# PowerChart – histories

## Care Delivery

### Quick reference guide

PowerChart provides historical information to assist in decision making about the appropriate treatment based on the patient's previous experiences.

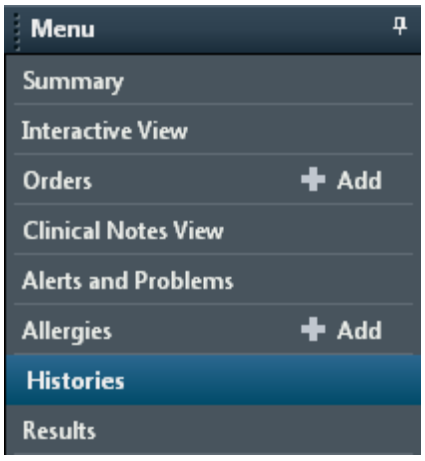
The Histories profile page provides a single area to document and review the following patient history data:

- Family history
- Past medical procedures
- Social history

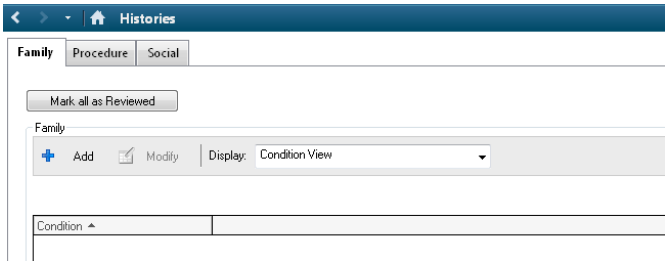
## Viewing the histories profile page

To open Histories for a patient:

1. Select Histories from the Menu bar.




The Histories profile page will display.




The number of tabs displayed in the Histories page will vary depending upon the user's login. History can be added by Family, Procedure and Social categories.

## Family history

The Family tab will display as the default page in condition view.

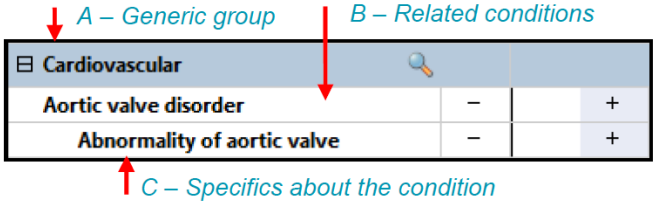
Family history can be documented for the patient by family members or by medical condition. There are three different views for family history information:

- Condition View
- Family Member View (Positive Only)
- Family Member View (All)

## Condition View

A family member's history can be displayed with three levels of detail about a condition.

The third level is optional when a positive condition is added and more specific details are required to describe the condition.



- A – Generic grouping of conditions
- B – Related conditions within the group
- C – Specific description of a condition

**Note:** Conditions are marked as positive to indicate the family member has a history of the selected condition or negative if they do not have a history.

## Family member view (all)

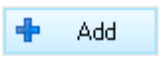
The Family Member View (All) displays history by family member. Additionally, the view displays any conditions that are marked as negative for each family member. Conditions that are marked negative always display after the positive conditions.

## Family member view (positive only)

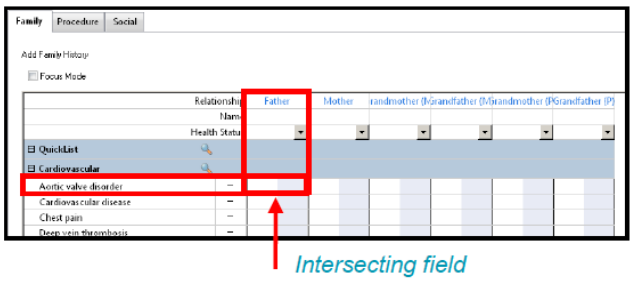
The Family Member View (Positive Only) displays history by the affected family member and only displays conditions that have been marked positive for each family member. Conditions marked negative are hidden unless the entire family history is marked as negative.

## Adding family history

To add a family member history:

1. Click on the Add  icon.






The Add Family History page displays with six default relationships of parents and grandparents.

