick & click" nature of using HPI popups tedious, slow, & frustrating—and distracting when trying to perform documentation in real time in the exam room.
- The Comments boxes on the HPI popups provide only a limited amount of space to type, which can vary from one to another, so that you never know when you're going to run out of space.
- And when entries from a series of "picks & clicks" are condensed into something resembling English, the result is often awkwardly-worded, not really reflecting any uniqueness of the story or the story-teller. Your eyes glaze over when you read it; often you can't even recognize whether you performed the visit or if it was done by one of your colleagues.

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

Reason for Visit

Introduction:

This 26 year old female presents for annual exam.

Do not launch HPI

Intake Comments

	Reason for Visit	History of Present Illness
<ul style="list-style-type: none"> abnormal pap smear abnormal bleeding amenorrhea annual exam breast mass/lump contraception genital lesion menstrual symptoms pelvic pain STI exposure urinary symptoms urinary symptoms pelvic pain vaginal symptoms 	annual exam	Gravida: 2. Parity: Term: 1. Abortion: 1. Living: 1. The patient states she uses oral contraceptive for birth control. Last LMP was 03/04/2014. Her menses is regular with a frequency of every 28 days. Negative for dysmenorrhea and menorrhagia. Negative for: breast lump(s) and breast pain. Pertinent negatives include dyspareunia, history of infertility, sexual dysfunction, urinary incontinence, urinary urgency, vaginal discharge and vaginal itching. The patient does not use tobacco. She does drink alcohol. Additional information: Doing well; no complaints.

There is an alternative many providers will find more comfortable than using the HPI popups. Click the Comments button.

Diagnostics Comments

Chief complaint/reason for visit:

Manage My Phrases

annual exam

My Phrases

1. Type whatever you want here for a Well Woman HPI. And save it as a My Phrase so you can quickly reuse it in the future.

- 2.

Here you have essentially unlimited space to type the story. Sketch it out with a few words & phrases in real time while interviewing the patient; flesh it out later if desired. You can jump from one complaint to another, just like patients do when telling their story. And you have access to **My Phrases**—a robust way to save & reuse text that you say repeatedly throughout the day. (Setup & use of **My Phrases** is covered in the User Personalization demonstration.)

- 6.

When done click **Save & Close**.

Save & Close

Cancel

Your entries are displayed. Note that use of HPI popups & HPI Comments are not mutually exclusive. Especially for new patients you may wish to use the "pick & click" options on the HPI popups for coding purposes, but use HPI Comments to actually "tell the story."

Introduction:

This 26 year old female presents for annual exam.

Do not launch HPI

- abnormal pap smear
- abnormal bleeding
- amenorrhea
- annual exam
- breast mass/lump
- contraception
- genital lesion
- menopausal symptoms
- pelvic mass/cyst
- STD exposure
- urinary incontinence
- urinary symptoms
- pelvic pain
- vaginal discharge/itching

Reason for Visit

annual exam (comments)

History of Present Illness

Type whatever you want here for a Well Woman HPI. And save it as a My Phrase so you can quickly reuse it in the future.

annual exam

Gravida: 2. Parity: Term: 1. Abortion: 1. Living: 1. The patient states she uses oral contraceptive for birth control. Last LMP was 03/04/2014. Her menses is regular with a frequency of every 28 days. Negative for dysmenorrhea and menorrhagia. Negative for: breast lump(s) and breast pain. Pertinent negatives include dyspareunia, history of infertility, sexual dysfunction, urinary incontinence, urinary urgency, vaginal discharge and vaginal itching. The patient does not use tobacco. She does drink alcohol. Additional information: Doing well; no complaints.

Diagnostics

Comments

Working down the **SOAP** tab, you come to the **Review of Systems**. Note that some items that are shared with the HPI popups may already be documented. For an established patient, this may be all the ROS you wish to perform.

Specialty ▼ Gynecology Visit Type ▼ Office Visit - GYN

Intake Histories **SOAP** Finalize Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

Care Guidelines | Global Days | Panel Control: [Dropdown] Toggle [Dropdown] Cycle [Dropdown]

Reason for Visit [Dropdown]

Review of Systems [Dropdown]

System	Neg/Pos	Findings
GU	Negative	Urgency and urinary incontinence.
Reproductive	Positive	Menses (Frequency: every 28 days. Last menses was 03/04/2014. Menses is regular), The patient is pre-menopausal.
Reproductive	Negative	Breast lump(s), breast pain, dysmenorrhea, dyspareunia, history of infertility, menorrhagia, sexual dysfunction, vaginal discharge and vaginal itching.

- Constitutional
- HEENT
- Respiratory
- Cardiovascular
- Vascular
- Gastrointestinal
- Genitourinary
- Reproductive
- Metabolic | Endocrine
- Neuro | Psychiatric
- Dermatologic
- Musculoskeletal
- Hematologic
- Immunologic
- General ROS - Female

If you need to record further ROS, a good place to start is with the one-screen ROS option you see, which is age & gender-specific. Click **General ROS - Female**.

Make additional entries as necessary. You can click on any system heading to take you to a more detailed ROS for that system. And you can save & reuse presets.

ROS-Female

Information on this ROS that has been pre-populated from a HPI must be changed on the HPI to prevent conflicting documentation.

