

EPR Core and Clinical Documentation Foundation




History & Physical

Quick Reference Guide

This **Quick Reference Guide (QRG)** provides step-by-step instructions on how to complete the **History & Physical**, a structured electronic document used by prescribers to chart the patient's history, admission assessment, and impression and plan. This note will be primarily used by physicians, residents, nurse practitioners, clinical assistants, physician assistants and related students.

The **History & Physical** document is completed on admission. Only one **History and Physical** is required per visit, however there is no limit to how many of the same kind of document can be entered per visit. There are no mandatory fields in this document, and the user decides which sections to complete.


How to Document in a History & Physical

Place the Patient into Context and Open the Document	<ul style="list-style-type: none"> Find the patient using Status Board, Patient List or the Find Patient functionality and place the patient visit into context Click on the Enter Document icon  on the Main Toolbar and select the History & Physical document
Chief Complaint/History of Present Illness	<ul style="list-style-type: none"> Utilize this section to document the Chief Complaint, History of Present Illness and to indicate if a Medication Reconciliation form has been completed
Medical History/Chronic Problems / Surgery History	<ul style="list-style-type: none"> If applicable, check off any existing Health Issues as entered for Medical History, Chronic Problems and Surgical History <ul style="list-style-type: none"> If not already available or updates are required, add and modify Health Issues by clicking the Health Issues Manager icon  and selecting applicable problems
Family Medical History	<ul style="list-style-type: none"> If applicable, check off any existing Health Issues as entered under Family Medical History <ul style="list-style-type: none"> If not already available or updates are required, add and modify Health Issues by clicking the Health Issues Manager Icon  and selecting applicable problems Family Medical History Negative For: Check off any that apply or utilize Additional Information for free text
Social History	<ul style="list-style-type: none"> Click Retrieve Last Charted Values in the lower left-hand corner of the window to check whether any information is available for retrieval. <ul style="list-style-type: none"> If values are returned, review and validate all content. If no information is available, manually enter the data according to your assessment requirements.

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	<p>Note: The Retrieve Last Chart Values button will pull Living Situation, Employment, and Other Social History from as far back as 12 months. Tobacco and Alcohol as far back as 3 months</p>
Allergies	<ul style="list-style-type: none"> • Allergies and Intolerances documented in the patient's chart will appear here and will be automatically selected for inclusion in the note. Uncheck any items you do not want to include. • If not already entered, add Allergies and Intolerances by clicking the Allergy Summary icon 
Review of Systems	<ul style="list-style-type: none"> • Review of Systems is the section to document what the patient <i>reports</i> and is organized by systems <p>Note: The actual physical exam that is performed is documented in a later section, "Physical Exam".</p> <ul style="list-style-type: none"> • For each system, choose from the following: <ul style="list-style-type: none"> ○ Reports/Denies: When selected, other options are displayed for further documentation ○ Not asked ○ See HPI
Vital Signs	<ul style="list-style-type: none"> • Click on Retrieve Last Charted Values in the lower left-hand side of the window <p>Note: The Retrieve Last Charted Values button will pull any Vital Signs recorded in the last 8 hours. Height from the last 6 months and weights from the last 24 hours from this visit only.</p>
Physical Exam	<ul style="list-style-type: none"> • Allows for a detailed examination of different systems
Body Images	<ul style="list-style-type: none"> • Body Images is the section to incorporate various body images into your documentation. To do so: <ul style="list-style-type: none"> ○ Click on the body image you want to draw on ○ Type in any measurements or comments that may apply to the diagram and select OK when you are finished

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<p>Lab Results</p>	<ul style="list-style-type: none"> • Lab – Content: Lists the specific lab results that will automatically populate in the Lab Results section if they are available in EPR • Lab – Results: Allows you to view and select lab results to pull into your document. Only results within the selected range will be available to check off. • Lab Results Comments: This is a free-text field for any additional lab information
<p>Diagnostic Results</p>	<ul style="list-style-type: none"> • Type in any comments you wish to add regarding any Diagnostic Results
<p>Impression and Plan</p>	<ul style="list-style-type: none"> • This section allows a user to identify health issues/problems with their respective assessments and plans. • The Impression field is a free-text box to document the impression of the patient's assessment/problems • If not already available or updates are required to the patient's Current Problems/Surgery Current: <ol style="list-style-type: none"> 1. Add and modify Health Issues by clicking the Health Issues Manager icon  2. Copy the Problem List by selecting one of the radio button selections within the Problem/Assessment/Plan 3. Once problems have been entered, you can prioritize them by moving them up or down your list using the up/down/clear options on the right side 4. Document the assessment and plan for the respective problems
<p>Summary</p>	<ul style="list-style-type: none"> • This section is a free-text field
<p>Attending Provider Comments</p>	<ul style="list-style-type: none"> • For students or residents whose notes require review or approval, this section allows Attending Providers to indicate that the note has been read and reviewed, and to add any additional comments. • Students/Residents should complete the H&P and save it as Incomplete. Attending Providers can then open the document, review and edit as needed, and save it as Final.
<p>Save the History & Physical</p>	<ul style="list-style-type: none"> • Click the Save/Close button <ul style="list-style-type: none"> ○ Click Submit as Final if your note is complete ○ Click Submit as Incomplete for the document to remain modifiable