2. Select the cell that intersects the family member column and condition line.
3. Click in the blue shaded cell to enter a plus sign to indicate that a family member has a history of the condition.

Or

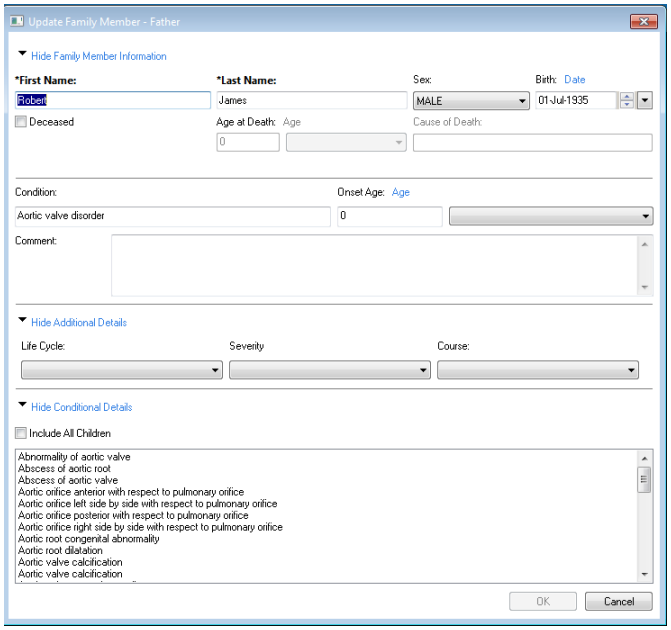
Click in the white cell to enter a minus sign to indicate that a family member does not have a history of the condition.

**Note:** To automatically mark a condition as negative for all family members, click the minus sign to the right of the condition. To clear a cell you have marked in error, right click on the Clear button.

For a positive condition, the system will prompt to double click the blue cell to add additional details such as:

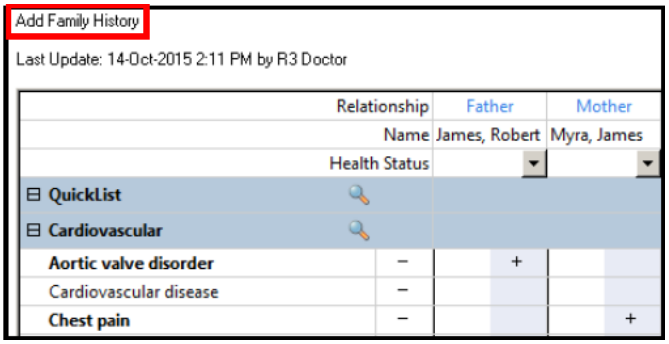
- Age of onset
- Comments
- Condition specific information

4. Double click on the blue cell for the condition to add the level of details required.



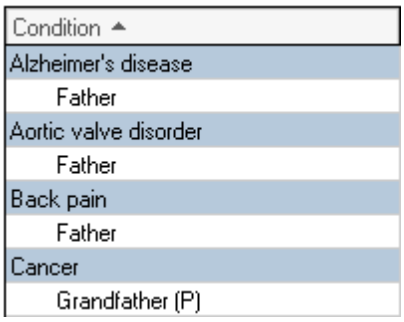

The Update Family Member [Name] window will display.

5. Add details as required. First Name and Last Name are mandatory fields.
6. Click OK.



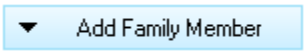

The Add Family History page will display.

7. Repeat steps 2 to 7 as required for each family member.
8. Click OK.




The condition and relevant family member display as a list on the Family page.

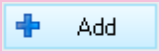
To add another family member to the list from the Add Family History page:

1. Click the  button.


A menu will be displayed.

2. Select the family member to be added.


A new column will be displayed for that member.

**Note:** Any columns for additional family members added will not appear the next time  is selected on the Add family History page.


The family member added will appear and remain on the condition list once you add details.