ROS Defaults:

All neg

Constitutional

Neg Pos

Chills
 Fatigue
 Fever
 Malaise
 Night sweats
 Weight gain
 Weight loss
 Other:

All neg

Cardiovascular

Neg Pos

Chest pain
 Claudication
 Edema
 Palpitations
 Other:

All neg

Reproductive

Neg Pos

Abnormal Pap
 Dysmenorrhea
 Dyspareunia
 Hot flashes
 Irregular menses
 Vaginal discharge
 Other:

All neg

Neurological

Neg Pos

Dizziness
 Extremity numbness
 Extremity weakness
 Gait disturbance
 Headache
 Memory loss
 Seizures
 Tremors
 Other:

All neg

Musculoskeletal

Neg Pos

Back pain
 Joint pain
 Joint swelling
 Muscle weakness
 Neck pain
 Other:

All neg

HEENT

All neg

Neg Pos

Ear drainage
 Ear pain
 Eye discharge
 Eye pain
 Hearing loss
 Nasal drainage
 Sinus pressure
 Sore throat
 Visual changes
 Other:

All neg

Gastrointestinal

Neg Pos

Abdominal pain
 Blood in stools
 Change in stools
 Constipation
 Diarrhea
 Heartburn
 Loss of appetite
 Nausea
 Vomiting
 Other:

All neg

Integumentary

Neg Pos

Breast discharge
 Breast lump
 Brittle hair
 Brittle nails
 Hair loss
 Hirsutism
 Pruritis
 Mole changes
 Rash
 Skin lesion
 Other:

All neg

Psychiatric

All neg

Neg Pos

Anxiety
 Depression
 Insomnia
 Other:

All neg

Hematologic / Lymphatic

Neg Pos

Easy bleeding
 Easy bruising
 Lymphadenopathy
 Other:

All neg

Immunologic

All neg

Neg Pos

Contact allergy
 Environmental allergies
 Food allergies
 Seasonal allergies
 Other:

All others negative

When done click **Save & Close**.

Your new entries display.

You can also directly access other system-specific ROS popups from here to make additions, changes, & deletions.

Reason for Visit

Review of Systems

- Constitutional
- HEENT
- Respiratory
- Cardiovascular
- Vascular
- Gastrointestinal
- Genitourinary
- Reproductive
- Metabolic | Endocrine
- Neuro | Psychiatric
- Dermatologic
- Musculoskeletal
- Hematologic
- Immunologic
- General ROS - Female

System	Neg/Pos	Findings
Constitutional	Negative	Fever.
ENMT	Negative	Nasal drainage, otalgia, sinus pressure and sore throat.
Respiratory	Negative	Cough and dyspnea.
Cardio	Negative	Chest pain and edema.
GI	Negative	Diarrhea, heartburn, nausea and vomiting.
GU	Negative	Dysuria, urgency and urinary incontinence.
Neuro	Negative	Dizziness and headache.
MS	Negative	Joint pain.

And you can save & reuse all of these entries, whether entered on the one-screen ROS or the system-specific ones, as discussed in the User Personalization demo.

Continuing down the SOAP tab, you can review the Vital Signs again. You can add another entry, review a history of previous readings, or see them in graph form.

03/19/2014 09:34 AM : "**USA SOAP" x

Specialty ▼ Gynecology Visit T

Intake Histories

Standing Orders | Adult Immunizations

Care Guidelines | Global Days

Panel Control: ▼ Toggle ▲ ↺ Cycle ↻

Reason for Visit

Review of Systems

Vital Signs ⚠ Vital Signs Outside Normal Range

Health Promotion Plan | History | Graph

Time	Ht (in)	Wt (lb)	BMI	BP	Pulse	Respiration	Temp (F)	Pulse Ox Rest	BSA	Pain level	Comments
10:52 AM	65.00	184.00	30.62	128/82	84	16	98.6				

Add Edit Remove

Physical Exam

One Page Exam
Constitutional
Eyes
Ears
Neck | Thyroid
Lymphatic
Breast

Exam Findings Details

You'll next move down to the Physical Exam section.

First notice the **Office Diagnostics** button. That gives you a chance to review things like urinalyses, pregnancy tests, etc., that your nurse may have done for you through standing orders. Even though you had the chance to review those on the **Home Tab**, it may be that the results weren't available yet when you first went into the room.

There is no such data entered in this example.

One Page Exam
Constitutional
Eyes
Ears
Neck | Thyroid
Lymphatic
Breast
Respiratory
Cardiovascular
Genitourinary
Skin | Hair
Musculoskeletal
Neurological
Psychiatric
Additional

Exam Findings Details

Image

Office Diagnostics

Physical Exam documentation is performed similarly to the ROS demonstrated above. You can directly access any system from the headings on the left, but you'll often want to start with the age & gender-specific **One Page Exam**.

Review of Systems

Vital Signs  Vital Signs Outside Normal Range

Physical Exam

- One Page Exam
- Constitutional
- Eyes
- Ears
- Neck | Thyroid
- Lymphatic
- Breast
- Respiratory
- Cardiovascular
- Genitourinary

Exam Findings Details



Even better, start from a saved preset, as covered in the User Personalization lesson.

While you may well complete the physical exam documentation later after you're done working with the patient, for the ease of discussion I'll go ahead & do it now, illustrating the value of using saved preset exams.

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize Checkout

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

- Reason for Visit
- Review of Systems
- Vital Signs ⚠ Vital Signs Outside Normal Range
- Physical Exam

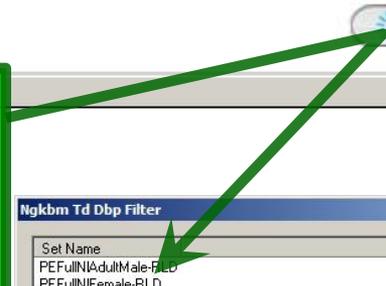


I'm going to click the Open Preset icon & double-click on **PEFullNIFemale-RLD**, a preset I've previously saved as my starting point for a typical normal exam for an adult female. It includes items entered via the One Page Exam & some of the system-specific exams. (Details on setup of these presets are covered in the User Personalization demo.)

