

File and Use the Patient Entered Data History Questionnaire

Once your patient has completed the Patient History Questionnaire via MyChart, pull that information into your Note easily using a system SmartBlock.

1. Open the patient's visit/Encounter.
2. Click the **Rooming** Activity tab.
3. Click **Patient Hx**. If **Patient Hx** is not listed in the table of contents, the patient has not completed the patient history questionnaire.

Medical History	Response	Date	Comments
<input type="checkbox"/> Depression	Yes		
<input type="checkbox"/> Anemia	No		
<input type="checkbox"/> Diabetes mellitus	Yes		
<input type="checkbox"/> Anxiety	Yes		
<input type="checkbox"/> Osteoporosis	Yes		
<input type="checkbox"/> Arthritis	Yes		
<input type="checkbox"/> GERD	No		
<input type="checkbox"/> Seizures	Yes		
<input type="checkbox"/> Asthma	Yes		
<input type="checkbox"/> Sickle cell anemia	Yes		
<input type="checkbox"/> Blood transfusion	No		
<input type="checkbox"/> Heart murmur	No		
<input type="checkbox"/> Stroke	Yes		
<input type="checkbox"/> Cancer	No		
<input type="checkbox"/> HIV/AIDS	No		
<input type="checkbox"/> Substance abuse	No		

4. To save the patient responses to the History section, click the **Select/Clear All** checkbox and then click the **File & Close** button.

Select/Clear All

File & Close

5. Click **History**. The patient-reported history information displays in the alphabetically list or under Other Medical History.

Medical History	Yes	No	Other	Medical History	Yes	No	Other	Medical History	Yes	No	Other
Arthritis	Yes	No		CHF	Yes	No		Hypertension	Yes	No	
Asthma	Yes	No		COPD	Yes	No		Stroke	Yes	No	
Blood transfusion	Yes	No		Coronary artery disease	Yes	No		Thyroid disease	Yes	No	
Cancer	Yes	No		Diabetes mellitus	Yes	No					

Other Medical History

Burn; Depression; Anxiety; Osteoporosis; Seizures (HC Code); Sickle cell anemia (HC Code); Cataract; Hyperlipidemia; Clotting disorder (HC Code); Chronic kidney disease; Peptic ulcer; and 5 Pertinent negatives