

Adding Family History to a Patient's Chart

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You can add your patient's family history to their chart. Once entered into the chart, this data is included in the clinical summary with referrals and C-CDA files for the patient.

Note: Family history can also be documented in the clinical note or through OnPatient and the Check-In App. However, that information is not automatically added to the patient's chart. It remains in the note, but that information can be entered into the chart with these steps.

1. To add a patient's family history to their chart and select **Family History**.

The screenshot shows the patient chart for Laurie Sample. The left sidebar contains a list of menu items, with 'Family History' at the bottom highlighted in green. An arrow points from this menu item to a green box labeled 'Family History' in the center of the page. The main content area shows the patient's profile and a table of family members.

Name	Relation	Race	Ethnic Group	Status	
Father Sample	Father			1 observation(s)	Action
Mother Sample	Mother			1 observation(s)	Action
Grandpa Sample	Maternal Grandfather			1 observation(s)	Action

2. Click **Add Family Member**.

This screenshot is identical to the previous one, but with an arrow pointing from a green box labeled '+ Add family member' to the corresponding button in the top right corner of the Family History table.

3. Select the relationship of the family member to the patient.

Add Family Member

×

Relation to patient: Father
 Mother
Name: Daughter
 Son
Family name: Granddaughter
Prefix: Grandson
 Brother
Age: Sister
Deceased age: Half Brother
 Half Sister
Races: Nephew
 Niece
Ethnicities: Maternal Grandfather
 Maternal Grandmother
Gender: Maternal Aunt
 Maternal Uncle
 Maternal Cousin
 Paternal Grandfather
 Paternal Grandmother
 Paternal Uncle
 Paternal Aunt
 Paternal Cousin

4. Enter the rest of the information and **Save**.

Add Family Member

×

Relation to patient:

Name:

Family name:

Prefix: Suffix:


Age: Birth date:

Deceased age:

Races:

Ethnicities:

Gender:



5. Click **+Add Observation** to add a clinical observation to the family member.

Grandma Sample Paternal Grandmother 0 observation(s) Action

- Edit
- + Add Observation
- ? Report health history unknown
- Delete

6. Use the search field to find the condition you need to document.

Add Observation

Clinical observation Search in SNOMED CT collection

Age (optional)

Observation	Age	SnoMED Concept ID
No observations		

Close Save

Add Observation

Clinical observation Search in SNOMED CT collection

Age (optional)

Heart

- Erythrocytosis due to cyanotic congenital heart disease
- Acute heart disease
- Specimen from heart
- Suspended heart syndrome
- Acute left-sided heart failure
- Heart valve disorder
- Heart valve disorder, NOS
- Valvular heart disease, NOS
- Heart valve disease, NOS
- Valvular heart disease

Close

7. Once you have selected the observation, you have the option of entering an age. Click **Save** when finished.

Add Observation

Clinical observation Heart-congenital defect

Age (optional) 53

Observation	Age	SnoMED Concept ID
No observations		

Close Save

8. Select **Edit** under the **Action** menu to edit the family member's information. You can also add additional observations.

Grandma Sample Paternal Grandmother 1 observation(s) Action

- Edit
- + Add Observation
- Delete

Click on the icon (



) next to the family member's name to view, edit or delete existing observations.

Grandma Sample Paternal Grandmother 1 observation(s) Action

Age	Observation	SnoMED Concept ID
53	Heart-congenital defect	156911006

Edit Delete

The data will appear under **Family History** with C-CDA files and referrals.

Family History

Father

Diagnosis	Age At Onset
Benign essential hypertension	None

Mother

Diagnosis	Age At Onset
Latent diabetes	42

Maternal Grandfather

Diagnosis	Age At Onset
Hypertensive heart disease with congestive heart failure	42

Paternal Grandmother

Diagnosis	Age At Onset
Heart-congenital defect	53