Ngkbn Td Dbp Filter

Set Name
PEFullNIAultMale-RLD
PEFullNIFemale-RLD

Refresh OK Cancel



Your exam displays. You can select aspects of the exam from the menu on the left, & modify findings as necessary for the individual patient.

Care Guidelines | Global Days | Panel Control: [Toggle] [Cycle]

Reason for Visit [v]
Review of Systems [v]
Vital Signs [v]
Physical Exam [v]

One Page Exam
Constitutional
Eyes
Ears
Neck | Thyroid
Lymphatic
Breast
Respiratory
Cardiovascular
Genitourinary
Skin | Hair
Musculoskeletal
Neurological

Exam	Findings	Details
Constitutional	Normal	Well developed.
Neck Exam	Normal	Palpation - Normal. Thyroid gland - Normal.
Breast	Normal	Inspection - Bilateral: Normal. Palpation - Bilateral: Normal.
Respiratory	Normal	Auscultation - Normal. Effort - Normal.
Cardiovascular	Normal	Regular rhythm. No murmurs, gallops, or rubs.
Abdomen	Normal	No abdominal tenderness.
Genitourinary	Normal	Urethral meatus - Normal. External genitalia - Normal. Perineum - Normal. Vagina - Normal. Cervix - Normal. Adnexa - Normal. No suprapubic tenderness. No vaginal discharge.
Extremity	Normal	No edema.

Using this combination of presets & editing of only specific pertinent findings, sometimes called **documentation by exception**, is a powerful & rapid way to record an accurate exam, customized to the way you want to say it.

Assessment/Plan

Assessments

Moving to the bottom of the **SOAP** tab, you might next perform any of several activities: Document assessments & plans, prescribe meds, order labs, plan X-rays, or request referrals.

For this exercise, let's address **Assessment/Plan**. Begin by clicking the **Add/Update** button.

Resident-Attending discussion took place Attending saw patient

Consent Procedure Scheduling **Add/Update** Remove

✦ Consent



Provider Comm.



Meds



Procedures



Patient Plan

Visit Document

Document Library



EM Coding



Dictation

Today's Concerns/Reason for Visit:

1. annual exam

(Select a row from any grid to add to Today's Assessments) Add Assessments on 1-click

Diagnosis History Show Chronic only

Diagnosis Description	Code

Clinical Problems

Show Chronic Show My Tracked problems No active problems

Description	Onset Date
Allergic rhinitis	

My Favorites Favorites Category: All Filter:

Description	Code
Benign essential hypertension	401.1
Coronary artery disease	414.00
Cough	786.2
CVA	434.91

Add Common Assessment | Diagnosis Code Lookup

Dx description: Code: Status: Site:

Impression: Differential Dx:

Mark diagnosis as chronic Add assessment to: Clinical problems My tracked problems My favorites

Add/Update

Today's Assessments

Description	Code	Status	Site	Impression/Differential Dx

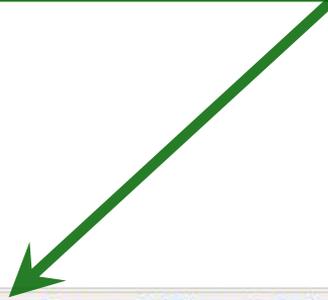
A group of tabbed popups appears; let's call this the **Assessment-Plan Suite**. Here you have multiple ways to select diagnoses. The easiest involve picking something from the patient's previous **Diagnoses History**, the **Problems** list, or your **My Favorites** list.

Save & Close Sort Remove

Today's Concerns/Reason for Visit:

1. annual exam

Clicking the **Add Common Assessment** button will give you a superbill-like short list of common diagnoses.



[Add Common Assessment](#) | [Diagnosis Code Lookup](#)

My Favorites Favorites Category: All Filter:

Description	Code
Benign essential hypertension	401.1
Coronary artery disease	414.00
Cough	786.2
CVA	434.91

Dx description: Code: Status: Site:

Impression: Differential Dx:

Mark diagnosis as chronic Add assessment to: Clinical problems My tracked problems My favorites

Add/Update

Today's Assessments

#	Description(code) Status Site	Impression/Differential Dx
---	-------------------------------	----------------------------

Save & Close

Sort

Remove

Common Assessments: GYN Assessment

Breast
+ Benign
+ Malignant

Cervix
+ Cancer
+ Dysplasia
+ Other
+ PAP Smear Results

Ovaries
+ Benign
+ Malignant

Peritoneum
Adhesions 614.6
Endometriosis 617.3
Pelvic inflam disease 614.9
Peritonitis 614.5

Urinary tract
Dysuria
+ Incontinence
+ Infection

Uterus
+ Benign
+ Malignant
Pelvic rela

Today's Ass

#	Diagn

Vagina
+ Malignant or PreMalig
+ Other
+ Prolapse
+ Vaginitis/osis

Vulva
+ Bartholin's gland
Benign neoplasm, vulva 221.2
+ Infection
Malignant neoplasm, vulva 183.4
+ Vulvovaginitis

Anus
+ Lesions

Screening
+ Follow-up abnormal
+ Pregnancy-related
+ Routine Gyn

Click Routine GYN & pick ROUTINE GYN EXAMINATION V72.31 from the ensuing popup.