3. Continue entering family history for each additional family member.
4. Click OK.

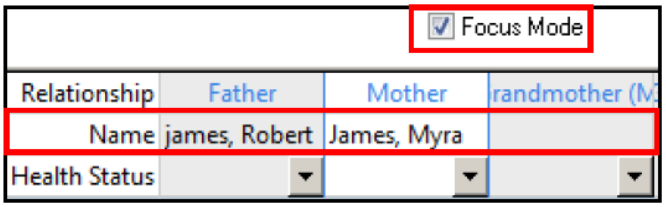
The condition and relevant family member display in list on the Family page.

## Viewing a single family member in focus mode

Focus Mode allows for a specific column to be highlighted for viewing of one family member.

To select Focus Mode:

1. Check the Focus Mode checkbox.
2. Click in the Name field of the family member to focus on.



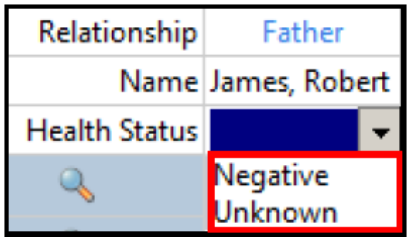

The column selected will be highlighted and the other family member columns will be shaded.

## Adding the family member health status

If the family member's history is unknown, this can be displayed at the top of the column. Health Status applies to the individual family member and is either negative or unknown.

To add the Health Status:

1. Click on the Health Status drop down arrow a list will display.
2. Select the required status.




3. Click OK.

## Adding procedure history

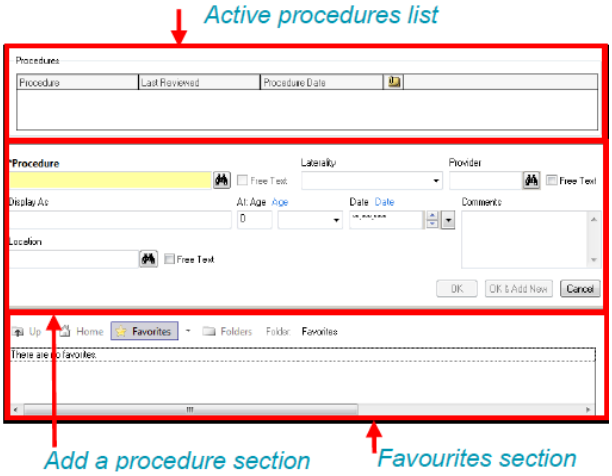
Procedure history allows you to document significant medical or surgical procedures that have occurred during the lifetime of the patient. You can view Procedure history data regardless of the encounter on which the procedure was documented.

**Note: I**f applicable, tick the checkbox to indicate if the family history is negative, unknown, unable to obtain or the patient is adopted.


Procedure history lists can be filtered by All, Active or Inactive.


To add Procedure history for a patient:

1. Click on the Add icon.



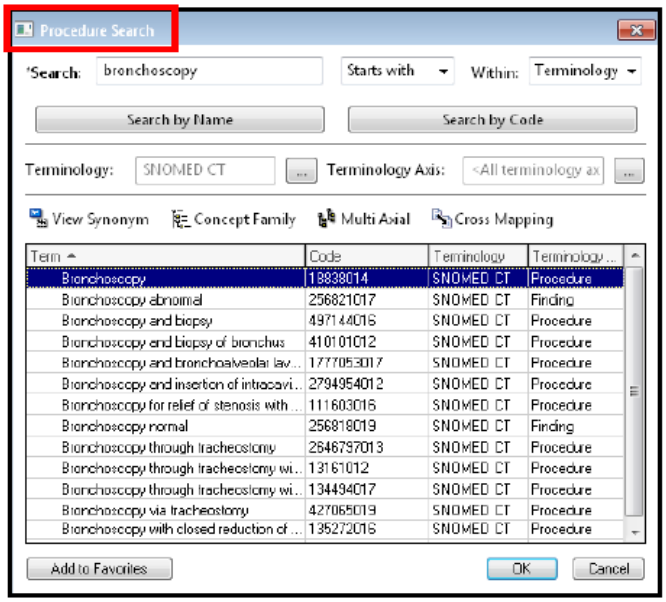
The Procedures page will open.

The Procedures page is divided into three sections:

- Active procedures list.
- Add a procedure pane.
- Favourites.

2. Click the Search icon.

The Procedure Search window will open.