Menopausal symptoms	627.2
Osteopenia	722.90
Osteoporosis, unspec	733.01
Postmenopausal bleeding	627.1
Premature menopause	256.31
Premenopausal menorrhagia	627.0
Symptomatic, artificial	627.4
Symptomatic, natural	627.2

Menstruation	
Amenorrhea	626.0
Dysfunct uterine bleeding	626.8
Dysmenorrhea	625.3
Irregular menstruation	626.4
Menorrhagia	626.2
Metrorrhagia	626.6
Postcoital bleeding	626.7
Premenstrual syndrome	625.4

Pregnancy	
Ectopic pregnancy	633.10
Missed abortion	632
Spontaneous abortion	634.90
Voluntary termination	635.92

Routine Counseling	
Preconception counseling	V26.49

Signs/symptoms
+ Dietary
+ Mental Health
+ Other
+ Sexual

Ngkbn Get Common DbpickList

DESCRIPTION	Code
ROUTINE MEDICAL EXAM	V70.0
ROUTINE GYN EXAMINATION	V72.31
SCRN OTH SPCF CHLMYD DIS	V73.88
SCREEN FOR VENERAL DIS	V74.5
SCREEN MAMMOGRAM HI RISK	V76.11
SCREEN MAMMOGRAM NEC	V76.12
SCRN MAL NEO BREAST NEC	V76.19
SCREEN MAL NEOP-CERVIX	V76.2
SCREEN MALIG NEOP-VAGINA	V76.47

Refresh OK Cancel

	Code	Status

Remove Save & Close

Common Assessment

Common Assessments:

- Breast**
 - + Benign
 - + Malignant
- Cervix**
 - + Cancer
 - + Dysplasia
 - + Other
 - + PAP Smear Results
- Vagina**
 - + Malignant or PreMalignant
 - + Other
 - + Prolapse
 - + Vaginitis/osis
- Vulva**
 - + Bartholin's gland
 - + Benign neoplasm, vulva 221.2
 - + Infection
- Screening**
 - + Follow-up abnormal
 - + Pregnancy-related
 - + Routine Gyn
- Family planning**
 - + IUD
 - + Oral Contraceptives
 - + Other
- Other Infections**
 - + Folliculitis 704.8
 - + HIV 647.69
 - + Sexually transmitted
- Adhesions** 614.8
- Endometriosis** 617.3
- Pelvic inflam disease** 614.9
- Peritonitis** 614.5
- Urinary tract**
 - + Dysuria 788.1
 - + Incontinence
 - + Infection
- Uterus**
 - + Benign
 - + Malignant
 - + Pelvic relaxation 618.89

Ngkbn Get Common DbpickList

DESCRIPTION	Code
OBESITY NOS	278.00
MORBID OBESITY	278.01
OVERWEIGHT	278.02

Refresh OK Cancel

Given her BMI, we'll also click Dietary & add OBESITY NOS.

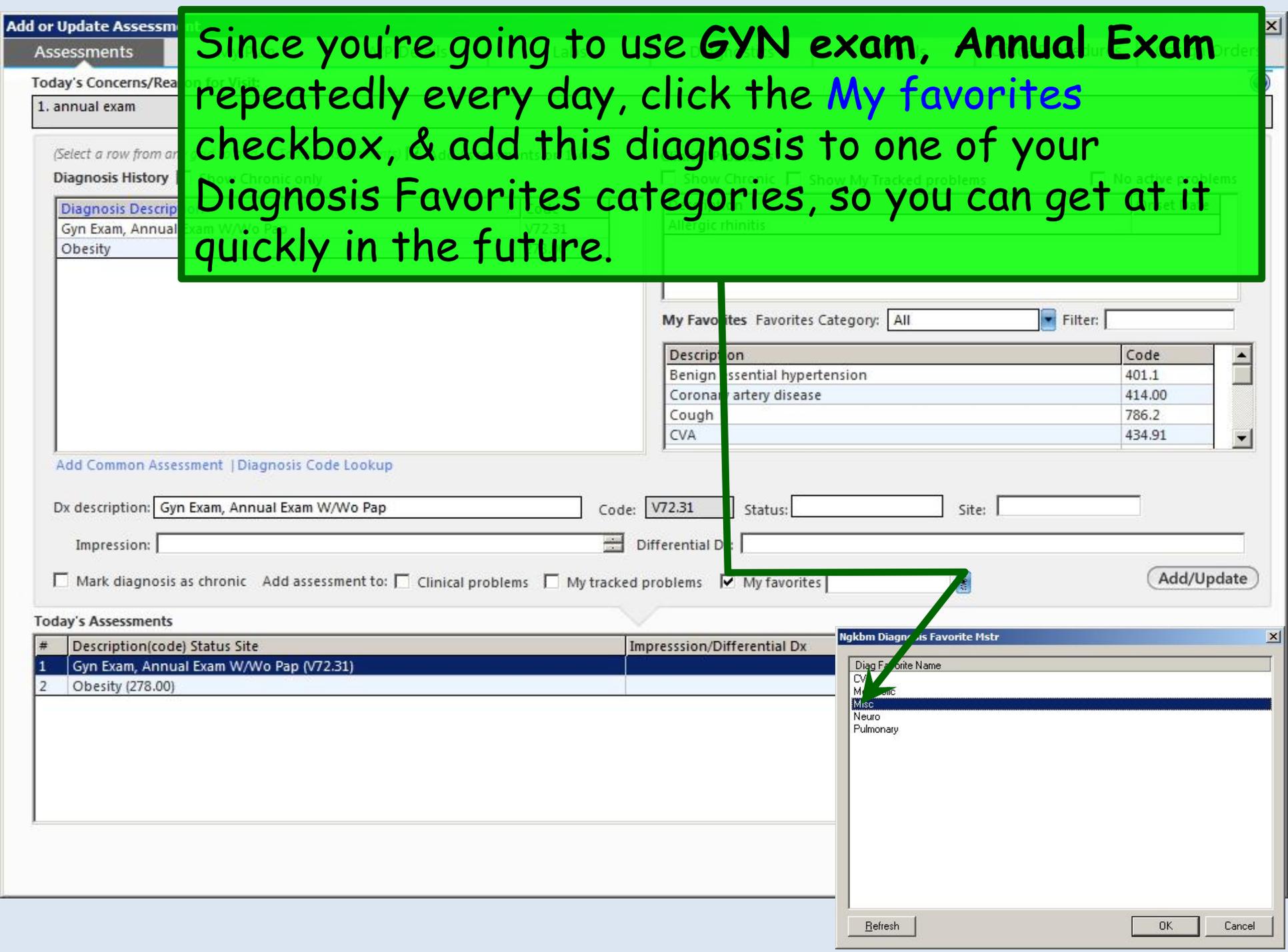
When done click Save & Close.

Today's Assessments

#	Diagnosis Description	Code	Status
1	Gyn Exam, Annual Exam W/Wo Pap	V72.31	

Remove Save & Close

Since you're going to use GYN exam, Annual Exam repeatedly every day, click the **My favorites** checkbox, & add this diagnosis to one of your Diagnosis Favorites categories, so you can get at it quickly in the future.



Add or Update Assessment

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Cosign Orders

Today's Concerns/Reason for Visit:

1. annual exam

(Select a row from any grid to add to Today's Assessments) Add Assessments on 1-Click

Diagnosis History Show Chronic only

Diagnosis Description	Code
Gyn Exam, Annual Exam W/Wo Pap	V72.31
Obesity	278.00

Clinical Problems

Show Chronic Show My Tracked problems No active problems

Description	Onset Date
Allergic rhinitis	

Similarly, **Add Obesity** to the **Clinical problems** list, & mark it as **chronic**.

Now let's document some plans. The **My Plan** tab has some potential, but we're still investigating how well that can be applied to our practice setting. So let's move on to **A/P Details**.

Add Common Assessment | Diagnosis Code Lookup

Dx description:

Code:

Impression:

Mark diagnosis as chronic Add assessment to: Clinical problems My tracked problems

Today's Assessments

#	Description(code) Status Site	Impression/Differential Dx
1	Gyn Exam, Annual Exam W/Wo Pap (V72.31)	
2	Obesity (278.00)	

Save & Close

Sort

Remove

Assessment Plan Details

Assessments | My Plan | **A/P Details** | Labs | Diagnostics | Referrals | Office Procedures | Cosign Orders

Today's Assessments: (Select an assessment and enter the details below.)

Assessment/Plan Expanded View

#	Description	Code	Status
1	Gyn Exam, Annual Exam W/Wo Pap	V72.31	
2	Obesity	278.00	

Selected Assessment:

Impression/Comments:

Differential Diagnosis:

(Only the first 215 characters will be displayed in the Diagnosis Module.)

Plan Details

[Previous Patient Details](#) | [Previous Provider Details](#) | [Health Promotion Plan](#)

Patient Details:

Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.

Provider Details:

Record your plans. While you can type your instructions here, you can also use **My Phrases** to greatly reduce your work for things you say repeatedly. (Setup of **My Phrases** is discussed in the User Personalization demo.)

Assessment Plan Details

Assessments | My Plan | A/P Details | **Labs** | **Diagnostics** | Referrals | Office Procedures | Cosign Orders

Today's Assessments: (Select an assessment and enter the details below.) Assessment/Plan Expanded View ⓘ

#	Description	Code	Status
1	Gyn Exam, Annual Exam W/Wo Pap	V72.31	
2	Obesity	278.00	

If we wanted to order X-rays or Referrals, we could do so using the Diagnostics or Referrals Tabs above. (We don't use the Labs Tab at present, since we have another way to place lab orders.) Those are covered in other lessons, so we won't do that on this encounter.

Previous Patient Details | Previous Provider Details | Health Promotion Plan

Patient Details: My Phrases Common Phrases

Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.

Provider Details: My Phrases Common Phrases

If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.

(Provider details will not print on the patient plan.)

Today's Orders:

When done click Save & Close.

Manage My Phrases Save & Close Cancel

Assessment/Plan

Your assessments & plans display.

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

Health Promotion Plan

1.	Assessment	Gyn Exam, Annual Exam W/Wo Pap (V72.31).
	Patient Plan	Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2.	Assessment	Obesity (278.00).
	Patient Plan	Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
	Provider Plan	If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.

Let's complete her prescriptions. Click **Meds**.

 Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

+ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

03/19/2014 09:34 AM : **USA SOAP

Medications Module

White Grid Preferences 26 year Old Female Weighing 184.00 lb | 83.46 Kg

Last Audit	Status	Medication Name	Generic Name	Start Date	Stop Date	Sig	Original Start
Status: Active (3 items)							
	Active	Levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet	LEVONORGESTREL-ETH ESTRADIOL	03/19/2014		1 daily	03/19/2014
	Active	loratadine 10 mg tablet	LORATADINE	03/19/2014		1 daily as needed for allergies	03/19/2014
	Active	Singulair 10 mg tablet	MONTELUKAST SODIUM	03/19/2014		1 daily	03/19/2014

Prescribe New Print Send Renew Interactions Stop Resources Dose Range Delete Eligibility Medication History Reconcile

Levonest (28) 50-30 (6)/75-40(5)/125-30(10) tablet Max. daily dose not checked - U

Sig: 1 daily [Remove Sig](#) [Edit Sig...](#)

Quantity: 1 Units: Tablet Refills: 11 Dispense As Written Prescribed Elsewhere Source:

Start: 03/19/2014 Stop: 03/20/2014 Duration:

Comments: *This field is for nonclinical comments to the pharmacist. Any additional clinical instructions for this prescription should be added using the 'Additional Instructions' segment of the Sig Builder.* PRN Reason:

Problem: [Add...](#)

Provider: DUFFY, ROBERT LAMAR MD

Location: USA FAMILY MEDICINE

Medication Module details are reviewed in another lesson.