3. Enter the name or code in the Search field.
4. Click Search by name or Search by Code.
5. Select the procedure from the list.

**Note:** When selecting a procedure, it can also be added to Favourites in the bottom section of the Procedure page for easy access when next adding a procedure. Click on Add to Favorites to add procedures into Favourites folders.

6. Click OK.

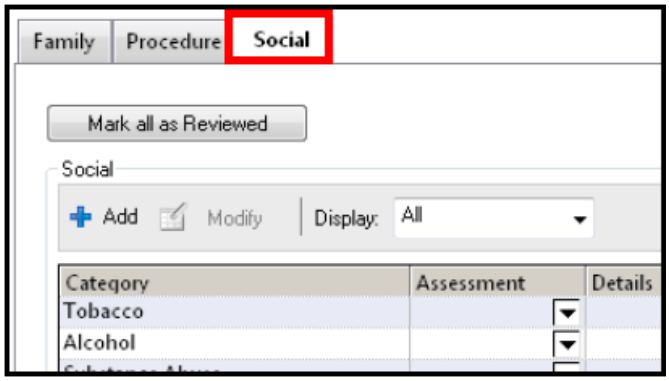

The procedure will appear in the Procedure page.

7. Enter any additional information about the procedure and click OK or OK & Add New if continuing to add procedures.

The details of the procedure will display on the Procedures page.

## Adding social history

Social history stores information about the patient such as alcohol, tobacco, illegal substance abuse, diet, home environment, exercise, and sexual history.



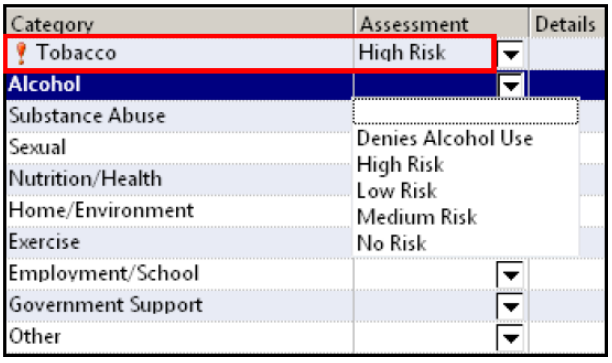

A list of predefined risk assessment values is available for each category.

Assigning an overall risk assessment to a category provides the system with the ability to alert or guide other users to review in detail the areas of social history marked as High Risk.

Social history lists can be filtered by All, Active or Inactive.

To add a risk assessment from the Assessment column:

1. Click on the Assessment drop down arrow.




A menu will display.

2. Select the risk assessment level.

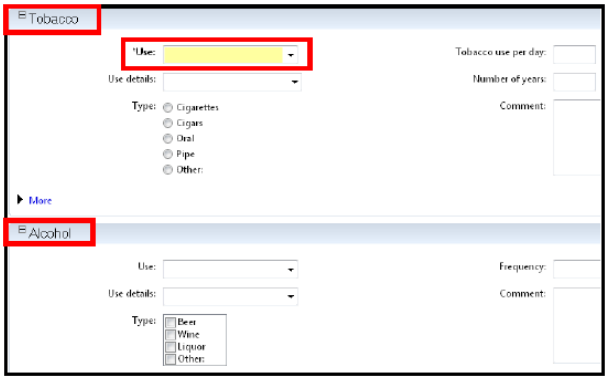
The risk level will display in the assessment column for that category.

**Note:** When a category is marked as High Risk, a red exclamation mark is displayed in front of the category name.

The assessment for that category will display on the Social history page.

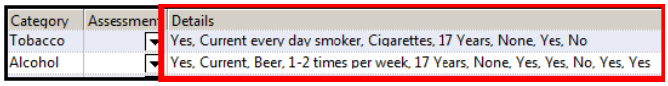
To add information in the Details column:

1. Click on the Add icon.




All categories will display under sub-headings. Any mandatory fields will be highlighted in yellow.

2. Enter the details required for each category.
3. Click OK.




The details will display for each category entered.

**Note:** To add details for an individual category, double click on the category line, enter the details in the fields provided and click OK.