We've refilled & ERx'd her birth control pill; the other meds are prescribed by another doctor. Close the med module & return to the **SOAP Tab**.

Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

Health Promotion Plan

1.	Assessment	Gyn Exam, Annual Exam W/Wo Pap (V72.31).
	Patient Plan	Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2.	Assessment	Obesity (278.00).
	Patient Plan	Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
	Provider Plan	If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.

The patient needs a work excuse, which might be generated by you or your nurse. Open the **Document Library**.

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

+ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

You have several options for generating a work excuse.

05/28/2014 10:08 AM : "USA Document Library" x

General

After Hours Care Note
Chart Summary
Confidential Note
Controlled Substance Agreement, Full
Controlled Substance Contract, Brief
Counseling Notepad
Discharge Summary-Preliminary
Durable Medical Equipment Order
FreeText
Hospital-Clinic Continuity Note
Immunization Record

Lab Results-All
Lab Results-Last 30 Days
Medication List
Missed Appointment Reminder
Patient Plan
Safety Contract
Telephone Notes/Clinic Memos
Visit Note (Master Document)
Vital Signs History
Weight Loss Program Sheet

Letters

Letter About Patient
Letter To Patient
Letter From Consultant
Letter To Consultant
Work/School Excuse Note
Work/School Excuse Note-FM
Work/School Excuse Note-Peds
Work/School Status, Brief
Work/School Status, Detailed

Assessments and Tools

ACC/AHA ASCVD Risk Estimator
Behavioral Assessments & Tools
Edinburgh Postnatal Depression Scale
Generate Report Scoring
Mini Mental Status Exam
Pediatric Symptom Checklist
St. Louis Univ Mental Status Exam (SLUMS)
SLUMS Diagram Generate Report

Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

Health Promotion Plan

1.	Assessment	Gyn Exam, Annual Exam W/Wo Pap (V72.31).
	Patient Plan	Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2.	Assessment	Obesity (278.00).
	Patient Plan	Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
	Provider Plan	If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.

One of the Meaningful Use criteria requires patients to receive a summary of the visit. Click [Patient Plan](#).

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

+ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

PATIENT PLAN FOR 03/20/2014

Name: Felonie Quagmire
Date of Birth: 01/06/198
Date of Visit: 03/20/2014
Visit Type: Office Visit - GY
Location: USA FAMILY MEDI

The Patient Plan generates. Click the **Printer icon** to print it, then return to the **SOAP Tab**.

Thank you for choosing us for your healthcare needs. The following is a summary of the outcome of today's visit and other instructions and information we hope you find helpful.

Primary Care Provider: STEPHEN VARNER MD

REASON(S) FOR VISIT

annual exam.

Assessment/Plan

It can be challenging from a time management standpoint to generate a **Patient Plan** before the patient leaves. This will become easier when we have expanded ways to electronically communicate with patients. In the meantime a strategy is to complete a very bare-bones assessment & plan, prescribe meds, then generate the **Patient Plan**. Print this for the patient, then flesh out the details later.



Assessment/Plan

Assessments

My Plan

A/P Details

Labs

Diagnostics

Referrals

Office Procedures

Review/Cosign Orders

View Immunizations

Office Diagnostics

Physical Therapy Orders

Health Promotion Plan

1.	Assessment	Gyn Exam, Annual Exam W/Wo Pap (V72.31).
	Patient Plan	Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2.	Assessment	Obesity (278.00).
	Patient Plan	Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
	Provider Plan	If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.

Now generate today's visit note.
One way to do this would be to
click [Visit Document](#).

Resident-Attending discussion took place Attending saw patient

Consent

Procedure Scheduling

Add/Update

Remove

+ Consent

Provider
Comm.

Meds



Procedures

Patient
Plan

Visit Document

Document Library



EM Coding



Dictation

PATIENT: Felonie Quagmire
DATE OF BIRTH: 01/06/1988
DATE: 03/19/2014 9:34 AM
VISIT TYPE: Office Visit - GYN

This 26 year old female presents for annual exam.

History of Present Illness:

1. annual exam
Gravida: 2. Parity: Term: 1. Abortion: 1. Living: 1. The patient states she uses oral contraceptive for birth control. Last LMP was 03/04/2014. Her menses is regular with a frequency of every 28 days. Negative for dysmenorrhea and menorrhagia. Negative for: breast lump(s) and breast pain. Pertinent negatives include dyspareunia, history of infertility, sexual dysfunction, urinary incontinence, urinary urgency, vaginal discharge and vaginal itching. The patient does not use tobacco. She does drink alcohol. Additional information: Doing well; no complaints.
Type whatever you want here for a Well Woman HPI. And save it as a My Phrase so you can quickly reuse it in the future.

Nursing Comments:

Intake Comments: Needs p...

Gynecologic History:

Patient is premenopausa...



Your visit note displays. You can review & edit it if desired. You can also click the **Check Mark** to sign it off; this is the same as signing the document in your PAQ.

Navigation

- Inte...
- History
- SOAP
- Finalize
- Check Out

> Order Management

- > Orders/Plan
- > Standing Orders
- > Standing Orders

Anticoagulation

- Procedures
- Tobacco Cessation
- Tuberculin Skin Test
- Nutrition

Chart Abstraction

- Demographics
- Document Library
- Immunizations
- Patient Comment
- Provider Test Action
- Vital Signs
- Screening Tools
- CQM Check
- MU Check

Preview Offline

But it can take 30-60 seconds to generate the document in real time, which can be annoying when you're trying to move on to the next patient. As an alternative, you can generate the note **offline**. To do this, hover the mouse over **Navigation** to get the **Navigation Bar** to slide out.

When the **Navigation Bar** displays, click **Offline**.

ion took place Attending saw patient

Consent Procedure Scheduling Add/Update Remove

Consent

Meds Procedures Patient Plan Visit Document Document Library EM Coding Dictation

Assessment/Plan

- Assessments
- My Plan
- A/P Details
- Labs
- Diagnostics
- Referrals
- Office Procedures
- Review/Cosign Orders
- View Immunizations
- Office Diagnostics
- Physical Therapy Orders
- Health Promotion Plan

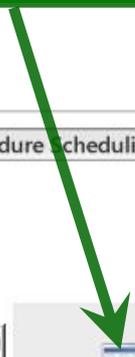
1.	Assessment	Gyn Exam, Annual Exam W/Wo Pap (V72.31).
	Patient Plan	Refilled birth control pills. Continue to use condoms to provide some protection against sexually transmitted diseases. Otherwise, continue yearly checkups.
2.	Assessment	Obesity (278.00).
	Patient Plan	Attention to wt; minimize high-calorie/fatty foods & salt. Exercise daily. Given 1500 calorie meal plan.
	Provider Plan	If successful with 1500 cal, we could drop to 1200 cal if she'd like a little faster wt loss.

Now move to the **Finalize Tab**. You can do this by navigating back to the top & clicking the **Finalize Tab**, but if you're at the bottom of the **SOAP Tab**, there is a shortcut to get there directly. Click **EM Coding**.

Resident-Attending discussion took place Attending saw patient

Consent Procedure Scheduling Add/Update Remove
 + Consent

Provider Comm. Meds Procedures Patient Plan Visit Document Document Library EM Coding Dictation



E&M coding for well woman visits can vary by insurance. The proper preventive visit code for an established 18-39 year old patient is 99395, which you could select manually if you know that.

Clicking **Additional E&M Code** will give you some more clues.

General

Established patient New patient

PE Type: Multi system Single system:

E&M Guidelines 1997:

Today's Assessment

Provider Sign Off

Physician Sign Off Request:

Submit to supervising physician for review

Evaluation and Management Coding

Medical Decision Making [View MDM Guidelines](#) | [View Risk Table](#)

Straight forward Low complexity
 Moderate complexity High complexity

Counseling

Counseled greater than 50% of time and documented content

Total visit time (minutes): [Counseling Details](#)

Total counsel time (minutes):

Evaluation and Management Code

Visit code:

Modifier(s):

Calculated EM code:

Submitted code:

Calculated eRx code:

Submitted eRx code:

[Additional E&M Code](#) | [View Other Codes](#) | [SNOMED Visit Type \(optional\)](#) | [Medicare Preventive Codes](#)

New patient:

99201
 99202
 99203
 99204
 99205

Established:

99211
 99212
 99213
 99214
 99215

Consultation:

99241
 99242
 99243
 99244
 99245

Preventive new:

99381
 99382
 99383
 99384
 99385
 99386
 99387

Preventive established:

99391
 99392
 99393
 99394
 99395
 99396
 99397

Preventive counseling:

99401
 99402
 99403
 99404

Post Op:

99024

Prenatal:

Visit 4-6:
 59425

Visits greater than 6:

59426

Behavioral Health:

90791 (Initial eval, no med services)
 90792 (Initial eval. w/ med services)

90846 (Family/Couple therapy w/o patient)

This popup points you toward the 99395 code.

Clicking in one of the Other boxes also provides another piece of info: if the patient has BCBS insurance, we would add code S0612 as well. (This patient doesn't have BCBS.)

Standing Orders | Adult Immunizations | Peds Immunizations

Additional E&M Code

(Only 2 codes may be selected from this pop-up. If more than 2 are needed, they must be added in the procedure module.)

Established:
 99211
 99212
 99213
 99214
 99215

Preventive established:
 99391 (Infant less than 12 months)
 99392 (1 - 4 years)
 99393 (5 - 11 years)
 99394 (12 - 17 years)
 99395 (18 - 39 years)
 99396 (40 - 64 years)
 99397 (65 years and older)

Prolonged services:
 Face to face: Total time: minutes
 Start Time: End Time:
 No. face to face: Total time: minutes
 Start Time: End Time:

Behavioral Health:
Psychotherapy w/ EM:
 90833 (30 min)
 90836 (45 min)
 90838 (60 min)
 90785 (Interactive Psychotherapy)
 90863 (Med Management w/ psychotherapy)
 Crisis Psychotherapy Total time: minutes

Additional Behavioral Health Codes:
 Code: Description:

Other:
 Code: Description:
 99050 (Services provided during non-regular h...
 99051 (Services provided during evenings, weekends, or holidays)

Service Item Mstr

Service Item Id	Description
S0613	ANNUAL BREAST EXAM (BCBS)
S0612	ANNUAL GYN EXAM NEW PT (BCBS)
S0610	ANNUAL GYN EXAM EST PT BCBS
G0439	Annual Wellness Visit, Established
G0438	Annual Wellness Vst, Initial
99363	ANTICOAG MGMT, INIT
99364	ANTICOAG MGMT, SUBSEQ
99450	Basic life/disability examination
G0101	CA SCREEN, PELVIC/BREAST EXAM
G8510	Depression Screen Neg
G8431	Depression Screen Pos, F/U Planned
G0108	DIAB MANAGE TRN PER INDIV
G0109	DIAB MANAGE TRN IND/GROUP
99499	E/M service NEC
G0181	HOME HEALTH CARE SUPERVISION
G0182	HOSPICE CARE SUPERVISION
99461	INITIAL NEWBORN SCREENING
G0180	MD CERTIFICATION HHA PATIENT
G0179	MD RECERTIFICATION HHA PT

We'll select 99395 then Save & Close out of these popups.

Click Submit Code.

Residents will need to click Submit to supervising physician for review.

Visit code: 99395

Modifier(s):

Calculated EM code:

Submitted code:

Calculated eRx code:

Submitted eRx code:

◆ Additional E&M Code | ✦ View Other Codes | ✦ SNOMED Visit Type (optional) | ✦ Medicare Preventive Codes

New patient:

- 99201
- 99202
- 99203
- 99204
- 99205

Established:

- 99211
- 99212
- 99213
- 99214
- 99215

Consultation:

- 99241
- 99242
- 99243
- 99244
- 99245

Preventive new:

- 99381
- 99382
- 99383
- 99384
- 99385
- 99386
- 99387

Preventive established:

- 99391
- 99392
- 99393
- 99394
- 99395
- 99396
- 99397

Preventive counseling:

- 99401
- 99402
- 99403
- 99404

Post Op:

- 99024

Prenatal:

- Visit 4-6:

- 59425

Visits greater than 6:

- 59426

Behavioral Health:

- 90791 (Initial eval, no med services)
- 90792 (Initial eval, w/ med services)

- 90846 (Family/Couple therapy, w/o patient)

03/19/2014 09:34 AM : "*USA SOAP" 03/19/2014 09:34 AM : "*Finalize" x

TOB HTN DM CAD

Specialty ▾ Gynecology Visit Type ▾ Office Visit - GYN

Intake Histories SOAP **Finalize** Checkout

Standing Orders | Adult Immunizations | Peds Immunizations | My Plan | Procedures | Order Management | Document Library

Care Guidelines | Global Days

Panel Control:

Established patient New patient

PE Type: Multi system Single system: E&M Guidelines1997:

Today's Assessment Provider Sign Off

Physician Sign Off Request:
 Submit to supervising physician for review

Evaluation and Management Coding

Medical Decision Making View MDM Guidelines | View Risk Table
 Straight forward Low complexity
 Moderate complexity High complexity

Total visit time (minutes): ✦ Counseling Details
Total counsel time (minutes):

A resident also needs to view encounter properties to set the Supervising Physician for billing purposes. Right-click on the **encounter folder** & select **Properties** in the popup.

The screenshot displays a medical software interface. A window titled "Patient History" is open, showing a list of folders. A context menu is open over a folder dated "03/15/2014 10:06 PM". The menu items are: Expand All, Expand Most Recent, Expand Unlocked, Collapse All, Lock Encounter..., Delete Encounter..., Encounter Level Insurance..., Customize Display..., Case..., Encounter Description/Remark..., and Properties... (highlighted with a green arrow). The background interface includes sections for "General" (Established patient, New patient, PE Type), "Today's Assessment", "Provider Sign Off" (Physician Sign Off Request, Medicare Patient Incident Sign Off), and "Evaluation and Management Coding" (Medical Decision Making, Counseling).

Billable Date: 04/19/2013
Billable Time: 9:32 A
Occurrence Code: [dropdown]
State: [dropdown]
Onset Date: [calendar]
Onset Time: [calendar]

The resident doctor clicks the Supervisor dropdown arrow & selects the attending.

Claims | Marketing | Properties | History

Providers
Rendering: DELP, MEREDITH R
Referring: [dropdown]
Referring Facility: [dropdown]
First Consulting: [dropdown]
Supervisor: BODIE, FRANKIE LAVONE
BEAVER, BARNEY
BENJAMIN, JOHN T
BETTENCOURT, ROBERT B
BHOWMICK, SAMAR K
BLAIR-ELORTEGUI, JUDY
BODIE, FRANKIE LAVONE
BRADHAM, KARI
BRANDON, JEFFREY C

Complaints: [text]
Date Last Seen: [calendar]
Admit Date: [calendar]
Discharge Date: [calendar]
Initial Treatment Date: [calendar]
Facility: [dropdown]
Encounter Types: Billable;Clinical
 Print Encounter On Statements Patient is Homebound
 Exempt from Outsourcing
Case: [text] Case Date: [calendar]
Service Type: [dropdown]

Then click OK to close the popup.

Specialty Gynecology Visit Type Office Visit - GYN

Intake Histories SOAP Finalize **Checkout**

Standing Orders Adult Immunizations Peds Immunizations My Plan Procedures Order Management Document Library

Care Guidelines Global Days

Panel Control: Toggle Cycle

Today's Orders

Lab/Radiology Order Processing Task Immunizations

	Status	Lab Order	Timeframe	Comments
<ul style="list-style-type: none">Labs<ul style="list-style-type: none">DiagnosticsReferralsOffice ServicesProceduresFollow upMedications (3)Patient EducationPhysical Therapy				

Requisition

The **Checkout Tab** may be utilized by office staff to document completion of various orders, referrals, appointments, etc. The degree & manner of its use will be individualized to the workflow of each clinic.

This concludes the
NextGen GYN Routine Annual Visit
demonstration.

The colder the X-ray table, the more
of your body is required to be on it.